

SAVE Home Application

SAVE Inc. Mission Statement

SAVE Inc. is dedicated to providing housing services to HIV/AIDS-challenged individuals and families so that they can live with personal dignity.

SAVE Home

SAVE Home is a residence operated by SAVE Inc. for those individuals with HIV/AIDS who are homeless and unable to care for themselves in their present circumstances. The living situation is an individual group residence. The rooms are single room occupancy. The kitchen, living room, bathroom facilities and laundry facilities are shared with other residents.

Philosophy

We encourage all residents to enjoy life, to live as fully as possible, and to strive to create a positive approach in a loving and caring network of support.

Waiting list

SAVE Home will maintain a waiting list of eligible persons with HIV/AIDS who have applied for housing and have been accepted when there are no immediate vacancies at the residency. Individuals on the waiting list will be assessed for admission appropriateness when a room becomes available. Placement on the waiting list occurs only on completion and acceptance of the application materials and does not guarantee actual admission to the residence.

Admission Criteria

Any potential SAVE Home resident will be processed through the following criteria:

- (1) SAVE Home applicants must have written verification of HIV/AIDS diagnosis from a qualified medical source.
- (2) Applicant(s) must be homeless as defined by HUD.
- (2) No minors (persons under 18) will be accepted to SAVE Home. Persons 18 to 21 years of age will be admitted at the discretion of the SAVE Home Manager.
- (3) SAVE Home reserves the right to exclude any applicant with a long-term history of chemical dependency, psychological disorders and/or institutionalization, which would strongly suggest that such a person, would either be a danger to, or an unreasonable strain on SAVE Home staff or residents.
- (4) Applicants will be accepted based on medical need and date of application.
- (5) Applicants must be willing and capable of cooperating with SAVE Home staff, adhering to house rules, and living cooperatively in a group situation.
- (6) Applicants must be willing to adhere to universal infection control measures.
- (7) Applicants must be willing to cooperate with monitored medication measures.

SAVE Home reserves the right to deny residency to any applicant who is deemed to be at significant risk to harm himself/herself or others.

SAVE Home Application Checklist

Name _____

- Case Management FACTORS Referral Form _____
- Letter verifying HIV infection _____
- Homeless verification _____
- Income Verification _____
- Picture ID _____
- Birth Certificate _____
- Social Security Card _____
- Police Report less than 30 days old _____

All items must be present before an applicant can be considered for residency. **NO EXCEPTIONS.** It takes a minimum of 3 working days after receiving the completed application to process it.

Please return completed application to:

Rochelle Wilson
Save Home Manager
PO Box 45301
Kansas City, Missouri 64171
(816) 960-0910 office
(816) 931-0602 fax
RWilson@Saveinckc.org

APPLICATION FOR SAVE HOME SHP

SECTION 1. APPLICANT INFORMATION

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

Current Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Other Contact Info?: _____

Social Security No.: ____ - ____ - ____ Date of Birth: ____ / ____ / 19____ Gender: M ____ F ____

Race: American Indian/Alaska Native []
Asian []
Black/African American []
Native Hawaiian/Pacific Islander []
White []
Multi-Racial []
(Specify multi-racial by checking relevant boxes.)

Citizenship: U.S. Citizen []
Eligible Non-Citizen []
Ineligible Non-Citizen []

(NOTE: ineligible non-citizens are not eligible for Shelter Plus Care assistance.)

Are you: Hispanic [] Non-Hispanic []

Do you have picture ID? Yes [] No []

What is your primary language? _____

Marital Status: Single [] Married []
Divorced [] Separated []

Can you speak limited English? Yes [] No []

SECTION 2. 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 1A. APPLICANT'S HOUSEHOLD COMPOSITION

List any persons below who will live in the Shelter Plus Care assisted unit aside from the applicant. Include any children not currently in your custody but for whom you expect to receive custody after obtaining permanent housing. Enter codes from the "Race Codes" and "Disability Codes" lists shown below. Do not list anyone currently living with you that will not live in the Shelter Plus Care assisted unit.

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

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

SECTION 4. 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/AFDC/TANF? 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 []
14. Does any member of your household receive income from assets including interest on checking, saving, and dividends from CD's, stocks or bonds, mutual funds, or from rental property? Yes [] No []

COMMENTS: _____

For each type of income that your household receives, 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's Name	Source or Type of Income	Monthly Amount	Non-Cash Benefits (specify type, e.g., food stamps)	Monthly Amount

SECTION 5. ASSETS INFORMATION

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

Household Member's 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 6. ZERO INCOME

If you have ZERO INCOME, please read the statement below, then sign and date. CASE MANAGER, please sign and date below applicant's signature to attest to the truth of the applicant's statement regarding zero income. *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)

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 7. 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 handicapped 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: \$ _____

SECTION 8. PRIOR LIVING SITUATION

Where did you sleep in the week prior to beginning services with the agency referring the application? Check **ONE** box:

Permanent housing for formerly homeless persons	<input type="checkbox"/>	Living with relatives	<input type="checkbox"/>	Owned housing	<input type="checkbox"/>
Non-housing (street, park, car, bus station, etc)	<input type="checkbox"/>	Living with friends	<input type="checkbox"/>	Hotel or motel (self-paid)	<input type="checkbox"/>
Emergency shelter	<input type="checkbox"/>	Rental housing	<input type="checkbox"/>	Foster care	<input type="checkbox"/>
Transitional housing for homeless persons	<input type="checkbox"/>	Domestic violence situation	<input type="checkbox"/>	Other (please specify)	<input type="checkbox"/>
Jail, prison or juvenile detention center*	<input type="checkbox"/>	Psychiatric treatment facility*	<input type="checkbox"/>	Don't know	<input type="checkbox"/>
Substance abuse treatment facility or detox center*	<input type="checkbox"/>	Hospital (non-psychiatric)*	<input type="checkbox"/>	Refuse to say	<input type="checkbox"/>

*If the applicant was in an institution for less than 30 days prior to beginning services, and was living on the street or in emergency shelter immediately before entering the institution, he or she should be counted in either the "non-housing" or "emergency shelter" category, as appropriate.

How long did you stay in the situation checked above?

One week or less	<input type="checkbox"/>	One year or more	<input type="checkbox"/>
More than one week but less than one month	<input type="checkbox"/>	Don't know	<input type="checkbox"/>
One-three months	<input type="checkbox"/>	Refuse to answer	<input type="checkbox"/>
More than three months but less than one year	<input type="checkbox"/>		

What was your last permanent address (where you last owned a home, paid rent or had a stable family situation)?

Street address: _____ City: _____ Zip Code: _____
Don't Know [] Refuse to Answer []

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 are grounds for termination of rental assistance.

Signature of applicant: _____ Date: _____
Signature of co-applicant: _____ Date: _____

ATTACHMENT A. VERIFICATION OF DISABILITY

Applicant Name: _____

NOTE: This form must be filled out by a **medical** professional trained to determine if the applicant's disability meets HUD's definition of a disability qualifying for SHP assistance as described below.

PLEASE CHECK ALL THAT APPLY:

I have determined that this individual is disabled as follows:

- The applicant has a *serious mental illness* that is expected to be of long-continued and indefinite duration; substantially impedes this person's ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.
- The applicant has a *chronic alcohol abuse disorder* that is expected to be of long-continued and indefinite duration; substantially impedes this person's ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.
- The applicant has a *chronic drug abuse disorder* that is expected to be of long-continued and indefinite duration; substantially impedes this person's ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.
- The applicant has a *severe and chronic developmental disability* that:
 1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
 2. Manifested before the person attained the age of 22;
 3. Is likely to continue indefinitely;
 4. Results in substantial functional limitations in three or more of the following areas of major life activity (*please check three or more of the following*):
 - Self-care
 - Receptive and expressive language
 - Learning
 - Mobility
 - Self-direction
 - Capacity for independent living
 - Economic self-sufficiency; and
 5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
- The applicant is *dually diagnosed* with both a chronic alcohol or drug abuse disorder and a serious mental illness that are expected to be of long-continued and indefinite duration; substantially impede this person's ability to live independently; and are of such nature that they could be improved by more suitable housing conditions.
- The applicant has a *physical or mental disability caused by HIV/AIDS or related disease* that is expected to be of long-continued and indefinite duration; substantially impedes this person's ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.

Title and signature of person verifying disability:

_____ (Print Name) _____ (Sign Name)

_____ (Title) _____ (Date)

License or certification type and number: _____

ATTACHMENT B. VERIFICATION OF HOMELESSNESS

Applicant Name: _____

Please check only the option below that describes the applicant's housing status on or about the date this application was submitted. Failure to include required documentation may significantly delay processing of the application.

The Applicant is homeless as defined by HUD because he or she:

- Lives in places not meant for human habitation, such as a cars, abandoned buildings, parks, sidewalks, etc. ("on the street")
 - Documentation attached:* letter from 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 applicant has been residing at the shelter

- Lives in transitional or supportive 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 the shelter(s) verifying the applicant has been residing at the shelter; **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.

- 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.

Title and signature of person verifying homelessness:

(Print Name)

(Sign Name)

(Name of Referring Agency)

(Date)

ATTACHMENT D. REQUIRED HMIS INFORMATION

ADULTS		(HOH Name)	(Other Adult Name)	CHILDREN		(Name)	(Name)	(Name)	
EDUCATION	In school? (yes/no)			EDUCATION	Enrolled? (yes/no)				
	Vocational training? (yes/no)				If not enrolled, state reason				
	Highest grade completed				If enrolled, type of school				
			Name of school						
VETERAN STATUS	Branch			HEALTH STATUS	General health status				
	Duration of active duty				Pregnant? (if yes, give due date)				
	Discharge status			EMPLOYMENT STATUS	Employed? (if yes, state tenure type)				
	Service era				Hours worked last week				
	Served in war zone? (if yes, no. of months.)				If not employed, looking?				
	War zone served in				Able to work?				
	Rec'd hostile or friendly fire?				NOTES/COMMENTS:				
	Registered at VA? If yes, give record number								
DOMESTIC VIOLENCE HISTORY	Victim of domestic violence? Yes / No								
	Date occurred								
	How long in past?								
HEALTH STATUS	General health status								
	Pregnant? (If yes, give due date)								
EMPLOYMENT STATUS	Employed? (if yes, state tenure type)								
	Hours worked last week								
	If not employed, looking?								
	Able to work?								

INSTRUCTIONS FOR ATTACHMENT D.

Required HMIS Information. Please refer to the following lists to enter the information requested on page 1. Enter number codes as shown below, where appropriate; or, if space is available, enter a written answer based on the choices shown below. Use additional sheets if there are more than three children in the household.

EDUCATION: Adults:

- **In School?:** state “yes” or “no” (includes college work, GED classes, high school)
- **Vocational Training?:** state “yes” or “no” (includes apprenticeship training)
- **Highest Grade Completed:** **1:** high school diploma; **2:** G.E.D.; **3:** one year of college, technical or vocational education; **4:** two years of college, technical or vocational education; **5:** three years of college, technical or vocational education; **6:** Bachelor’s Degree or equivalent; **7:** Five or more years of college, Master’s Degree or Ph.D.; **8:** 11th-12th grade with no diploma; **9:** 10th grade with no diploma; **10:** 9th grade with no diploma; **11:** 8th grade with no diploma; **12:** 7th grade with no diploma; **13:** 6th grade with no diploma; **14:** 5th grade with no diploma; **15:** 4th grade with no diploma; **16:** 3rd grade with no diploma; **17:** 2nd grade with no diploma; **18:** 1st grade with no diploma; **19:** no grade completed

EDUCATION: Children:

- **Enrolled?:** state “yes” or “no” (pre-school through 12th grade)
- **If Not Enrolled, State Reason:** **1:** residency required; **2:** prior school records not available; **3:** no birth certificate; **4:** legal guardian requirements; **5:** transportation problems; **6:** lack of pre-school programs; **7:** immunization requirements; **8:** physical exam records not available; **9:** other; **10:** none
- **If Enrolled, Type of School:** **1:** public; **2:** parochial or private school **3:** Give name if known

VETERAN STATUS: Adults:

- **Branch (of Service):** **1:** Army; **2:** Air Force; **3:** Navy; **4:** Marines; **5:** other
- **Duration of Active Duty:** enter number of months served
- **Discharge Status:** **1:**Honorable; **2:**General; **3:** Medical; **4:**Bad Conduct; **5:**Dishonorable; **6:**other
- **Service Era:** choose one; if the service dates overlap two Service Eras, choose the one containing the majority of the service time. **1:** Persian Gulf (8/1991-Present); **2:** Post-Vietnam (5/1975-7/1991); **3:** Vietnam (8/1964-4/1975); **4:** Between Korea and Vietnam (2/1955-7/1964); **5:** Korea (6/1950-1/1955); **6:** Between WW2 and Korea (8/1947-5/1950); **7:** WW2 (9/1940-7/1947); **8:** Between WW1 and WW2 (12/1918-8/1940); **9:** WW1 (4/1917-11/1918)
- **Served in War Zone?:** if “yes”, give number of months served; if “no”, state “no”
- **War Zone Served in:** **1:** Europe; **2:** North Africa; **3:** Vietnam; **4:** Laos/Cambodia; **5:** South China Sea; **6:** China/Burma/India; **7:** South Pacific; **8:** Persian Gulf; **9:** other
- **Rec’d Hostile or Friendly Fire?:** state “yes” or “no”
- **Registered at VA?:** if “yes”, provide VA record number if known; if not registered, state “no”

DOMESTIC VIOLENCE HISTORY: Adults:

- **Victim of Domestic Violence? Yes/No:** self-explanatory
- **Date Occurred:** provide most recent date of victimization
- **How Long in Past?:** **1:** within past three months; **2:** three-six months ago; **3:** six-twelve months ago; **4:** more than one year ago; **5:** don’t know; **6:** refused to say

HEALTH STATUS: Adults and Children:

- **General Health Status:** **1:** excellent; **2:** very good; **3:** good; **4:** fair; **5:** poor; **6:** unknown
- **Pregnant?:** indicate a “yes” answer by entering a delivery date; if “no”, enter “no”

EMPLOYMENT STATUS: Adults and Children:

- **Employed?:** indicate a “yes” answer by stating the type of employment tenure: **1:** permanent; **2:** temporary; **3:** seasonal
- **Hours Worked Last Week:** state the number of hours worked in week prior to intake
- **If Not Employed, Looking?:** state “yes” or “no” **Able to Work?:** state “yes” or “no”