

**APPLICANT INFORMATION**

Last Name	First Name	Middle Initial	Sex	Social Security Number
Do you use any other Social Security Number or Name(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes: SSN: _____ Name(s): _____			Date of Birth (MM/DD/YY)	
Monthly Income:	Source of Monthly Income:	Veteran of the U.S. Armed Services <input type="checkbox"/> Yes <input type="checkbox"/> No		
Current Living Situation: <input type="checkbox"/> On the Street <input type="checkbox"/> Other _____ <input type="checkbox"/> Emergency Shelter _____ CIS ID # _____ <input type="checkbox"/> Transitional Housing				

**EQUAL HOUSING OPPORTUNITY INFORMATION**

Race – Check All that Apply	Ethnicity	Disability
<input type="checkbox"/> White <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other: _____	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Disabled <input type="checkbox"/> Enrolled in RBHA
If the applicant is claiming disability status, will he/she require any of the following? <input type="checkbox"/> A wheelchair accessible barrier free unit <input type="checkbox"/> Other modifications to unit <input type="checkbox"/> Unit for Hearing-Impaired <input type="checkbox"/> 1 <sup>st</sup> floor unit <input type="checkbox"/> Additional Bedrooms <input type="checkbox"/> Unit for Vision-Impaired  If you checked any of the above boxes, please explain exactly what you will need to accommodate your situation. _____ _____		
If the applicant is claiming disability status, will he/she require a live-in aide or care attendant? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**REFERRING AGENCY**

Referring Agency (RBHA, DRC, Shelter, ect.)	Name and Title	Phone – (10 digits) ( )
Representative Payee Name (If Applicable)	Agency	Phone – (10 digits) ( )

**PLEASE CHECK ANY SPECIAL NEEDS THE APPLICANT MAY HAVE:**

<input type="checkbox"/> Mental Illness <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse HIV/AIDS	<input type="checkbox"/> Physical Disability <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Other _____	<b>Felony Conviction?</b> Yes _____ No _____ (This is NOT a bar to Program Eligibility.)
--	---	---

**Agency Representative and Participant- Please Sign and Date**

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Rep. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_



*ABC Homeless Housing Programs*  
***Verification of Homelessness Form***

FAX to ABC at 602-712-9222

Today's Date: \_\_\_\_\_ CIS ID Number: \_\_\_\_\_

Applicant Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ DOB: \_\_\_\_\_

If applicant is enrolled with Southwest Network, the Provider Network Organization (PNO), please complete:

Case Manager: \_\_\_\_\_

Site: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Does this recipient meet the chronically homeless definition?**

Living on the streets for 1 year or more, or experienced 4 or more episodes of homelessness within the last 3 years?  
(Documentation must be in writing)

Yes  No

Check the box which describes the recipient's current homeless situation and attach the appropriate documentation with this form. **Applications will not be accepted without the proper documentation as described below.**

- Recipient lives in places not meant for human habitation, such as cars, parks, sidewalks, and abandoned buildings (on the street).**

**Documentation Needed:**

Please document recipient's living situation such as where, how long, and personal observations. Please document on letterhead and both case manager and applicant must sign and date this document.

Example: *Joe has been living under the 7<sup>th</sup> Ave Bridge for the last 6 months. This case manager has found the recipient at this area with his personal belongings and sleeping bag and certifies that the recipient is in fact homeless.*

If the case manager does not have first hand knowledge of applicant's homelessness, another service provider may provide the documentation, such as an outreach worker. It must follow the same format as above and signed by the person completing the verification.

- Recipient has been in an emergency shelter.**

**Documentation Needed:**

Please obtain written verification from the emergency shelter staff that the recipient has been residing at the emergency shelter for homeless persons. The verification should be on agency letterhead, signed and dated.

- Recipient is in transitional or supportive housing for homeless persons who originally came from the streets or emergency shelter**

**Documentation Needed:**

Please obtain written verification from transitional housing facility staff that the recipient has been residing at the facility. The verification should be on agency letterhead, signed and dated.

In addition, obtain written verification that the recipient was living on the streets or in an emergency shelter prior to living in the transitional housing facility, or discharged from an institution, or evicted prior to living in transitional housing facility and would have been homeless if not for the transitional housing program.

Example: *Document the phone call to emergency shelter that recipient was at homeless shelter prior to entering transitional housing program. Please include dates of stay and the name of shelter staff member.*

**All questions can be directed to Nicky Stevens, Housing Specialist for Arizona Behavioral health Corporation at (602) 712-9200 x207 or by email to NickyS@azabc.org**

**To be completed by ABC:**

**I certify that this Recipient meets the HUD Definition of Homelessness and there is documentation that demonstrates the applicant's eligibility.**

\_\_\_\_\_  
**ABC Representative**

\_\_\_\_\_  
**Date**



## CERTIFICATION OF DISABILITY FOR ELIGIBILITY PURPOSES

**RE:** \_\_\_\_\_  
**Name of Applicant** **CIS Number**

I authorize the release of information, relative to my physical or mental impairment, to Arizona Behavioral Health Corporation, to verify whether my handicap or disability is covered by the definitions below. This information will be used to verify my eligibility, or will allow deductions to me, under certain housing programs.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The definition of a disabled person includes a person who meets any one of the following criteria:**

1. Has a physical, mental, or emotional impairment that:
  - Is expected to be of long-continued and indefinite duration;
  - Substantially impedes his or her ability to live independently, and;
  - Is of such a nature that ability to live independently could be improved by more suitable housing conditions.

- OR -

2. Has a disability as defined in Sec. 223 of the Social Security Act (42 U.S.C. 423):

"Inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months," or

"In the case of an individual who has attained the age of 55 and is blind and unable by reason of such blindness to engage in substantial, gainful activity requiring skills or ability comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time."

- OR -

3. Has a developmental disability as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001(7)):

"Severe chronic disability that: (a) is attributable to a mental or physical impairment or combination of mental and physical impairments;(b)is manifested before the person attains age 22; (c) is likely to continue indefinitely; (d) results in substantial functional limitation in three or more of the following areas of major life activity: (1) self-care, (2) receptive and responsive language, (3) learning, (4) mobility, (5) self-direction, (6) capacity for independent living, and (7) economic self-sufficiency; and (e) reflects the person's needs for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated."

---

**CERTIFICATION OF DISABILITY (Must be signed by Doctor or Nurse at Clinic)**

In my professional opinion, the applicant DOES / DOES NOT meet the definition of a Disabled Person, as defined above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Professional Title

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Office Name and Address

**PENALTIES FOR MISUSING THIS CONSENT:**

Title 19, 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, HUD, (or any employee of HUD) and may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willfully requests, obtains or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages, and seek other relief, as may be appropriate, against the officer or employee of HUD responsible for the unauthorized disclosure or improper use.