

HOMEWORKS OF LONG ISLAND HOUSING APPLICATION

1-800-449-2088

(631) 716-0008

FAX (631) 716-0039

INSTRUCTIONS

- Please **PRINT** clearly, complete application and submit with any additional information as needed.
- Please be advised that completing the application as fully as possible will help expedite your application.
- May include: Psychosocial, physical exam, proof of HIV/AIDS, psychiatric assessment, proof of income, proof of homelessness.
- If a question does not pertain to you, write “not applicable”.
- An Authorization for Release of Confidential HIV Related Information (NYSDOH #2557) must also be included if applicable

Concurrent referrals are being made to the following agencies:

Self-Referral? Yes No – If no, then complete below:

Referring Agency Name: _____ **Phone #:** _____

Address (street, city, state and zip) _____

Referring Worker Name: _____

Referring Worker Signature: _____ **Date:** _____

Section A: Identifying Information

Applicant Name: _____ **Date of Birth:** _____ **Age:** _____

Social Security #: _____ **Gender:** Male Female **Marital Status:** _____

Ethnicity (check one)

Hispanic/Latino/a

Non-Hispanic/Latino/a

Race: (check one) For statistical purposes only.

White Black or African American Asian More than one race

American Indian or Alaskan Native Native Hawaiian or Pacific Islander

Address: _____
Street **City** **State** **Zip**

Phone: () _____

Emergency Contact Name: _____ **Phone #:** () _____

Address: _____

Case Manager Name: _____ **Phone #:** () _____

Address: _____

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Current Medications: _____

Recent Medical or Psychiatric Hospitalizations: (Within the past 3 years)

<u>Dates</u>	<u>Reason</u>
_____	_____
_____	_____
_____	_____

Treating Physician's Name: _____ **Phone #:** _____

Address: _____

Physical Functioning Level: (Check all that apply)

- Bedridden Amputee Blind Deaf Wheelchair
 Cannot Bathe/
Dress Self Cannot Feed Self Cannot Climb Stairs Incontinent
 Needs Help with Toileting Needs Help Taking Medications

Does the applicant/family have a medical condition that requires special services? Yes No

If Yes, Indicate services:

- Special Medical Equipment Medical Supplies Nursing Services
 Home Care Injectable Medication Other: _____

Section D: Psychiatric Information (If applicable)

Current Psychiatric Diagnosis: _____

Current Psychotropic Medications: _____

Treating Physician Name: _____

Phone #: () _____

Address: _____

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Does applicant/family have a history of any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Homicidal Ideas/Attempts | <input type="checkbox"/> Disruptive Behavior | <input type="checkbox"/> Assaultiveness |
| <input type="checkbox"/> Delusions | <input type="checkbox"/> Severe Depression | <input type="checkbox"/> Sexual Acting Out |
| <input type="checkbox"/> Suicidal Ideas/Attempts | <input type="checkbox"/> Compulsive Behaviors | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Criminal Arrests/Convictions | <input type="checkbox"/> Arson/Fire Setting | <input type="checkbox"/> Inappropriate Touching |
| <input type="checkbox"/> Substance/Alcohol Abuse | <input type="checkbox"/> Psychiatric Hospitalizations | |

Please explain all checked items and indicate whether or not it is a current problem:

Does applicant have history of alcohol/substance abuse? Yes No

List Substance(s): _____

Frequency of use: Daily Once Weekly Several Times a Week
 Other: _____

Last Alcohol Use: _____
Last Drug Use: _____

Does applicant have a history of alcohol/substance abuse treatment? Yes No

If so, where?

<i>Treatment Facility</i>	<i>Dates Attended</i>	<i>Program Completed?</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Citizenship of Applicant: USA Other **Is Applicant a Veteran?** Yes No

Household Members: (List all Children)	First Name	Last Name	DOB	Gender	Residing in Household? Y/N
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Household Members Special Conditions: _____

List Entitlements currently receiving or pending: (List ALL family income for persons residing in household.)

Benefit	Monthly Amount	ID# or "Pending"
<input type="checkbox"/> Social Security		
<input type="checkbox"/> Supplemental Security Income (SSI)		
<input type="checkbox"/> Social Security Disability (SSD)		
<input type="checkbox"/> PA/ E5 Enhancement		
<input type="checkbox"/> Veteran's Benefits		
<input type="checkbox"/> Medicaid		
<input type="checkbox"/> Medicare		
<input type="checkbox"/> Food Stamps		
<input type="checkbox"/> Pension		
<input type="checkbox"/> Wages		
<input type="checkbox"/> Worker's Compensation		
<input type="checkbox"/> Unemployment		
<input type="checkbox"/> Other		

Does Applicant have a Representative Payee? No Yes -- If Yes:

Name: _____ Phone#: () _____

Does Applicant have an Overpayment? No Yes -- If Yes, Please Explain: _____

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Section B: Housing/Employment

Applicant Housing Preference: Type/Model _____

Is Applicant currently homeless: Yes No Have you ever been evicted? Yes No

Please list where applicant has resided for the past five years:

Dates	Type of Housing	Reason for Leaving
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has applicant been employed during the last five years: Yes No

Does applicant want employment: Yes No

Does applicant want educational/vocational training: Yes No

Education/Training History:

- Special Education
- Some High School
- High School Diploma
- GED
- Some College
- College Degree
- Master's Degree or higher
- Vocational Training/Trade: _____

Indicate all support services needed once applicant/family is housed:

- Healthcare
- Educational Prog.
- MICA Day Prog.
- MI/MR
- Psychiatric Prog.
- Therapy
- Alcohol/Drug Tx
- Vocational Prog.
- Case Mgt.
- Probation/Parole

Section C: Medical Information—ONLY IF APPLICABLE

In order to disclose HIV information, the applicant must sign the special release form found at the end of this application. Attach additional sheets if necessary.

Medical Diagnosis: _____

Symptomatic: _____

Asymptomatic: _____

AIDS: _____

Allergies: _____

Last T-cell Count: _____ Last Viral Load _____

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Section E. Legal History

Does Applicant have a criminal record/history? No Yes -- If Yes:

Is applicant supervised by: Probation Parole TASC

Other _____

Name of supervising officer: _____

Telephone number (include direct extension or line): _____

Please give brief explanation of criminal history (i.e., reason for arrests/convictions, length and location of incarceration, if applicable): _____

As an applicant for housing, please tell us anything else about yourself you feel we should know:

I agree with this referral and declare that the statements contained in this application are true and correct and that I have not willfully or knowingly made a false statement, given false information or omitted information in connection with this application. I also understand that I may be required to submit verification and/or proof to support any or all claims I have made.

Signature

Date

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HOMELESS STATUS CERTIFICATION

I, _____, certify and acknowledge that I meet one of the following
(Name)

criteria for being considered Homeless*. *Please circle one.*

- a. I reside in a place not meant for human habitation, such as cars, parks, sidewalks, and/or abandoned buildings;
- b. I reside in an emergency shelter;
- c. I reside in a transitional or supportive housing for homeless persons and I originally came from the streets or emergency shelters;
- d. I reside in any of the above places but I am spending a short time (up to 30 consecutive days) in a hospital or other institution;
- e. I am being evicted within a week from a private dwelling unit and no subsequent residence has been identified and I lack the resources and support networks needed to obtain housing;
or
- f. I am being discharged within a week from an institution in which I have been a resident for more than 30 consecutive days and no subsequent residence has been identified and I lack the resources and support networks needed to obtain housing.
- g. I am fleeing domestic violence and no subsequent residence has been identified and I lack the resources and support networks needed to obtain housing.

**as defined by the Office of Housing and Urban Development*

Applicant's Signature

Applicant SSN/Other Identification

Date

Witness Signature

Title

Date

Name of Agency

Address

City, State, Zip