IDAHO HOUSING AND FINANCE ASSOCIATION
HOUSING OPPORTUNITIES FOR PERSONS WITH HIV/AIDS

APPLICATION INSTRUCTIONS

This application packet is for services offered under the Housing Opportunities for Persons With AIDS (HOPWA) program. The application consists of forms and worksheets that should be completed according to the instructions and signed by both the Applicant and the Service Provider. The Household with HIV/AIDS (Applicant) must complete the application. If the Applicant is a minor, the legal guardian must sign and date the application in lieu of the minor. When completed, the case manager should email the application to VickiS@ihfa.org, fax to (208)331-4808, or send by mail to:

Rental Assistance, HOPWA Program, Idaho Housing and Finance Association
P.O. Box 7899, Boise, ID 83707-1899

----------All Forms are to be completed by the Service Provider----------

Use of Applicant Information Notice (pg.1) - This serves as a notice to the Applicant regarding reporting requirements for the grant and the confidentiality of applicant information. The Service Provider may answer any questions that the Applicant may have regarding this notice, and the Applicant may request a signed copy from the Service Provider. If the Applicant is a minor, both the Legal Guardian's name and Social Security Number and the Applicant's name and Social Security Number are required (the Applicant may use a Tax Identification Number or an Alien Registration Number in lieu of a Social Security Number if one has not been issued to the Applicant or Legal Guardian). The Service Provider should also sign, date, and enter a confidential identification number for future reference.

HOPWA Application (pg.2) - The Applicant (or Legal Guardian) should provide all information requested in this section and must choose the type of service(s) by checking the appropriate box in the **Services Requested** section (pg.3). The Service Provider should then identify and explain the different services offered under the HOPWA program. The Applicant should then complete the **Household Composition** section (pg. 4) by placing his/her name in the first row (indicated by "SELF"). In addition, any other Household members who are requesting services should place their names on the subsequent rows. If this application is requesting Housing Assistance, the Applicant must include all members of the family who will live in the residence. Information listed under the **Most Recent/Current Living Arrangement** section (pg. 4) is requested by the U.S. Department of Housing and Urban Development (HUD) and is part of their Annual Performance Report on demographic information. This information will not be used to determine eligibility.

Income & Sources Worksheet (pg.5) - This worksheet should be completed unless the Applicant has no income, in which case they should sign and date the **Statement of No Income** (pg.6). All sources of income must be reported including the salary of every Household family member. If the Applicant is a minor, both the Legal Guardian's name and Social Security Number and the Applicant's name and Social Security Number are required. The Applicant (or Legal Guardian) should sign and date the form in the appropriate place certifying that the information provided is truthful and accurate.

Service Provider/Case Manager Certification (pg.7) - Complete the Service **Provider/Case Manager Certification** and the **Certification of HIV/AIDS Status** section (pg. 7) for the Applicant. Sign and date all fields.

Disability Assessment (pg. 8) / **Health Insurance Worksheet (pg. 10)** - Instructions included on forms.

Service Provider Requirements - **Service providers should certify the applicant's awareness of HUD's reporting requirements.** Certification shows IHFA the signing provider has presented the information notice to the applicant and has verified that this applicant understands the reporting requirements for HOPWA grant assistance.
Service providers should certify the Applicant's Income. Income and HIV/AIDS certifications are paramount to your client's eligibility for HOPWA services. This shows IHFA you have verified a qualifying income by county of residence and number in household using HUD's income limits chart to determine each applicant's eligibility for the program.
Service providers should certify HIV/AIDS status. This shows IHFA the provider is qualified to verify HIV/AIDS status and has determined this status as positive in determining each applicant's eligibility for the program.

*Supporting documentation for certifications **MUST BE ON FILE** at the certifying agency.*

IHFA HOPWA APPLICATION

USE OF APPLICANT INFORMATION NOTICE

The U.S. Department of Housing and Urban Development (HUD) and its grantee, Idaho Housing and Finance Association (IHFA) that distributes the HOPWA funds in Idaho, are responsible under federal law (AIDS Housing Opportunity Act, 42 U.S.C. § 12901 et seq. and 24 C.F.R. § 574 et seq.) to determine proper accounting and disbursement of HOPWA funds.

An Applicant for HOPWA assistance under the Housing Opportunities for Persons with AIDS (HOPWA) grant must provide verification of HIV status and qualifying income by completion of this application. This information is sufficient to qualify an applicant for housing assistance.

If the Service Provider offers other types of assistance eligible under the HOPWA grant HUD/IHFA must review documentation verifying payments made on behalf of an Applicant before reimbursements can be made.

Further verification demonstrating provision of these services may also be required for review by HUD/IHFA. HUD and IHFA do not make copies of this documentation as a part of the verification. Neither is information reviewed during the verification included in any database by HUD or IHFA as a result of such verification. Demographic information that does not identify the Applicant may be used to satisfy HOPWA reporting requirements.

HUD and IHFA are compelled by federal law to maintain the privacy of all confidential information reviewed in the verification process.

YOUR SIGNATURE BELOW IS ONLY TO ACKNOWLEDGE RECEIPT OF THIS NOTICE. YOU MAY REQUEST A COPY FROM YOUR SERVICE PROVIDER.

Applicant Signature: _____ Social Security #_____

Legal Guardian Signature: _____ Social Security #_____
(if applicant is a minor)

Service Providers/Case Managers Certification

By signing below, the case manager hereby certifies that this Information Notice has been presented and that the applicant understands the reporting requirements by HUD for this grant assistance.

_____

Service Provider/Case Manager Date

Please assign Applicant a Confidential I.D. Number to be used for billing purposes: #_____

IHFA HOPWA APPLICATION

Applicant Information

Intake/Entry Date: _____ **Client ID:** _____

First Name: _____ **Middle Int.:** ____ **Last Name:** _____

☐ Full Name Reported ☐ Partial, street, or code name ☐ Doesn't know ☐ Refused

Social Security Number: _____

☐ Full SSN Reported ☐ Approximate/partial SSN ☐ Doesn't know ☐ Refused

Date of Birth: _____

☐ Full DOB ☐ Approximate/partial DOB ☐ Doesn't know ☐ Refused

Veteran?

☐ Yes ☐ No ☐ Doesn't know ☐ Refused

Clients Relationship to Head of Household (All Clients):

☐ Self (Head of Household) ☐ Head of Household's spouse/partner ☐ Head of Household's child

☐ Head of Household's other relation member ☐ Other non-related member

Gender:

☐ Male (M) ☐ Female (F) ☐ Trans male (F to M) ☐ Trans female (M to F)

☐ Gender Non-Conforming (ie. not exclusively M or F) ☐ Doesn't know ☐ Refused

Race:

☐ American Indian/Alaska Native ☐ White ☐ Black/African American ☐ Asian

☐ Native Hawaiian/other Pacific Islander ☐ Doesn't know ☐ Refused

Ethnicity:

☐ Hispanic or Latino ☐ Non-Hispanic/Non-Latino ☐ Doesn't know ☐ Refused

Victim of Domestic Violence (Adults and Head of Household only)?

☐ Yes ☐ No ☐ Doesn't know ☐ Refused

If Yes, indicate the most recent occurrence:

☐ Within past 3 months ☐ 3 to 6 months ago ☐ 6 months to 1 year ago

☐ 1 year ago or more ☐ Doesn't know ☐ Refused

If Yes, are you currently fleeing?

☐ Yes ☐ No ☐ Doesn't know ☐ Refused

Street Address _____ **City, State, Zip** _____

Telephone Number _____ **Emergency Contact #** _____

Name of Guardian (if applicable) _____

THIS FORM IS TO BE COMPLETED BY THE SERVICE PROVIDER

If client is diagnosed with AIDS/tested positive for HIV, please complete the following:

If the client has HIV/AIDS, are they receiving public HIV/AIDS medical assistance?

☐ Yes ☐ No ☐ Doesn't know ☐ Refused

If no, why not?

☐ Applied: Decision Pending ☐ Applied: Not Eligible ☐ Did not apply

☐ Insurance type N/A for client ☐ Doesn't know ☐ Refused

If the client has HIV/AIDS, are they receiving AIDS Drug Assistance Program ADAP)?

☐ Yes ☐ No ☐ Doesn't know ☐ Refused

If no, why not?

☐ Applied: Decision Pending ☐ Applied: Not Eligible ☐ Did not apply

☐ Insurance type N/A for client ☐ Doesn't know ☐ Refused

T-Cell (CD4) count available? ☐ Yes ☐ No ☐ Doesn't know ☐ Refused

If yes, T-Cell count (number 0 – 1500): _____

How was data obtained?

☐ Medical Report ☐ Client Report ☐ Doesn't know ☐ Refused

Viral Load Available?

☐ Yes ☐ No ☐ Doesn't know ☐ Refused

If yes, Viral Load: _____

How was data obtained?

☐ Medical Report ☐ Client Report ☐ Doesn't know ☐ Refused

Services Requested - Please indicate Housing or Supportive Service requested with this application.

☐ **Supportive Services** (includes case management, housing placement and limited health services)

☐ **Opt-Out -** Check here to opt-out of HOPWA services including case management. This means that your housing needs were met and you do not need additional supportive services at this time. If you require it, you can opt back into services at your request, and must meet the eligibility requirements described in the eligible person definition as indicated in § 574.3. Low-income is defined as 80% or below Area Median Income (AMI).

☐ **Housing Information**

☐ **Resource Identification**

☐ **Homeless Prevention**

☐ **Housing Assistance** (tenant-based rental assistance/housing voucher)

Household Composition - The HOPWA program requires that the Applicant have HIV/AIDS in order to be eligible for Housing or Supportive Services. Please place the Applicant's name in the first row and place any Household family member living in the Household where services are provided under this application on the following rows.

Name	SSN	Relation to Applicant	Date of Birth	Gender	Ethnicity		Race
				(See desc. below)	Hisp.	Non-Hisp.	(See codes below)
		SELF					

GENDER: ***M*** *(Male),* ***F*** *(Female),* ***TM*** *(Trans Male - female to male),* ***TF*** *(Trans Female - male to female),* ***GNC*** *(Gender Non-Conforming - not exclusively male or female),* ***R*** *(Client refused),* ***DK*** *(Client doesn't know)*

RACE: ***AI/AN*** *(American Indian/Alaska Native),* ***B/AA*** *(Black or African American),* ***A*** *(Asian),* ***W*** *(White),* ***NH/PI*** *(Native Hawaiian/other Pacific Islander),* ***DK*** *(Client doesn't know),* ***R*** *(Client refused)*

Most Recent/Current Living Arrangement - For applicants requesting long-term rental assistance, please check the box which best describes your most recent or current living arrangement:

(Check Only One)

☐ Homeless from the streets	☐ Emergency Shelter	☐ Transitional Housing	☐ Hospital*
☐ Psychiatric Facility*	☐ Jail or Prison	☐ Substance Abuse Facility*	
☐ Rental Housing	☐ Friend or Relative	☐ Domestic Violence Shelter**	
☐ Applicant-Owned Housing	☐ Other (please specify): _____		

* These categories can only be checked if the applicant was in an in-patient facility for 30 days or longer. If the applicant was an in-patient for less than 30 days, please identify the living arrangement prior to hospitalization.

** Applicant need not spend any time in a Domestic Violence Shelter to qualify for housing. The applicant(s) must prove they are fleeing a domestic violence situation that is typically verified through DV shelters.

IHFA HOPWA APPLICATION

Income & Sources Worksheet

THIS FORM IS TO BE COMPLETED BY THE SERVICE PROVIDER. Complete one worksheet for each adult household member. Respond to the following questions for the head of household and each additional adult in the household. If the household is composed of an unaccompanied child or two or more minors, data must be collected about the minor that has been designated as the head of household. The Project Entry Date will serve as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

Applicant Name _____ Social Security # _____

Client # _____ Date: _____

Legal Guardian Name _____ Social Security # _____
(if Applicant is a minor)

Are you…

☐ Head of Household ☐ Other Adult Household member

Collection Point(s): At project entry, annual assessment, and project exit. Update as income changes.

☐ Entry ☐ Update ☐ Annual Assessment ☐ Exit

Monthly Income Received from any source?

☐ Yes ☐ No ☐ Doesn't know ☐ Refused

If yes, record whether or not the client receives income and the amount for each listed source BELOW.
Income data should be recorded for sources of income that are current as of information date. Income received by/on behalf of a minor should be recorded under the Head of Household unless funding source instructs otherwise. If the exact amount of income is unknown the client should estimate the amount. Updates are required for persons aging into adulthood.

Source of Income Received	Yes	No	If Yes, Monthly Amount:
Alimony or other spousal support			$
Child Support			$
Earned Income (i.e. employment income including self-employment)			$
General Assistance			$
Pension or retirement income from a former job			$
Private Disability Insurance			$
Retirement Income from Social Security			$
Social Security Disability Income (SSDI)			$
Supplemental Security Income (SSI)			$
Temporary Assistance for Needy Families (TANF)			$
Unemployment Insurance			$
VA Non-Service Connected Disability Compensation			$
VA Service Connected Disability Compensation			$
Worker's Compensation			$
Other (specify):			$
TOTAL (Monthly Income from all sources)			$

Non-Cash Benefits Received from any source?

☐ Yes ☐ No ☐ Doesn't know ☐ Refused

If yes, record whether the client is currently receiving any of the benefits. Updates are required if aging into adulthood.

Non-Cash Benefit	Yes	No	If Yes, Monthly Amount:
Supplemental Nutrition Assistance Program (Food Stamps)			**$**
TANF Child Care Services (ICCP)			**$**
TANF Transportation Services			**$**
Other TANF-funded Services			**$**
WIC - Special Supplemental Nutrition Program for Women, Infants, and Children			**$**
Other (specify):			**$**
Other (specify):			**$**
Other (specify):			**$**
Other (specify):			**$**
TOTAL (Monthly Income from all sources)			**$**

STATEMENT OF NO INCOME - <u>DO NOT</u> <u>complete if income was reported above.</u>

I, _____, do hereby state that I am not presently receiving any type of income such as: gross amount of wages, salaries, overtime pay, commissions, fees, tips and bonuses; net income from operation of business profession or from rental or real property; interest, dividends and other net income of any kind for real and personal property; full amount of periodic payments received from social security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of periodic receipts; including a lump sum payment for the delayed start of periodic payment; payment in lieu of earnings, such as unemployment and disability compensation, workman's compensation and severance pay; public assistance; alimony and child support payments; regular pay, special pay and allowance of a member of the Armed Forces (whether or not living in the dwelling) head of family or spouse; education scholarships and veteran's educational benefits which exceed the cost of tuition, fees, books and expenses.

I do hereby state that all income information is correct and know that falsifying or deliberately omitting information regarding income (or household income) may result in immediate termination from the program and/or criminal charges or civil suit(s) to repay the amount of assistance received. By signing below, the applicant hereby certifies that the information above is correct and true to the best of his/her knowledge.

Applicant Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____
(if Applicant is a minor)

NOTE: The Service Provider must complete the INCOME CERTIFICATION and document it in client files.

Service Provider/Case Manager Certification

Applicant and Applicant Household income must be 80% or less of area median income to qualify for HOPWA services. The case manager must complete income verification. **Source documentation** (copy of SSI check, child support order, pay stubs, etc.) must be made available in the client's file. This must be completed prior to the client receiving services. Income verification must be completed for every person 18 years of age or older living in the household.

Area median income in: _____
County or MSA is: $_____
Monthly for a family of: _____

By signing below, the service provider/case manager hereby certifies that appropriate third-party documentation verifying the statements made above has been collected on all required persons in the Household, that information is correct to the best of his/her knowledge, and is available in the client's file.

_____ _____
Service Provider/Case Manager Signature Date

Service Provider Information
Service Provider's Name:
Agency or Organization:
Agency's Executive Director:
Physical address where services are provided:
Phone number(s):
Address or PO Box of Executive Director:
Official use only:

Certification of HIV/AIDS Status

By signing below, I certify that (applicant's name)_____ has AIDS or is HIV-positive.

Certifying Individuals name: _____ Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Credentials (MD, RN, MSW, etc.): _____

Signature: _____ Date: _____

Disability Assessment

Complete a worksheet for each Household member. Information on a disability may be needed to determine program eligibility and is used with other information to identify whether a client meets the criteria for chronic homelessness. In households with children accompanied by an adult, children's disabilities should be determined based on interviews with the adult in the household. Entry of information in HMIS does not constitute a "diagnosis" by the worker who did the data collection. Unless required by the funder documentation of the disability is not required.

Applicant Name: _____ Social Security # _____

Household Member Name: _____ Social Security # _____

Client # _____ Date: _____

Legal Guardian Name: _____ Social Security # _____
(if Applicant is a minor)

Does the client have a disabling condition? ☐ Yes ☐ No ☐ Doesn't know ☐ Refused

Physical Disability	Yes	No	DK	R
Does the client have a physical disability or impairment?				
If yes…				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?				
Is above condition going to be long term?				

Developmental Disability	Yes	No	DK	R
Does the client have a developmental disability?				
If yes…				
Expected to substantially impair ability to live independently?				
Is above condition going to be long term?				

Chronic Health Condition	Yes	No	DK	R
Does the client have a chronic health condition?				
If yes…				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?				
Is above condition going to be long term?				

HIV/AIDS	Yes	No	DK	R
Diagnosed with AIDS or tested positive for HIV?				
If yes…				
Expected to substantially impair ability to live independently?				
Is above condition going to be long term?				

Mental Health Problem	Yes	No	DK	R
Does the client have a mental health problem?				
If yes…				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?				
Is above condition going to be long term?				

Substance Abuse (Indicate Type)	Yes	No	DK	R
Alcohol Abuse?				
Drug Abuse?				
Both Drug and Alcohol?				
If yes…				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?				
Is above condition going to be long term?				

Health Insurance Worksheet

Complete a worksheet for each Household member. Health insurance information is important to determine whether clients currently have health insurance coverage and are accessing all mainstream project medical assistance benefits for which they may be eligible, and to ascertain a more complete picture of their economic circumstances. Record whether or not the client is covered by each of the listed insurance types. If not received, enter the reason why such insurance is not being received for each health insurance source.

Applicant Name: _____ Social Security # _____

Client # _____ Date: _____

Legal Guardian Name: _____ Social Security # _____
(if Applicant is a minor)

Are you… ☐ Head of Household ☐ Other Household member

Collection Point(s): At project entry, annual assessment, and project exit. Update as income changes.

☐ Entry ☐ Update ☐ Annual Assessment ☐ Exit

Is client covered by Health Insurance? (Complete tables below)

☐ Yes ☐ No ☐ Doesn't know ☐ Refused

MEDICAID		
		No
		Yes
(Required for HOPWA only)		Applied; decision pending
(if no) ***Reason***		Applied; client not eligible
		Client did not apply
		Insurance type N/A for this client
		Client doesn't know
		Client refused

MEDICARE		
		No
		Yes
(Required for HOPWA only)		Applied; decision pending
(if no) ***Reason***		Applied; client not eligible
		Client did not apply
		Insurance type N/A for this client
		Client doesn't know
		Client refused

State Children's Health Insurance Program *(or use local name)*		
		No
		Yes
(Required for HOPWA only)		Applied; decision pending
(if no) ***Reason***		Applied; client not eligible
		Client did not apply
		Insurance type N/A for this client
		Client doesn't know
		Client refused

Veteran's Administration (VA) Medical Services		No
		Yes
(Required for HOPWA only)		Applied; decision pending
(if no) ***Reason***		Applied; client not eligible
		Client did not apply
		Insurance type N/A for this client
		Client doesn't know
		Client refused

Employer-Provided Health Insurance		No
		Yes
(Required for HOPWA only)		Applied; decision pending
(if no) ***Reason***		Applied; client not eligible
		Client did not apply
		Insurance type N/A for this client
		Client doesn't know
		Client refused

Health insurance obtained through COBRA		No
		Yes
(Required for HOPWA only)		Applied; decision pending
(if no) ***Reason***		Applied; client not eligible
		Client did not apply
		Insurance type N/A for this client
		Client doesn't know
		Client refused

Private Pay Health Insurance		No
		Yes
(Required for HOPWA only)		Applied; decision pending
(if no) ***Reason***		Applied; client not eligible
		Client did not apply
		Insurance type N/A for this client
		Client doesn't know
		Client refused

State Health Insurance for Adults *(or use local name)*		No
		Yes
(Required for HOPWA only)		Applied; decision pending
(if no) ***Reason***		Applied; client not eligible
		Client did not apply
		Insurance type N/A for this client
		Client doesn't know
		Client refused

Indian Health Services		No
		Yes
(Required for HOPWA only) *(if no)* ***Reason***		Applied; decision pending
		Applied; client not eligible
		Client did not apply
		Insurance type N/A for this client
		Client doesn't know
		Client refused

Other		No
		Yes
(Required for HOPWA only) *(if no)* ***Reason***		Applied; decision pending
		Applied; client not eligible
		Client did not apply
		Insurance type N/A for this client
		Client doesn't know
		Client refused