Transitional Housing (TH) Application – Posada Youth

SECTION 1. Applicant Information

Applicant Name:

First:_____**Middle**_____**Last:**_____

Social Security Number:_____-_____- _____

Date of Birth: _____/_____/ _____

SECTION 2. Case Manager Contact

Case Manager:_____

Agency:_____

Office Phone: (_____) _____

Cell Phone: (_____)_____

Email: _____

SECTION 3. Emergency Contact

Name:_____**Relationship:** _____

Address:_____Apt. #: _____

City:_____

State:_____ Zip: _____

Phone: (_____)_____
Cell: (_____) _____

Referral - For Posada Use Only

Referral Agency Name:_____**Contact Person:** _____

Address:_____

City:_____

State:_____ Zip: _____

Phone: (_____)_____
Cell: (_____) _____

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SECTION 4. APPLICANT'S INFORMATION

Applicant Name: _____

☐ U.S citizen ☐ Eligible non-citizen

Applicant's Primary Language:

_____

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

Country of origin if not U.S.: _____

Race:
☐ American Indian/Alaska Native
☐ American Indian/Alaska Native & Black or African American
☐ American Indian/Alaska Native & White
☐ Asian
☐ Asian & White
☐ Black/African American
☐ Black/African American & White
☐ Native Hawaiian/Other Pacific Islander
☐ White
☐ Other Multi-Racial

Ethnicity:
☐ Hispanic ☐ Non-Hispanic

Gender:
☐ Male ☐ Transgender, male to female
☐ Female ☐ Transgender, female to male

Marital Status:
☐ single ☐ separated
☐ married ☐ divorced
☐ widowed ☐ same-sex couple

Are you pregnant? ☐Yes ☐ No No.of months: ____
Delivery date:_____/_____/ _____

Temporary Address/Location:
Where do you currently live? Provide at least a city and zip code.
Street address_____Apt. _____

City_____State _____

Zip Code_____Phone_____

Last Permanent Address/Location:
Where did you last live for at least 90 days where you paid rent or had a mortgage? Provide at least a city and zip code.
Street address_____Apt. _____

City_____State_____Zip Code _____

1. **Where did you spend the night before filling out this application?**

☐ Emergency shelter (includes a motel or hotel room paid for by an emergency shelter voucher; and a respite bed)
☐ Transitional housing program
☐ A place not meant for human habitation (car, park, etc.)
☐ Jail, prison or juvenile detention center
☐ Substance abuse treatment facility/detox center
☐ Safe Haven
☐ Hospital (non-psychiatric)
☐ Psychiatric hospital or similar facility
☐ Other

2. **How long did you stay in the above situation?**
☐ One week or less ☐ 1-2 years
☐ More than one week ☐ 2-4 years
☐ 1-3 months ☐ Four or more years
☐ 4-6 months ☐ Don't know
☐ 7-12 months

3. **Do you have health insurance? Check all that apply.**
☐ Medicare ☐ private insurance
☐ Medicaid ☐ medication assistance
☐ VA Medical ☐ no insurance

4. **What is the primary reason for your homelessness? Check one.**
☐ stranded/transient ☐ relocating
☐ physical abuse ☐ loss of income
☐ insufficient income ☐ fire
☐ kicked out of house ☐ housing condemned
☐ substandard housing ☐ no power
☐ no water ☐ eviction
☐ building sold ☐ spousal desertion
☐ mental health issues ☐ Section 8 violation
☐ drug/alcohol issues ☐ never lived independently
☐ high-risk neighborhood ☐ Katrina, etc.
☐ marriage/separation ☐ victim of crime
☐ displaced ☐ institution discharge
☐ shelter termination ☐ employment situation
☐ domestic violence ☐ disaster
☐ mental/emotional abuse ☐ release from incarceration

5. **Have you ever been a victim of domestic violence?**
☐ Yes ☐ No ☐ Don't Know ☐ Refuse to Answer

6. **If yes, how long in the past did this occur?**
☐ Within past three months
☐ 3-6 months ago
☐ 6-12 months ago
☐ More than one year ago
☐ Don't Know ☐ Refused to Answer

7. **Are you currently in school and/or working on any degree or certificate? Yes_____No _____**

8. **Have you received vocational training or been in a trade apprenticeship Yes_____No _**

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SECTION 4 - Continued

What is the highest grade you've completed?

- ☐ no school completed
- ☐ nursery school to 4th grade
- ☐ 5th grade to 6th grade
- ☐ 7th grade to 8th grade
- ☐ 9th grade
- ☐ 10th grade
- ☐ 11th grade
- ☐ 12th grade, no diploma
- ☐ high school diploma
- ☐ GED
- ☐ Associates degree
- ☐ some college, no degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ doctorate
- ☐ other graduate or post-secondary education
- ☐ Certificate of advanced training or skilled artisan
- ☐ Don't Know

Are you employed? ☐Yes ☐No

If yes, what type of employment is it?

☐Permanent ☐Temporary ☐Seasonal

How many hours did you work last week? _____

If not employed, are you looking for work?

☐ Yes ☐ No

What is your general physical health status?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Do you have a mental illness?

☐Yes ☐No ☐ Don't Know

If yes, is the mental illness a disabling condition?*

☐ Yes ☐ No

[*If Attachment A, "Disability Verification," indicates a mental illness or a dual diagnosis, you must answer "yes" to the above.*]

Are you receiving services or treatment for the mental illness? ☐ Yes ☐No

Do you have a substance abuse disorder?

☐ Yes, alcohol abuse ☐ Yes, drug abuse ☐ Yes, both alcohol and drug abuse ☐ No ☐ Don't Know

If yes, is the substance abuse disorder a disabling condition? ☐ Yes ☐ No

[*If Attachment A, "Disability Verification," indicates a substance abuse disorder, you must answer "yes" to the above.*]

Are you receiving services or treatment for the substance abuse disorder?

☐ Yes ☐ No

Do you have HIV or AIDS?

☐ Yes ☐ No ☐ Don't Know

If yes, is this a disabling condition?

☐ Yes ☐ No

[*If Attachment A, "Disability Verification," indicates a diagnosis of HIV or AIDS, you must answer "yes" to the above.*]

If yes, are you receiving services or treatment for HIV or AIDS?

☐ Yes ☐ No

Do you have a developmental disability?**

☐Yes ☐No ☐ Don 't Know

If yes, is the developmental disability a disabling condition?

☐ Yes ☐ No

[*If Attachment A, "Disability Verification," indicates a developmental disability diagnosis, you must answer "yes" to the above.*]

If yes, are you receiving services or treatment for the developmental disability?

☐ Yes ☐ No

Do you have a chronic health condition*?**

☐ Yes ☐ No ☐ Don 't Know

If yes, please specify what the condition is:

If yes, is the chronic health condition a disabling condition?

☐ Yes ☐ No

If yes, are you receiving services or treatment for the chronic health condition?

☐ Yes ☐ No

Do you have a physical disability?

☐ Yes ☐ No ☐ Don 't Know

If yes, please specify what the disability is:

If yes, is the physical disability a disabling condition?

☐ Yes ☐ No

Are you receiving services or treatment for the physical disability?

☐ Yes ☐ No

* **"Disabling condition"** means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

** **"Developmental disability"** includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and some learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

*** **Chronic health conditions** include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysem

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SECTION 5. INCOME

Have you or anyone who will live with you received cash income from any source in the past 30 days? ☐Yes ☐No

If yes, please check the boxes next to all sources of **CASH** income in the list below received by all household members (do not include food stamps) and state the amount received per month.

Type Amount/Month

☐ Employment income (NET - before tax) $_____
☐ Child support $_____
☐ Social Security Disability (SSDI) $_____
☐ Supplemental Security Income (SSI) $_____
☐ Social Security retirement $_____
☐ TANF $_____
☐ Social Security retirement $_____
☐ Veteran's pension $_____
☐ Veteran's disability payment $_____
☐ Unemployment Insurance $_____
☐ Alimony/other spousal support $_____
☐ Pension from a former job $_____
☐ Worker's Compensation $_____
☐ Private disability insurance $_____
☐ Other sources of income $_____

Specify any other sources of cash income and amount below:

_____
_____
_____

If any of the income sources checked above are received by a household member other than the Applicant, please describe here:

_____
_____
_____

Have you or anyone who will live with you received non-cash benefits or services in the past 30 days? ☐ Yes ☐ No

Please check all sources of **NON-CASH** benefits and services.

Type Name of household member receiving assistance

☐ Food stamps/EBT _____
☐ Medicaid/MO HealthNet _____
☐ Medicare _____
☐ WIC _____
☐ TANF childcare services _____
☐ TANF transportation services _____
☐ Other TANF-funded services _____
☐ Children's Health Insurance Program _____
☐ VA Medical Services _____
☐ Other assistance source _____

SECTION 6. ZERO INCOME DECLARATION

Complete this section only if the Applicant has NO cash income.

APPLICANT: **If you have no cash 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 cash 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)

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SECTION 7. ASSET INFORMATION

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

Household Member'sName	Bank / Institution Name	Account Number	Types of Account (checking, savings, investment)	Current Balance

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

Have you sold or given away real property or assets in the past two years? Yes No

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

SECTION 8. EXPENSES

Expenses: Please provide the information requested below. These answers may help reduce the amount of rent for which you will be responsible in the TH program.

Do you pay for childcare that enables you or another household member to work or go to school.?

If yes, give the name and address of the childcare provider, weekly cost and the name of the household member working or in school:

Provide Name & Address: _____

_____

Name of household member who works or goes to school: _____

Weekly Cost:_____

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

If yes, give the name of the household member who works because of this expense:

Do you incur unreimbursed medical expenses on a regular basis? ☐ Yes ☐ No

If yes, amount per month: $_____

Do you owe money on back rent? ☐ Yes ☐ No

If yes, amount: $ _____

Do you owe money on past due utility bills?

☐ Yes ☐ No

If yes, amount: $ _____

Do you or any member of your household owe money to any Housing Authority or any housing assistance program?
☐ Yes ☐ No

If yes, amount: $ _____

SECTION 9. Criminal Background

Have you or any member of your household been evicted from public housing or a Housing Choice Voucher program because of drug of drug-related criminal activity? ☐ Yes ☐ No

Are you or any member of your household illegally using a controlled substance or abuse alcohol? ☐ Yes ☐ No

Do you and all members of your household have U.S Citizenship or have eligible immigration status? ☐ Yes ☐ No

Are you or any member of your household subject to a lifetime registration under a State Sex Offender Registration Program?
☐ Yes ☐ No

Have you or any member of your household been convicted of a violent criminal act or a felony drug-related act within the past 3 years? ☐ Yes ☐ No

Have you or any member of your household been terminated from another assisted housing program for fraud within the last two years? ☐ Yes ☐ No

Have you or any member of your household been convicted of the manufacture and/or sales of methamphetamine?
☐ Yes ☐ No

SECTION 10. VETERANS STATUS

Is anyone in this household a veteran? ☐ Yes ☐ No

If yes, name: _____

If no, skip the rest of this section.

What date did the veteran begin military service?
_____/_____/ _____

What branch was served in?
☐ Army ☐ Air Force ☐ Navy ☐ Marines
☐ Other ☐ Don't know

When was the service? Choose one; if the service dates overlap two choices, choose the one containing most of the service time.
☐ Post-September 11th (September 11, 2001-present)
☐ Persian Gulf (August 1991-September 10, 2001)
☐ Post-Vietnam (May 1975-July 1991)
☐ Vietnam (August 1964-April 1975)
☐ Between Korea and Vietnam (Feb. 1955-July 1964)
☐ Korea (June 1950-January 1955)
☐ Between WW2 and Korea (August 1947-May 1950)
☐ WW2 (September 1940-July 1947) ☐ Don't know

Duration of Active Duty: _____ Enter months served

Was the service in a war zone? ☐ Yes ☐No
☐ Don't know

If yes, which one?
☐ Europe ☐ North Africa ☐ Vietnam
☐ Laos and Cambodia ☐South China Sea
☐ China, Burma, India ☐ Korea ☐ South Pacific
☐ Persian Gulf ☐ Afghanistan ☐ Don 't knows

Number of months in war zone: _____

Did the veteran receive fire, either hostile or friendly?
☐ Yes ☐ No ☐ Don 't Know

Discharge Status: ☐ Honorable ☐ General
☐ Medical ☐ Bad Conduct ☐ Dishonorable
☐ Other ☐ Don't Know ☐ Refused to Answer

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SECTION 11. APPLICANT CERTIFICATIONS

Applicant: please read the paragraphs below and then sign to show that you have read the information, understand it and agree to it.

I understand that if I am approved to receive assistance from Posada's TH program, I agree to follow all of the rules of the TH program.

I understand that I must report all increases and decreases in my income to my case worker within 30 days of the change in income;

I understand that I must adhere to the Individual Development plan that I established with my Posada case worker;

I understand that if my referring agency can no longer provide case management or supportive services, I will secure a new agency of my choice to provide those services.

I understand that if I change supportive service agencies I must notify my local processing center agency of the change within 30 days.

I understand that having support services is not a mandatory requirement of the TH program and that I'm under no obligations to maintain support services as a condition of this program.

I understand that as a TH participant I am requiredto obey the rules and restrictions of my lease, including paying my share of rent on time, not disturbing fellow tenants, and keeping my unit clean and free of damages.

I certify that all information given on this application by me or other parties is accurate and complete to the best of my knowledge and belief. I also understand that making false statements or providing false information is grounds for denial or termination of the TH program.

▶ _____

(Print Name of Applicant, or of Parent, Guardian or Legal Representative of Applicant

▶ _____

(Signature of Applicant, or of Parent, Guardian or Legal Representative of Applicant)

_____/_____ / _____

(Date)

SECTION 12. CASE MANAGER CERTIFICATIONS

CASE MANAGER: please read the following and indicate your understanding and agreement by signing below.

I understand that by referring this Applicant to the TH program, my agency is committing to providing case management and/or other supportive services for the Applicant for as long as the Applicant continues to qualify for such services. In the event that my agency is unable to continue services to the applicant, I will assist the applicant in connecting with another support service provider that will assist them with fulfilling their obligations and commitments to the TH program.

I will ensure that all children in this household are properly enrolled in school and are connected to the appropriate services within the community, including early childhood education programs.

I will assist the Applicant in his or her housing search once the Applicant is approved for TH assistance.

I will ensure that this Applicant for TH receives case management services consistent with the Individual Development Plan included in this application, and that those services will be adequate to help him or her maintain stable independent housing. The City of Pueblo strongly recommends at least one visit per quarter to the Participant's home.

I understand that if I leave my position or **if** this Applicant is assigned to a different Case Manager, I am responsible for ensuring that The City of Pueblo is notified of the change in case management and for facilitating the transfer of services to another person or agency.

I understand that making false statements or providing false information is grounds for denial or termination of the Applicant's rental assistance.

I certify that all information provided on this application is accurate and complete to the best of my knowledge and belief.

▶ _____

(Print Name of Posada Case Manager)

▶ _____

(Signature of Posada Case Manage

_____/_____ / _____

(Date)