Applicants may apply for Charles County Maryland Housing Opportunities for Persons Living with HIV/AIDS (HOPWA) housing services by completing this application with your primary case manager and submitting a completed application package to:

Housing Counseling Services, Inc.
Metropolitan Housing Access Program (MHAP)
2410 17th Street, N.W., Suite 100
Washington, DC 20009
Tel: 202.667.2681
Fax: 202.667.0862
Email: mhap@housingetc.org

A completed housing application package will consist of the following items

- Completed Charles County Maryland HOPWA Housing Application
- Verification of HIV/AIDS diagnosis of applicant (lab report or physician statement)
- Verification of Charles County Maryland residency
- Documentation of all household income within the last 30 days (if adult household member has no income, he/she must complete and submit a Zero Income Statement)
- Picture ID for all adult (18 years or older) members of household
- Verification of all minor children (younger than 18) in household (Birth Certificate or Social Security card)
- Completed Individual Housing Plan form
- Case manager submitting housing application must sign Page 8

Applicants applying through a community case manager will receive a confirmation of receipt of MHAP Housing application from HCS upon our receipt. Failure to submit all required eligibility documentation with the application will result in the denial of the application. HCS may request additional documentation to verify circumstances presented in the application. HCS may also request that the applicant meet with HCS staff person if it is determined that there are concerns regarding housing stability.

*If you are not receiving case management services you may contact HCS for a referral for case management services.
Section 1: Applicant Information

Date: ___________________________  Unique ID: ___________________________

Applicant’s Name:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle</th>
</tr>
</thead>
</table>

Current Address:

<table>
<thead>
<tr>
<th>Street</th>
<th>Apt. #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Phone Number: ___________________________  ___________________________

<table>
<thead>
<tr>
<th>Home</th>
<th>Alternate</th>
</tr>
</thead>
</table>

EMERGENCY CONTACT (Whom should the program call in case of emergency?)

<table>
<thead>
<tr>
<th>Name:______________________________</th>
<th>Relationship: ___________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:______________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street</th>
<th>Apt</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Phone Number (HM): ___________________________ (WK): ___________________________

Is the emergency contact aware of applicant’s HIV status?  __Yes  __ No
METROPOLITAN HOUSING ACCESS PROGRAM
HOUSING PROGRAM APPLICATION
CHARLES COUNTY MARYLAND

Section 2: Applicant Demographic Information

1. Gender: ___Male      ____Female      ____Transgendered: MtF or FtM (circle)
2. Ethnicity: ___Latino/Hispanic      ___Not Latino/Hispanic
3. Race: (Check only one)

Single Race
___ American Indian/Native American (I)  ___ Asian (A)  ___Black/African American (B)
___ Native Hawaiian or Other Pacific Islander (PI)  ___ White (W)

Or Multi-Race
___ American Indian or Alaska Native and White (IW)  ___ Black/African American and White (BW)
___ Asian and White (AW)  ___ American Indian/Alaska Native & Black /African American (IB)
___ Other Multiple Race (O)

4. Language: Is English applicant’s primary language? ___Yes  ___No  If no, primary language:____

Client’s Acuity Level ______ (must choose from options below)
Level 4=Client is homeless, in immediate danger of homelessness, or unable to live independently
Level 3= Client in transitional housing or unstable housing, at risk for eviction due to financial strain, or needs ongoing financial assistance to maintain current rental unit
Level 2= Client has adequate housing but needs occasional financial assistance to remain stable
Level 1= Client is not in danger of losing housing (but is rent burdened)

5. Current Housing Situation:
___ Renter      ___ Live with Family/Friends      ___ Own      ___ Homeless      ___ Transitional Housing

6. Homelessness Status:
___Recently homeless for less than one year      ___Continuously homeless for 1 year or more
___Four episodes of homelessness within the past 3 years      ___Not applicable/Not Homeless

7. Veteran Status: Is applicant a U.S. Veteran? ___Yes  ___No

8. Family Status (Check all that apply): ___ Single Person Household      ___ Multiple-person Household
___ Children under 18 years      ___Pregnant Household Member      ___Children 6 years and younger
___ Children 6 years or younger regularly visit the home (visits at least 6 hours per week)

9. Current HIV Status: ___ Stage 1 (CD4>500)  ___ Stage 2 (CD4 200-499)  ___ Stage 3 (CD4 <200)

10. Date of Last Contact with Health Care Provider: ________________

11. Do you currently have medical insurance? ___Yes  ___No

12. Employment Training:
Have you participated in an employment training program within the last 12 months? ___Yes  ___No
If yes, did the employment training result in employment? ___Yes  ___No
### HOUSEHOLD COMPOSITION & INCOME INFORMATION

Please complete this section for applicant and any other persons currently living in applicant’s household.

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATION TO APPLICANT</th>
<th>DATE OF BIRTH</th>
<th>RACE*</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>HIV POSITIVE (Y or N)</th>
<th>MONTHLY GROSS INCOME</th>
<th>ANNUAL GROSS INCOME</th>
<th>SOURCES OF INCOME (Work, SSDI, TANF, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Applicant</td>
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<td>5.</td>
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</tbody>
</table>

Please submit additional form to list other household members.

* For race, use abbreviations in parenthesis for responses to Question 3 on Page 3

Is the applicant also head of household?  ____Yes  ____No

If no, who is head of household: ____________________________

Identify all housing programs that household has applied to previously:

___HOPWA Housing  ___Housing Choice Voucher Program (Section 8)  ___Public Housing

___Shelter Plus Care Housing  ___Project Based Housing  ___Senior Housing

___Other: ____________________________

Results/Outcome of housing program application(s):

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Has a member of the household ever been terminated from a federally subsidized housing program?  ____Y  ____N

If yes, please identify housing program and describe the circumstance surrounding the termination.

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________
Provide responses to the questions below. If the applicant’s response is “Yes” to a question, please provide a brief explanation in the “Comments” column.

<table>
<thead>
<tr>
<th>Needs</th>
<th>Response</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the applicant’s household currently in an unstable housing situation or currently homeless?</td>
<td>___Yes ___No</td>
<td></td>
</tr>
<tr>
<td>Does the applicant or a household member have special housing needs (ex. wheelchair accessible, nurse/home health aide, bedridden, nursing facility)?</td>
<td>___Yes ___No</td>
<td></td>
</tr>
<tr>
<td>Does the applicant or a household member have difficulty performing activities of daily living?</td>
<td>___Yes ___No</td>
<td></td>
</tr>
<tr>
<td>Does the applicant have any current mental health diagnosis/concerns or is the applicant currently receiving mental health treatment?</td>
<td>___Yes ___No</td>
<td>(If yes, please identify diagnosis and provide contact information for treatment provider.)</td>
</tr>
<tr>
<td>Is the applicant or a household member currently using (or recently used) an illegal/illicit drug?</td>
<td>___Yes ___No</td>
<td>(If yes, please provide date of last use: ____ )</td>
</tr>
<tr>
<td>Has the applicant or a household member been convicted of criminal charge?</td>
<td>___Yes ___No</td>
<td></td>
</tr>
</tbody>
</table>
| Does the applicant currently receive primary medical/community case management services? | ___Yes ___No | Name of case management agency_____________________
Name of case manager_____________________
Telephone number_____________________

Housing Counseling Services, Inc. – 04/01/14
### Individual Housing Plan (IHP)

#### Name:

#### Address:

#### Unique ID:

#### Telephone:

<table>
<thead>
<tr>
<th>Identified Areas of Need</th>
<th>Goal (s)</th>
<th>Interactions/Activities/Actions</th>
<th>Review/Due Date</th>
<th>Persons responsible for action</th>
<th>Outcome/Linkages</th>
</tr>
</thead>
</table>

Client Signature: ____________________________  
Date: _________________

Case Manager Signature: ____________________________  
Date: _________________

---

Housing Counseling Services, Inc. – 04/01/14
Disclosure Statement

To the best of my knowledge and belief, I certify that the foregoing information is true, complete, and accurate. I understand that if I have provided any false information, this may result in the denial of my financial assistance application.

I understand that Housing Counseling Services, Inc. (HCS) may need to contact individuals and/or agencies (including landlords, mortgage companies, utility companies, employers, government agencies, and medical/support service providers) to acquire information and/or documentation and to verify eligibility for its programs. My signature serves as my consent for HCS to contact individuals, businesses, and/or service provider(s) necessary to document my eligibility and my need.

Also, as a participant in a program funded by the local and federal government, I understand that annual audits will be conducted to verify HCS’ compliance with local and federal regulations. I authorize HCS to allow the review of my personal program file, including all verifications and documentation, by the HCS Organizational Auditor or Funding Agency Compliance Auditor/Monitor. All Auditors/Monitors are prohibited from disclosing any personal client information to any source. This authorization will remain in effect as long as an Organizational Auditor or Compliance Auditor/Monitor determines that the review of client files is necessary to complete federally mandated audits, reviews and report(s).

My consent is subject to revocation in writing by me at any time. This form has been read by me or to me prior to my signing it.

Applicant Name (printed):

Date of Birth: Last four digits of SSN:

Signature: Date:

Witness Signature: Date:
METROPOLITAN HOUSING ACCESS PROGRAM
HOUSING PROGRAM APPLICATION
CHARLES COUNTY MARYLAND

Authorization of Representation/Release of Information

The applicant authorizes that ________________________________ (name of case manager) is permitted to represent the applicant in the process of applying to this housing program and has permission to release and receive information and/or documentation related to all matters concerning the applicant in the process. In addition, the applicant authorizes Housing Counseling Services (HCS) to release information to housing and service providers operating within the HOPWA Housing system. This release may be revoked at any time verbally or in writing.

Client Signature:                                                       Date:

Application Completed By

Application completed by
(Case manager name):_________________________________________________

Organization: __________________________________________________________

Address: __________________________________________________________________

Phone Number:_____________________________________________________________

Case Manager Signature: _________________________________________________

Date:_______________________________________________________________

By signing this application, the case manager confirms that this housing application was completed at the request of the applicant and in the presence of the applicant.

HOPWA Lead-Based Paint Visual Assessment Requirement

At the time of enrollment in a HOPWA funded housing program, federal regulations require that a lead-based paint visual assessment must be performed if the housing to be assisted was constructed before 1978 and at least one of the following conditions are present:

1. A household member is pregnant
2. A household member is 6 years or younger
3. A child 6 years or younger regularly visits the home.

If it is determined that these conditions are present, the unit must pass a lead-based paint visual assessment before the HOPWA Housing Provider will authorize occupancy of the unit.