NEIGHBORWORKS ALASKA

TENANT BASED RENTAL ASSISTANCE PROGRAM

APPLICATION

Date Complete Application Received:	**Time Complete Application Received:**
Head of Household Name:	
Current Residence:	
City, State, Zip:	
Contact Phone:	

Applicant must meet one of the eligibility requirements below:

- ☐ Currently homeless (Living in a Shelter or a Place Not Meant for Human Habitation)
- ☐ At risk of homelessness (Eviction notice or Institutionalized)
- ☐ Precariously housed (Couch Surfing/Doubled-up)
- ☐ Lack of resources to obtain and maintain permanent housing (Houseless w/o resources)

Applicant must meet one of the eligibility requirements below:

- ☐ Enrolled in/eligible for Community Case Management Services (CSS, SCF, 9-Star, etc.)
- ☐ Enrolled in/eligible for DHS Assertive Community Treatment (ACT)
- ☐ Enrolled in/eligible for DBH Intensive Case Management (ICM)

Applicant must meet one of the eligibility requirements below:

- ☐ Head of household, spouse, or child with disabilities based on HUD 24 CFR 5.403 definitions
- ☐ AK Mental Health Trust Authority beneficiary

Applicant must meet one of the eligibility requirements below:

- ☐ Eligible for Medicaid waivers ☐ Eligible for Medicaid state plan options
- ☐ Eligible for other long-term state funded serves (describe): _____
- ☐ Eligible for other long-term community services (describe): _____

HOUSEHOLD COMPOSITION AND CHARACTERISTICS - List the Head of Household and all other persons who will be living in the unit. Indicate the relationship of each family member to the Head of Household.

Member's Full Name	Relationship	Birth Date	Age	Sex	Social Security No.

HEAD of HOUSEHOLD (check one) – THIS INFORMATION IS REQUIRED. It is being collected to ensure compliance with federal Fair Housing and Equal Opportunity regulations.

Race of Head of Household:

- ☐ White
- ☐ Native Hawaiian/Other Pacific
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Other, Multi-Racial

Ethnicity of Head of Household:

☐ Hispanic: A person of Mexican, Cuban, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. Terms such as "Latino" or "Spanish Origin" apply to this category.

☐ Non-Hispanic – A person not of Mexican, Cuban, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Applicant(s) eligibility as a low-income household must have a total annual income less than 60% of the Anchorage Median Income for household size.

INCOME INFORMATION- What is the total annual income of all household members? Include Wages, salaries and tips, alimony, child support, military income, part-time income, temporary income, Social Security, TANF, other benefits, and other income.

FOOD STAMPS ARE NOT CONSIDERED INCOME – do not list food stamps.

List ALL adult household members and their incomes. Attach a separate sheet if you need more space.

Member's Full Name	Source of Income	Amount	Payment Basis (Weekly, monthly, etc.)	Annual Amount
TOTAL				

ASSET INFORMATION

List below the types and sources of any household assets. Provide both the current cash value and the estimated annual income from the asset.

Household Member Member's Full Name	Type and Source of Asset (bank accounts, investments)	Cash Value of Asset	Annual Income from Asset

EXPENSE INFORMATION

Indicate the MONTHLY dollar expenditures for your family. Circle any of the listed expenses that are delinquent.

Rent $	**Phone $**	**Medical $**	**Credit Card $**
Electric $	**Car Payment $**	**Cable TV $**	**Credit Card $**
Gas $	**Car Insurance $**	**Medical Insurance $**	**Loan $**
Water $	**Child Care $**	**Rentals $**	**Loan $**
Other (specify) $			

☐ Yes ☐ No Does your household pay childcare expenses for children under the age of 13 that enable a family member to work or go to school?

Answer the following questions only if the Head of Household OR the Spouse is aged 62 or older, OR if the Head of Household OR the Spouse is disabled:

☐ Yes ☐ No **Current Medical:** Does your household have any unpaid medical bills?
List types and amounts of unpaid balances: _____

☐ Yes ☐ No **Future Medical:** Do you anticipate medical expenses to be incurred in the next 12 months?
List types and amounts: _____

☐ Yes ☐ No **Medicare:** Does your household have Medicare coverage?
List monthly premium amount: _____

☐ Yes ☐ No **Insurance:** Does your household have medical insurance *other than Medicare*?
List the name and address of carrier, the policy number, and monthly premium amounts.
_____

☐ Yes ☐ No **Disabled Household Members:** Does your household pay a care attendant (live-in aide) OR for equipment for any disabled household member in order to enable that person or another household member to work? If yes, provide name, address, and phone number of care attendant, and/or list types and monthly cost of equipment:
_____

APPLICANT CERTIFICATION- Household members aged 18 and over must sign this application. I/We understand that the information provided above is collected to determine if I/we can receive HOME Program assistance. I/We hereby certify that all the information provided herein is true and correct. I/We understand that providing false statements or information is grounds for termination of housing assistance and is punishable under federal law. I/We authorize NWAK to verify all information provided on this application.

Signature of Applicant: Date

Signature of Applicant: Date

Warning: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government.

NeighborWorks Alaska
Verification of Handicap or Disability
For Admission/Eligibility for
Permanent Supportive Housing Programs

Explanation to Third Party Completing Form

Please identify any of the relevant definitions that apply to the individual. Any other request for information about the individual is not relevant (e.g., diagnosis, treatment plan). HUD requires the Grant Funded program to verify all information that is used in determining this person's eligibility or level of benefits. This form can ONLY be completed by a state licensed individual with the ability to diagnose AND treat the handicap or disability represented on this form.

Applicant Name:_____

Applicant DOB:_____ **Full or Last 4 of Social Security #:**_____

For each item below, please check YES or NO to the statement that accurately describes the person listed above.

☐ YES ☐ NO 1. Has a disability, as defined in 42 U.S.C. 423, which means;[1]

a. Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months or
b. In the case of an individual who has attained the age of 55 and is blind, inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he/she has previously engaged with some regularity and over a substantial period of time. For the purposes of this definition, the term blindness, as defined in section 416(i)(1) of this title, means central vision acuity of 20/200 or less in the better eye with use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for the purposes of this paragraph as having a central visual acuity of 20/200 or less.
c. Determination of disability should include the combined effect of all of the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity.

☐ YES ☐ NO 2. Has a physical, mental or emotional impairment that:

a. Is expected to be of long-continued and indefinite duration;
b. substantially impedes the person's ability to live independently; and
c. Is such that the person's ability to live independently could be improved by more suitable housing conditions (e.g., a substance abuse disorder if the person's impairment could be improved by more suitable housing conditions);

☐ YES ☐ NO 3. Has a developmental disability as defined by the Developmental Disability Assistance and Bill of Right Act (42 USC 6001(8)) generally provided as follows:
A severe, chronic disability which:

a. Is attributable to mental and/or physical impairments or combination of mental and physical impairments;
b. Was manifested before age 22;
c. Is likely to continue indefinitely;
d. Results in substantial functional limitations in 3 or more of the following areas of major life activity:
   (i) Self-care,
   (ii) Receptive and expressive language,
   (iii) Learning,

(iv) Mobility,
(v) Self-direction,
(vi) Capacity for independent living, and
(vii) Economic self-sufficiency; and

e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or general medical or psychiatric care, treatment, or other services which are lifelong or extended duration and are individually planned and coordinated.

☐ YES ☐ NO 4. Has a chronic mental illness, i.e.

a. If he or she has a severe and persistent mental or emotional impairment that seriously limits his or her ability to live independently (e.g.. by limiting functional capacities relative to primary aspects of daily living such as personal relations, living arrangements, work, recreation, etc.) and whose impairment could be improved by more suitable housing condition
b. Is of long-continued and indefinite duration **AND** substantially impedes the person's ability to live independently.

☐ YES ☐ NO 5. Is the above a person whose disability is based solely on any drug or alcohol dependence (the person has no other disability which meets the above definition).

For example, drug or alcohol abuse or an HIV/AIDS condition that **DOES NOT** substantially impede a person's ability to live independently does not qualify as a disability in these housing programs. The determination must also take into consideration the combined effect of all the individual's impairments without regard to whether any such impairment, if considered separately, would be of such severity. (See Item 1 (b) above)

Signature & Credentials

Name and Title (print or type legibly)

Agency name and contact number

[1] Section 223 of the Social Security Act (42 U. S. C. 423)

NeighborWorks® Alaska

Authorization to Release Confidential Information

NAME: _____ **DOB:** _____ **SSN:** _____.

I hereby authorize NeighborWorks® Alaska to:

X Release information to: X Obtain information from:

Agency Name: _____.

Agency Address: _____.

The following information is requested: X written X verbal

Purpose of information:

- ☐ Service Planning
- ☐ Care Coordination
- ☐ Legal Use
- ☐ Eligibility Determination
- ☐ Other:
- ☐ Housing
- ☐ Medical Records

Information Requested:

- ☐ Psychosocial Assessments
- ☐ Discharge Summary
- ☐ Psychiatric Evaluation
- ☐ Treatment/Service Plan
- ☐ Income verification
- ☐ Info needed to fulfill grant requirements
- ☐ Other:

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that an ROI disclosure of information carries with it the potential for unauthorized disclosure, and federal confidentiality rules may not protect the information. I understand that the information released may include information regarding psychiatric treatment, substance abuse treatment/rehabilitation, and HIV status. If I have any questions about the disclosure of my health information, I can contact NeighborWorks® Alaska at (907) 677-8472. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to NeighborWorks® Alaska. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire 90 days after I am discharged from NeighborWorks® Alaska Sponsor-based Rental Assistance Project or on this date set forth by me:

***Prohibition on Disclosure**: This information has been disclosed to you from records whose confidentiality is protected under Federal Regulations (42 CFR Part 2), prohibiting you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is NOT sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be fined not more than $500.00 in the case of a first offense and not more than $5000.00 in the case of each subsequent offense.*

Client Signature: _____.

Printed Name: _____.

Date: _____.

Witness: _____.

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Date: _____.

Witness: _____.