METROPOLITAN HOUSING ACCESS PROGRAM
HOUSING SERVICES REFERRAL PACKAGE
CHARLES COUNTY, MARYLAND

Housing Referral Information Sheet

Persons living with HIV/AIDS in Charles County, MD who are experiencing homelessness, housing instability, or other housing problems can be referred by their community case manager to Housing Counseling Services' Metropolitan Housing Access Program (MHAP) for assistance. Please complete the MHAP Housing Services Referral Package to provide information regarding the housing issues/barriers the client and their household is experiencing and to confirm the household's eligibility for Charles County, MD's Housing Opportunities for Persons Living with HIV/AIDS (HOPWA) housing services. Please submit this referral package and supporting documentation by fax, email, or mail 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 services referral package will consist of the following items

- Completed Charles County, MD HOPWA Housing Services Referral Package
- Physician's statement confirming HIV diagnosis **and** recent lab report detailing CD4 and viral load counts
- Verification of Charles County, MD residency (lease, utility bill, statement from shelter/transitional housing, notarized statement)
- Documentation of all household income including Public Assistance received within the last 30 days. (if adult household member has no income, he/she must submit a *Zero Income Affidavit*)
- Documentation of all household assets and financial resources (most recent bank, stock, bonds, cds and other financial statements for all accounts. Bank statements must include all activities during that period).
- Picture ID for all adults (18 years or older) members of household
- Verification of all minor children (younger than 18) in household (Birth Certificate or Social Security card)
- Case manager submitting housing services referral package must sign Page 8
- Signed MHAP Homeless Management Information System Release of Information Form (all household members 18 years of age or older must sign this form)

Community case managers will receive a confirmation of receipt of the MHAP Housing Services Referral Package from HCS upon our receipt. HCS may request additional information/documentation to verify circumstances presented in the referral package.

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Section 1: Client Information

Date: _____ **Unique ID: _____**

Client's Name: _____
Last Name First Name Middle

Current Address: _____
Street Apt. #
_____
City State Zip Code

Phone Number: _____ _____
Home Alternate

Email: _____

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

Name:_____ **Relationship**: _____

Address:_____
Street Apt City State Zip

Phone Number (HM): _____ (WK): _____

Email:_____

Is the emergency contact aware of client's HIV status? __Yes __ No

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Section 2: Client 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 your primary language? __Yes __ No If no, primary language: _____

5. Current Housing Situation:

__ Renter ___Live with Family/Friends ___Own ___Hospital/Rehabilitation Center
___Homeless, living on the street or in shelter/transitional housing ___Other_____

6. Homelessness History: (Homeless = living on the street or in a shelter/transitional housing)

a. Total number of <u>months</u> you have been homeless over the past 3 years: _____
b. How many <u>separate instances</u> of homeless have you experienced over the past 3 years?_____
c. If currently homeless, briefly explain the cause of your homelessness:
   _____
   _____
d. If currently homeless, what is the zip code of your last permanent address:_____

7. Is anyone in your household an U.S. military veteran (not including a reservist)?___Yes ___No
If yes, provide the veteran's name(s)_____

8. Family Status (Check <u>all</u> that apply):

__ Single Person Household __ Multiple-person Household __ Children under 18 in household
__ Pregnant Household Member __Household member 6 years or 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

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Section 3: Household Information

HOUSEHOLD COMPOSITION & INCOME INFORMATION

Please complete this section for client and any other persons currently living in client's household.

NAME	RELATION TO CLIENT	DATE OF BIRTH	RACE *	SOCIAL SECURITY NUMBER	HIV POSITIVE (Y or N)	MONTHLY GROSS INCOME	SOURCES OF INCOME (Work, SSDI, TANF, etc.)
1.	Client				Y		
2.							
3.							
4.							
5.							
Please submit additional form to list other household members.						Total	

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

Is the client 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.

_____

_____

_____

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Section 4: Housing and Support Services Needs Assessments

Provide responses to the questions below. If the response is "Yes" to a question, please provide a brief explanation in the "Response" column.

Question	Response	
Briefly describe the reason you are referring this client for housing services.		
Does the client or a household member have special housing needs (ex. wheelchair accessible, nurse/home health aide, bedridden, nursing facility)?	**___Yes ___No**	**If yes, please identify who has a special housing need and explain the special housing need.**
Does the client or a household member have a <u>severe and persistent</u> mental impairment that limits his/her ability to live independently?	**___Yes ___No**	**If yes, please identify diagnosis. Also, please provide copy of psychiatric evaluation if available.**
Is the client or a household member currently using (or recently used) an illegal/illicit drug?	**___Yes ___No**	**If yes, please provide date of last use and name of drug.**
Has the client or a household member been convicted of a felony)?	**___Yes ___No**	**If yes, please provide date of conviction and felony type.**

HOUSING COUNSELING SERVICES

Section 5: Disclosures and Authorizations

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 housing services. 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 verify eligibility for its programs and to maintain contact with me. 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.

I also understand that information I provide during this referral process may be entered into the Homeless Management Information System (HMIS). HMIS allows homeless prevention service providers to coordinate serve delivery to at risk households in the region as well as track and report on individual, local, and regional service utilization and trends. I understand that MHAP staff may need to speak with me to collect additional information about my household for entry into HMIS. I understand that failure to provide information requested by HCS for HMIS may be grounds for the denial of housing services.

Further, 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

Client Signature: Date:	Witness: Date:

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Authorization of Representation/Release of Information
The client authorizes that _____ (name of case manager) is permitted to represent the client in the process of submitting this referral for housing services to HCS and has permission to release information and receive information related to all matters concerning this referral process. In addition, I authorize 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:

Referral Completed By
Referral completed by (Case manager name):_____
Organization: _____
Address: _____
Phone Number:_____
Case Manager Signature: _____
Date:_____
By signing, the case manager confirms that this referral package was completed at the request of and in the presence of the above named client.