CENTER HOUSE – SHELTER PLUS CARE APPLICATION

Center House in Asbury Park provides quality, affordable and supportive housing for homeless individuals living with HIV. Our primary goal is to provide a supportive housing environment where residents can achieve needed residential stability and live with dignity, respect, and a sense of home.

The Center in Asbury Park will make the final determination of residency.

The following supporting documents are required for application and Center House residency. Please attach supporting documents to a completed and signed application. This information is needed in order to best serve a resident with a comprehensive service contract and not necessarily to use as a means of denying an application.

- Social Security Card *(copy) Originals presented at Section 8 Interview*.
- Birth Certificate *(copy) Originals presented at Section 8 Interview.*
- Award letter from SSI, SSD, VA, GA *(if applicable)*
- Banking statements, most recent *(if applicable)*
- Medicaid Card *(copy*
- GA / Food Stamp Card *(copy)*
- Form PA-4 (Medical verification)
- Verification of PPD placement & reading within the last 12 months. If PPD positive, please attach verification of most recent chest x-ray.
- Verification of corrections history and outstanding warrants.
- A current Mental Health Evaluation (Psych Evaluation) is required for all applicants.
- Applicants who are currently attending or have previously attended an IOP, partial care Day Program, or long term in-patient substance use treatment program must provide psycho –social assessment and treatment plan from those programs.
- Applicants who have had suicidal ideation or attempted suicide must provide documentation of intervention and treatment plan.

Please submit all applications to:
Robert Kaeding
Executive Director
The Center in Asbury Park
806 Third Avenue
Asbury Park, NJ 07712

ELIBILITY REQUIREMENTS

Individuals (single adults) applying for residency at Center House are required to meet the following ***qualifying criteria***:

1. Homelessness as defined by the U.S. Department of Housing and Urban Development.

2. Income eligibility for Section 8 Voucher based upon a designated percentage of Monmouth County Median Income.

3. Living with HIV / AIDS and disabled as defined by U.S. Department of Housing and Urban Development.

SUBSTANCE USE ASSESSMENT POLICY

- Center House is not an inpatient substance use rehab nor is it an outpatient substance use treatment program. Applicants in recovery from substance use or alcohol abuse are requested to document a minimum of 6 months sobriety with an appropriate recovery support system.

- Upon assessment, all applicants must agree to random drug screening.

- Upon assessment, an admission of illegal drug use or testing positive for illegal drug use will result in ineligibility for residency at Center House. (Completion of an outpatient or inpatient substance use treatment program will be required for reconsideration for residency at Center House)

HIV DIAGNOSIS AND TB SCREENING

Has applicant been diagnosed with HIV/AIDS? □Yes □ No

(attach document form PA-4)

Where does client receive HIV care?_____

Primary HIV Care Provider_____Phone_____

Has applicant been screened for TB within the last 12 months? □Yes □ No

(If yes, please attach verification of PPD placement & reading. If PPD positive, attach verification of most recent chest x-ray.)

CORRECTIONS HISTORY

Has applicant ever been incarcerated in New Jersey or any other state?
(If yes, please attach verifying documents)_____

_____

Has applicant had an illegal drug conviction(s) in New Jersey or any other state?

□Yes □ No

(If yes, please attach verifying documents)_____

Does applicant have an outstanding warrant(s)?

□Yes □ No

(If yes, please attach verifying documents)_____

Is applicant currently on probation or parole? □Yes □ No

(If yes, please list name and phone of Probation Officer)_____

SUBSTANCE USE / ABUSE HISTORY

Does applicant have a history of substance use / abuse? □Yes
If yes, is applicant currently in treatment? □Yes □ No

If yes, provide name of IOP(s) and name and phone of case manager(s):

_____

(Attach IOP psycho –social assessment and treatment plan)

Has applicant graduated from IOP or long term treatment? □Yes □ No

If yes, provide name of IOP(s) and name and phone of case manager(s):

_____

(Attach IOP psycho –social assessment and treatment plan)

MENTAL HEALTH

Does applicant have a history of mental illness? □Yes □ No

Diagnosis_____

(Provide current psych evaluation and treatment plan)

Is applicant currently a participant in a partial care Day Program? □Yes □ No

If yes, provide name of IOP(s) and name and phone of case manager:

_____

(If yes, provide psycho –social assessment and treatment plan)

Has there ever been any reported suicidal ideation or attempts □Yes □ No

(*If yes, provide documentation of intervention and treatment plan*)

APPLICANTS

Before you sign this application please read the statements below. If you do not understand or have any questions, please ask the agency representative assisting you.

I agree that the statements that I have made on this form are true and complete to the best of my knowledge. I know that lying about my situation, failing to give necessary information or causing others to hold back information is against the law and may subject me to prosecution.

I understand that any information I give is subject to verification by the Center House.
I authorize Center House to contact any individual or other source that may have knowledge of my situation in order that information on this application may be verified.

I agree to let Center House know immediately of any change in my living conditions, family situation or money received from any source.

I understand that I will not be discriminated against because of race, age, color, creed, national origin, sex, marital status, handicap, gender expression or political belief.

I understand that the members of the Shelter Plus Care Committee will review my circumstances to determine if qualifying criteria are met. The members of this committee include representatives from the following agencies: Monmouth County Division of Social Services; Visiting Nurse Association of Central Jersey; Jersey Shore University Medical Center's A-Team; MCPHA; W. Canright House; The Center in Asbury Park and others as may be determined appropriate. The Center in Asbury Park & its agents will make final determination and continue to review my circumstances as needed.

I, _____ attest that I have read and agree to these statements. I fully realize that Center House relies upon the truth and accuracy of my statements.

I certify under penalty of perjury that my answers regarding this application are correct and complete. I further understand that the law provides for fine or imprisonment or both for a person hiding facts or not telling the truth.

_____ _____

Applicant Signature
Date

_____ _____

Agency Representative, Title Date

Monmouth County Public Housing Agency

SHELTER PLUS CARE CHECKLIST

Client Name:_____ Project:_____

The purpose of this checklist is to assist you in completing an Application for Shelter Plus Care. Please submit this page with the application.

☐ Sections 1-8 of the Application are filled out completely.

☐ The Applicant (and co-Applicant, if any) has signed the Applicant Certification. (Following Section 8)

☐ Attachment A (Disability Verification) is completely filled out with ONE option checked and is signed by a person with the proper credentials.

☐ Attachment B (Homelessness Verification) is completely filled out with ONE option checked and is signed by the Case Manager.

☐ Attachment C (Chronic Homelessness Verification) is completely filled out to indicate whether or not the applicant fits the definition of "chronically homeless".

☐ Documentation of the Applicant's chronic homelessness is attached, if needed (*see Attachment C* for the definition of chronic homelessness).

☐ Complete documentation of the applicant's homelessness is attached (*see Attachment D* for required documentation).

☐ A copy of the Applicant's documentation of legal non-citizen status is attached, if applicable.

☐ Copy of Birth Certificate and Social Security Card for each family member.

☐ Other: _____

Public Housing Agency

SHELTER PLUS CARE APPLICATION

Project:_____

SECTION 1. APPLICANT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Current Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Date: _____

SECTION 2. REFERRING CASE MANAGER INFORMATION

Case Manager Name:_____ Agency:_____

Address:_____

Office Phone: (_____) _____Fax: (_____) _____

Alt. Phone: (_____) _____ Email: _____

SECTION 3. EMERGENCY CONTACT INFORMATION

Name:_____Relationship:_____

Address: _____Apt. #:_____

City: _____ State: _____ Zip:_____

Phone: (_____)_____ Other Contact Info: _____

SECTION 4. APPLICANT'S HOUSEHOLD COMPOSITION

In the space below, please give the requested information about the Applicant and any other people who will live with the Applicant in the assisted household (spouse, children, significant other, etc.).

Include any children not currently in the Applicant's custody but for whom the Applicant expects to receive custody after obtaining permanent housing. Please do not list anyone currently living with the Applicant who will not live in the Shelter Plus Care assisted household.

Household Members Full Name	Race Code(s)	Hispanic? Yes or No	Relationship to Applicant (spouse, mother, son, etc.)	Marital Status (single, married, divorced, separated)	Gender M or F	Disability Code(s)	Date of Birth	Social Security Number
(Applicant Name)			**Self**					

RACE CODES		DISABILITY CODES	
A.	American Indian/Alaska Native	A.	Serious mental illness
B.	Asian	B	Alcohol abuse
C	Black/African-American	C.	Drug abuse
D.	Native Hawaiian/Other Pacific Islander	D.	Developmental disability/mental retardation
E.	White	E.	Dual diagnosis (mental illness with substance abuse)
F.	Multi-Racial (if multi-racial, please also enter codes A-E to specify)	F.	HIV/AIDS and related disease

Citizenship :U.S. Citizen ☐ Non-Citizen ☐

NOTE: Non-citizens must provide federally-issued documentation of their legal status as an immigrant.

What is the Applicant's primary language?

If English is not the Applicant's primary language, can the Applicant speak limited English? Yes ☐ No ☐

Does the Applicant have picture ID? Yes ☐ No ☐

SECTION 5. INCOME INFORMATION

Please answer each of the following questions. For each "Yes" answer, give details in the Comments section that follows.

1. Is any member of your household employed, full-time, part time or seasonally? ..... Yes ☐ No ☐
2. Does any member of your household expect to work for any period during the next 12 months?..... Yes ☐ No ☐
3. Does any member of your household work for someone who pays them cash?..... Yes ☐ No ☐
4. Is any member of your household on leave of absence from work due to layoff, medical, maternity, military leave? ..... Yes ☐ No ☐
5. Does any member of your household now receive, or expect to receive unemployment? ..... Yes ☐ No ☐
6. Does any member of your household now receive or expect to receive child support? ..... Yes ☐ No ☐
7. Is any member of your household entitled to child support that he/she is not now receiving? ..... Yes ☐ No ☐
8. Does any member of your household now receive or expect to receive alimony? ..... Yes ☐ No ☐
9. Is any member of your household entitled to alimony that he/she is not now receiving? ..... Yes ☐ No ☐
10. Does any member of your household receive or expect to receive welfare, such as TANF or GA?..... Yes ☐ No ☐
11. Does any member of your household receive or expect to receive Social Security? ..... Yes ☐ No ☐
12. Does any member of your household receive or expect to receive income from a pension or annuity? .. Yes ☐ No ☐
13. Does any member of your household receive cash contributions from individuals/agencies not living in the unit? ..... Yes ☐ No ☐

COMMENTS:

For each type of income that the Applicant or anyone who lives with the Applicant receives, please give the source of the income and the amount of the income that can be expected from the source during the next 12 months.

Household Member Name	Source or Type of Cash Income (employment, SSDI, TANF, etc.)	Monthly Amount	Non-Cash Benefits (such as food stamps)	Monthly Amount

COMMENTS:

SECTION 6. ASSETS INFORMATION

Please list all checking, savings, and investment accounts below for all persons that will be living in your household.

Household Member Name	Bank Name	Account Number	Type of Account (checking, savings, investment)	Current Balance

List the value of all stocks, bonds, trusts, pension contributions or other assets: _____

Have you sold or given away any real property or assets in the past two (2) years? Yes ☐ No ☐

If yes, what is the current market value of the asset?

SECTION 7. ZERO INCOME

If the Applicant *has* income, please check this box ☐ and skip Section 7

If the Applicant has *no* income, please fill out Section 7, below.

APPLICANT: If you have no income, please read the statement below, then print your name, sign your name, and fill in the date. *Please be aware that falsification of this statement is grounds for denial or termination of housing assistance.*

To the best of my knowledge and belief, I have no income at the time of making this application.

_____ _____ _____
(Print Applicant Name) *(Sign Applicant Name)* *(Date)*

CASE MANAGER: If the Applicant has no income, please read the statement below, then print your name, sign your name, and fill in the date.

To the best of my knowledge and belief, _____ (print applicant name) has no income at the time of making this application.

_____
(Print Case Manager Name) *(Sign Case Manager Name)* *(Date)*

SECTION 8. EXPENSES

Do you pay childcare, which enables you or another household member to work or go to school? Yes ☐ No ☐
If "Yes", give name and address of the childcare provider, weekly cost and name of household member working/in school:

Provider Name & Address: _____

Name of household member: _____ Weekly Cost: _____

Do you pay for a care attendant or for any equipment for the disabled member(s) of the household necessary to permit that person or someone else in the household to work? Yes ☐ No ☐

List household members who receive Medicaid or Medicare: _____

Do you owe money on back rent? Yes ☐ No ☐ If "Yes", amount: $ _____

Do you owe money on past utility bills? Yes ☐ No ☐ If "Yes", amount: $ _____

Ever been placed in a shelter? ☐ Yes or ☐ No Shelter Name/Date: _____

Ever denied by any shelter? ☐ Yes or ☐ No If yes, why?_____

Does client have an eviction notice? ☐ Yes or ☐ No Warrant of Removal? ☐ Yes or ☐ No If Yes, date?_____

Has client ever had a rent subsidy? ☐ Yes or ☐ No from whom? _____

Has client ever lost a rent subsidy? ☐ Yes or ☐ No from whom? _____

Reason(s)_____

Any outstanding unpaid ills? ☐ Yes or ☐ No If yes, explain: _____

Education (Highest Grade) _____ Work History _____

Any drug Convictions (Since Aug1996)? ☐ Yes or ☐ No If Yes explain_____

Are you under lifetime registration under any state sex offender law? ☐ Yes or ☐ No What State? _____

To your knowledge are there any outstanding warrants? ☐ Yes or ☐ No If Yes explain_____

Where does client receive medical treatment? _____

APPLICANT CERTIFICATION

I/we certify that all information given on this application is accurate and complete to the best of my/our knowledge and belief. I/We also understand that making false statements or providing false information is grounds for denial or termination of rental assistance.

Signature of Applicant_____ Date: _____

Signature of Co-Applicant: _____ Date: _____

ADITIONAL INFORMATION RELATED TO ESTABLISHING THE APPLICANT'S HOMELESSNESS

Please use this space if needed to supply more information that may be needed to determine the applicant's eligibility.

Shelter + Care Verification of Disability

_____

(***Name of Individual Claiming Disability***)

The above-named person is applying for participation in a federally-assisted housing program. To determine the applicant's eligibility, we must verify that he/she is disabled as defined by the U.S. Department of Housing and Urban Development (HUD). HUD regulations define disability as follows:

A. A person with a physical, mental, or emotional impairment that:
1. Is expected to be of long continued and indefinite duration;
2. Substantially impedes his or her ability to live independently; **and**
3. Is of such a nature that such ability could be improved by more suitable housing conditions

OR

B. A severe, chronic developmental disability which:
1. Is attributable to mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the person attains age twenty-two;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity:
   (i) Self-care, receptive and expressive language,
   (ii) Learning,
   (iii) Mobility,
   (iv) Self-direction,
   (v) Capacity for independent living, and
   (vi) Economic self-sufficiency; and
5. Reflects the person's need for a combination of and sequence of special, interdisciplinary, or generic care, a treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

CERTIFICATION OF DISABILITY

I certify that the above referenced person is disabled according to the above definition(s) I have indicated.
(Please check the definition(s) that applies) ☐ **A**; or ☐ **B**; and describe your patient's condition:

☐ Substance Abuse ☐ Mental Health ☐ HIV/AIDS ☐ Other: _____

_____

_____

_____

_____

_____

_____

Physician's or Licensed Professional's Name: _____

Address: _____

License Number: _____ Telephone Number: _____

Signature: _____ Date of Signature: _____

ATTACHMENT B VERIFICATION OF HOMELESSNESS

PURPOSE: This form should be used to describe the Applicant's homelessness situation on or about the day that this application is signed by the Applicant. If none of the choices below apply to the Applicant, then that person is not currently eligible for Shelter Plus Care assistance.

Please be sure to attach the documentation described for each choice. Failure to send the required documentation will significantly delay processing.

The Applicant is homeless as defined by HUD because he or she (CHOOSE ONE):

☐ Lives in places not meant for human habitation, such as a cars, abandoned buildings, parks, sidewalks, etc. ("on the street").
☐ *Documentation attached:* letter from an outreach worker or other homeless services worker able to verify the applicant's street homelessness; or a letter describing the Applicant's street homelessness signed and dated by the Applicant.

☐ Lives in an emergency shelter.
☐ *Documentation attached:* letter from the shelter(s) in question verifying the dates the applicant has been residing at the shelter.

☐ Lives in transitional or housing for homeless persons whose prior housing was emergency shelters or places not meant for human habitation.
☐ *Documentation attached:* letter from the transitional housing facility in question verifying the applicant has been residing in the transitional housing; **AND**

☐ *Documentation attached:* letter from outreach worker or other homeless services worker able to verify the applicant's street homelessness; or a signed dated letter from applicant's case manager attesting to the client's street homelessness prior to transitional housing.

☐ Is currently spending thirty consecutive days or less in a hospital, in-patient treatment program, jail, or other institution but prior to the institution lived in an unsheltered setting or emergency shelter.
☐ *Documentation attached:* signed and dated verification from the institution staff that the applicant has been residing there for thirty days or less; **AND**

☐ *Documentation attached:* letter from the shelter(s) in question verifying the applicant was residing at the shelter(s) prior to going to the institution; **OR**
☐ *Documentation attached:* letter from outreach worker or other homeless services worker able to verify the applicant's street homelessness; or a signed dated letter from applicant's case manager attesting to the client's street homelessness prior to being in the institution.

How long did the Applicant stay in the situation checked above prior to the date of this application?

- ☐ One week or less
- ☐ More than one week but less than one month
- ☐ One-three months
- ☐ More than three months but less than one year
- ☐ One year or more
- ☐ Don't know
- ☐ Refuse to answer

What was the Applicant's last permanent address? (where they last owned a home, paid rent or had a stable family situation)

Street address: _____

City: _____ Zip Code:_____

Don't Know ☐ Refused to Answer ☐

_____

(Print Name of Case Manager) *(Signature of Case Manager)*

_____

(Name of Referring Agency) *(Date)*

ATTACHMENT C VERIFICATION OF CHRONIC HOMELESSNESS

PURPOSE: "Chronic homelessness" is the term HUD applies to single individuals who are disabled and who experience long-term and/or frequent episodes of homelessness. Several DMH Shelter Plus Care grants are reserved only for people who fit this definition. *Please fill this form out whether or not the Applicant fits the definition of chronically homeless.*

In order to be designated as chronically homeless, a person must meet all three of the conditions shown below. Please indicate whether the applicant meets each condition by checking the appropriate box.

1. The applicant is an unaccompanied homeless individual who is not part of a homeless family and is not accompanied by a child or children, a spouse, or any companion.

Yes ☐ No ☐

2. The applicant has a disabling condition defined as a diagnosable alcohol or drug abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions.

Yes ☐ No ☐

3a. The applicant has been continuously homeless for a year or more living on the streets and/or in an emergency homeless shelter.

Yes ☐ No ☐

OR

3b. The applicant has had at least four episodes of homelessness in the past three years that are distinct and sustained stays on the streets and/or in emergency shelters where the applicant was unaccompanied and disabled during each episode.

Yes ☐ No ☐

Use the area below, if needed, to provide further details regarding the applicant's status as chronically homeless:

_____

_____

_____

_____

_____

_____

_____

_____

(Print Name of Case Manager) (Signature of Case Manager)

_____

(Name of Referring Agency) (Date)

Attachment D Shelter + Care Homelessness History

Instructions: This Homelessness History provides a suggested timeline to be used by Shelter + Care programs targeted to chronically homeless persons. It may be used to analyze whether or not the chronology of the homeless person's history meets the time frame for the definition of chronic homelessness.

Client Name:_____

Time Period (For each homeless instance)	Living Arrangement Shelter, Motel etc. (Town/State)	Documented?
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO

New Jersey Department of Health and Senior Services

PHYSICIAN CERTIFICATION

Name (Last, First)	Sex ☐ Male ☐ Female	Medicaid No.
Home Street Address		Telephone Number
City, State, Zip Code		Veteran Status ☐ Yes ☐ No
Date of Birth	Social Security Number	Medicare Number
Primary Contact Name		Primary Contact Telephone No.

MEDICAL AND CARE NEEDS – TO BE COMPLETED BY PHYSICIAN

1. Diagnosis(es): _____

2. Medications: _____

3. Treatment/Therapies/Surgeries: _____

4. Does patient have any physical limitations? ☐ Yes ☐ No If Yes, describe:

   Please describe any related care needs:

5. Does patient have any emotional or behavioral problems? ☐ Yes ☐ No If Yes, describe:

   Is counseling or support required? ☐ Yes ☐ No If Yes, explain:

6. Does patient require treatment for active tuberculosis? ☐ Yes ☐ No

7. Does patient require treatment for any mental illness? ☐ Yes ☐ No

8. Does patient have symptoms or a diagnosis of mental retardation or a developmental disability? ☐ Yes ☐ No

9. Is there a reasonable indication that patient might need hospital or nursing home care within 30 days without home and community-based services? ☐ Yes ☐ No

I certify to the above-named individual's diagnosis and related care needs.

Name of Physician (Print)	Signature	Date
Address		Telephone Number

PA-4
MAY 09