APPLICATION PROCESS

Please complete the application and submit it by the methods listed below along with the following items:

IF APPLYING FOR ANY HOPWA ASSISTANCE…

_____ **COMPLETED, ORIGINAL APPLICATION**

_____ **COPY OF SOCIAL SECURITY CARD(S)** for all household members

_____ **COPY OF INSURANCE CARD(S)** for all household members

_____ **COPY OF PHOTO ID(S)** – Arkansas driver's license or state ID for all household members over the age of 16.

_____ **COPY OF PROOF OF MEDICAL STATUS** – Western Blot results, lab results showing a Viral Load, or statement from your medical provider (included) for all HIV+ household members. If you do not have this information, it must be obtained from your physician's office.

_____ **COPY OF CONDITIONS OF RELEASE FROM PRISON** (if applicable).

_____ **PROOF OF INCOME** for all household members – copies of at paystubs if working (2 paystubs if paid biweekly and monthly; 4 paystubs if paid weekly), or a copy of Social Security Awards Letter if receiving retirement, disability, or SSI. If there any household members over the age of 18 with no income, each member must complete the "Zero Income Affidavit" form.

IF APPLYING FOR TENANT-BASED RENTAL (SUBSIDY) ASSISTANCE ONLY…

_____ **PROOF OF SECTION 8 OR PUBLIC HOUSING APPLICATION SUBMITTAL OR PROOF OF WAITING LIST POSITION** – No application will be processed without this information. HOPWA is a transitional program and is not a permanent solution to housing assistance.

IF APPLYING FOR SHORT-TERM RENTAL, MORTGAGE, AND UTILITY ASSISTANCE ONLY…

_____ **COPY OF CURRENT LEASE OR A RECENT MORTGAGE STATEMENT –** This documentation must be submitted regardless if an applicant is seeking assistance with rent or mortgage.

_____ **COPY OF UTILITY BILL** (if applying for utility assistance) – Utilities must be in a household member's name. You must include the entire bill. Termination or disconnect notices CANNOT be accepted.

PLEASE NOTE: Incomplete applications CANNOT be processed and will be returned to you for additional information. Based upon the nature of your emergency, you may be REQUIRED to provide additional information before receiving assistance.

If you have any questions, please call the office at **(870) 931-4448** before submitting the application.

We look forward to working with you.

Mailing address:

Arkansas Supportive Services
PO Box 154
Jonesboro, AR 72403

Documentation may be sent via fax and email to Adam Watkins, LCSW.

Fax: **(870) 931-4149**
Email: **adam@arsupportiveservices.org**

HOUSING APPLICATION & ASSESSMENT

(*Mandatory Information for HUD)

Name _____ DOB_____ SS#_____

Street Address _____ Phone _____

City _____ State _____ Zip _____ County _____

*** RECENT LIVING SITUATION**

* If client came from one of these facilities in the last 30 days, or was on the street or in an emergency shelter prior, consider the person homeless from the streets or shelter as appropriate.

( ) homeless from the streets
( ) homeless emergency shelter
( ) transitional housing
( ) domestic violence shelter
( ) jail/prison
( ) substance use treatment facility*
( ) hotel/motel without paid assistance
( ) permanent housing for formerly homeless (SHP/S+C/SRO MR etc.)
( ) psychiatric/ mental health facility*
( ) hospital or other medical facility*
( ) living with relatives/friends
( ) participant-owned housing
( ) rental housing
( ) foster care or foster care group home
( ) other: _____

*** DEMOGRAPHICS & HOUSEHOLD/ FAMILY COMPOSITION: Include your information on the first line.**

Use one of the following race and ethnicity codes to fill-in chart below:

***Race:** **W**-White
A-Asian
A/W-Asian/White
B/AA-Black/African American
O/MR-Other/Multi-racial
NH/PI-Native Hawaiian/Pacific Islander
AI/AN-American Indian/Alaskan Native
AI/AN/W-American Indian/Alaska Native/White
B/AA/W-Black/African American/White
AI/AN/B/AA-American Indian/Alaska Native/Black/African American

***Ethnicity:** **H**-Hispanic or **NH**-Not Hispanic

***Relationship:** Self, Husband, Wife, Domestic Partner, Mother, Father, Sibling, Daughter, Son, Grandparent, Grandchild, Aunt, Uncle, Cousin, Roommate, Other

Name	M or F	DOB	HIV + Yes or No	Race	Ethnicity	Relationship	$ Income
						SELF	

***TOTAL Gross Monthly Family/Household Income:** $_____ (*Attach income verification)*

* Please Answer YES or NO to the following questions:	YES	NO
1. Do you have a housing plan with any other agency for maintaining or establishing stable on-going stable housing?	☐	☐
2. Do you have medical insurance?	☐	☐
3. Are you receiving Ryan White services?	☐	☐
4. Are you a Veteran from U.S. military service?	☐	☐
5. Are you a survivor of domestic violence?	☐	☐
6. Are you chronically homeless by HUD's definition? *	☐	☐

* A "chronically homeless person" is "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more **OR** has had at least four episodes of homelessness in the past three years."

Name of RW Case manager _____Date of last Contact _____

Name of HIV physician: _____ Date of last Visit_____

Name of Mental Health Provider _____Date of last Visit _____

List ALL prescribed Medications _____

_____

What type of assistance are you applying for?

Monthly subsidy assistance ☐ Assistance with first month's rent and deposit only☐

Emergency rent or mortgage assistance☐ Emergency utility assistance☐

Supportive Services☐

Do you have a roommate? (Not a partner or family member) Yes ☐ No ☐

Will family members or partner be living with you? Yes☐ No☐

Do you have any pets? Yes☐ No☐

HOUSING SUBSIDY

Do you currently receive rental assistance? Yes ☐ No☐

Have you applied for Section 8 or with the Public Housing Authority? Yes ☐ If so, when? _____ No ☐

Are you willing to apply for Section 8 or Public Housing? Yes ☐ No ☐

If no, why? _____

BACKGROUND

Have you been convicted of a felony? Yes ____ No ____ If yes, when? _____

Are you currently on Probation or Parole? Yes ____ No ____

Which one? _____ For what period?_____

Date(s) of release from incarceration: _____

(Conditions of Release must be included with application)

Do you have any pending court dates? Yes ____ No ____ If yes, when? _____

Conditions that affect housing: _____

Are you or any household member required to register? _____

Do you have an outstanding warrant? Yes ____ No ____

Current Living Situation

Living in: ( ) house ( ) apartment ( ) mobile home ( ) homeless ( ) wants to move

Years living at this residence: _____Number of Bedrooms: _____

Rental unit:

Rent amount: $_____ Security deposit amount for rental unit: $_____

Written lease? Yes ____ No ____

Length of rental agreement: _____ Name(s) on lease: _____

Landlord/management company name (check payable to): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Landlord/management company daytime phone: _____

Mortgage:

Payment amount: $_____ Name(s) on mortgage: _____

Mortgage Company name: _____Years left on mortgage: _____

UTILITIES

What utilities do you pay? ( ) gas ( ) electric ( ) trash ( ) water ( ) sewer ( ) NONE ( ) other: _____

Heating: ( ) gas ( ) electric ( ) propane

Cooking: ( ) gas ( ) electric ( ) propane

Water heater: ( ) gas ( ) electric ( ) propane

CURRENT HOUSING CONDITION			
	Yes	**No**	**N/A**
1. Is your rent or lease payment late? If yes, what is the total amount owed $_____ and for what period? _____	☐	☐	☐
Why are you late?			
Is your mortgage payment late? If yes, what is the total amount owed $_____ and for what period? _____	☐	☐	☐
Why are you late?			
Are any of your utility bills overdue/past due? If yes, what is the total amount owed $_____ and for what period? _____	☐	☐	☐
Why are you late?			
2. Have your utilities been shut-off? If yes, how much is needed to reconnect services $_____	☐	☐	☐
3. Have you ever been evicted for non-payment of rent?	☐	☐	☐
4. Are you having problems with water leaks or water damage in your unit?	☐	☐	☐
5. Are you having problems with your heater?	☐	☐	☐
6. Are you having problems with your air conditioner?	☐	☐	☐
7. Are you having problems with your door or window locks?	☐	☐	☐
8. Are you having problems with your plumbing?	☐	☐	☐
9. Are you having problems with your elevator?	☐	☐	☐
10. Are you having problems with a gas leak, gas smell in your unit?	☐	☐	☐
11. Do you have any broken windows?	☐	☐	☐
12. Are you having problems with poor lighting outside and/or in the hallways?	☐	☐	☐
13. Are you having problems with your water heater?	☐	☐	☐
14. Are you having problems with smoke detectors not working or missing from your unit?	☐	☐	☐
15. Do you need housing that is wheelchair or handicapped accessible?	☐	☐	☐

NOTICE

The HOPWA Program is provided by HUD (Housing and Urban Development) which is funded by federal money. Any client using fraudulent information to obtain housing or utility assistance will be terminated from the program immediately and will not be eligible for assistance in the future. In addition, please see the code below:

WARNING: 18 U.S.C.1001 provides, among other things, that whoever knowingly and willingly makes or uses a document or writing containing any false, fictitious, or fraudulent statements or entry, in any matter within the Jurisdiction of any department or agency of the United States, shall be fined not more than $10,000 or imprisoned for not more than five years, or both.

By signing below, I am certifying that the information on this application is true and correct. I acknowledge that it is my responsibility to report any and all changes in the income of my household within **ten** days of the change. I understand that intentionally misrepresenting income or family composition is grounds for denial or termination of housing assistance and that false statements or information are punishable under Law (Federal and State).

Signature: _____ Date: _____

Signature: _____ Date: _____

HOPWA STRMU ASSISTANCE
Nature of Emergency

Please describe your current situation. You will need to provide detailed information regarding the reason you cannot pay your rent, mortgage or utility bills. You will need to list any other bills and/or circumstances that justify your need. Please give the dollar amounts of your bills. When you have completed this form please sign and date at the bottom. Copies of bills justifying your need must be sent in with this application. **No application will be processed until we receive this information**.

[Applicant Signature] [Date]

CLIENT BUDGET

CLIENT NAME _____ DATE: _____

Current housing situation: _____

Number in household: _____

Total monthly income: * _____ Total monthly expenses: _____

***** For short-term rent, mortgage and utility or supportive services-only applicants, use **gross** income from Eligibility Calculation Worksheet.

***** For tenant-based (TBRA), project-based, or facility-based housing applicants use **adjusted** income amount from Income and Resident Rent Calculation Worksheet.

Income Sources	Household Member's Name	Amount	Month/Year	
TANF*		**$**		**per**
Job*		**$**		**per**
Social Security Check		**$**		**per**
VA Benefits		**$**		**per**
Military Pay		**$**		**per**
Retirement		**$**		**per**
Unemployment		**$**		**per**
Child Support		**$**		**per**
Educational Assistance		**$**		**per**
Self Employment		**$**		**per**
Foster Care		**$**		**per**
Food Stamps		**$**		**per**
Money from Family		**$**		**per**
Other Income		**$**		**per**

Vehicle Information

Do you or any household member own a vehicle(s)? Yes ____ No ____

If **YES** and the vehicle is financed, how much is owed $ _____ What is the monthly payment? $ _____

Do you have car insurance? Yes ____ No ____ If Yes, How much do you pay per month? $_____

Medical Information

Do you have medical/health insurance? Yes ____ No ____

If Yes, What type of coverage do you have? _____

EXPENSES for Two MONTHS

#1 Current Monthly Expenses

Rent	$	Medical Insurance	$	Clothing	$
Mortgage	$	Out of pocket Medical	$	Life Insurance Policy	$
Gas	$	Public Transportation	$	Furniture Payment	$
Electric	$	Automobile Payment	$	Credit Card Payments	$
Water	$	Car Insurance Payment	$	Day Care/Childcare	$
Trash	$	Gasoline/Car Repairs	$	Cable/Satellite/Internet	$
Cell Phone	$	Household Supplies	$	Court Fines	$
Telephone	$	Food	$	Other	$

#2 Next Month's Expenses

Rent	$	Medical Insurance	$	Clothing	$
Mortgage	$	Out of pocket Medical	$	Life Insurance Policy	$
Gas	$	Public Transportation	$	Furniture Payment	$
Electric	$	Automobile Payment	$	Credit Card Payments	$
Water	$	Car Insurance Payment	$	Day Care/Childcare	$
Trash	$	Gasoline/Car Repairs	$	Cable/Satellite/Internet	$
Cell phone	$	Household Supplies	$	Court Fines	$
Telephone	$	Food	$	Other	$

1. Do you need help budgeting your money? ( )Yes ( ) No
2. Are you currently enrolled in job training or job placement services? ( )Yes ( ) No
3. Are you currently applying for assistance from other agencies? ( )Yes ( ) No
   If yes, what assistance have you applied for? _____

_____

Housing Plan

Plan to Increase Income and Reduce Expenses:

Action	Target Date:
1.	
2.	
3.	
4.	

Client's Signature: _____ Date: _____

Housing/Case Manager Signature: _____ Date: _____

Smoke/ Carbon Monoxide Detector Verification Form

Client's Name _____

Date of Birth _____

Please check:

◯ House/Apartment is equipped with a smoke detector/ carbon monoxide detector or alarm.

◯ Battery operated smoke detector was provided to client for installation

◯ Agency installed battery operated smoke detector

Has agency conducted a site check to ensure installation?

◯ Yes

◯ No

Address of the property for which assistance is provided:

Street: _____

City: _____ Zip: _____

_____ _____

Client Signature Housing Coordinator

PERMISSION TO RELEASE CONFIDENTIAL INFORMATION TO SECURE NECESSARY SERVICES

HOPWA HOUSING ASSISTANCE

I authorize personnel of NARAN to share my identity, the fact that I have a confirmed diagnosis of HIV or AIDS, and that I seek their services for support. I authorize only those agencies or individuals who are listed below to share information with NARAN or receive information from NARAN. Unless I have initialed and signed additional release forms for specific purposes, no information which might identify me may be shared by representatives of NARAN with any other person or organization. I understand that NARAN will take all necessary precautions to protect my identity. This consent expires twelve months after signed, when revoked, in writing, by the authorized person, or upon exit from the program.

By my signature below, I hereby agree that I shall not hold NARAN liable for the performance or quality or degrees of performance of services agreed to by affiliates. I authorize NARAN to release my identity, my HIV/AIDS status when necessary, and my need for services and support to the individuals, groups, or agencies listed below.

Name of Authorized Persons*	**Applicant's Initials**	**Date**
Agency Name: Arkansas Department of Health		
Case Manager: SAS & MCM with ARcare		
Physician:		
Clinic:		

**This includes Clergy, Counselors, other Agencies, Family members, Attorneys, Landlords, or anyone that the client may so choose.*

My signature below authorizes NARAN to release necessary information to the agencies and individuals initialed by me, above. Further, if I am unable to participate in a determination of those services which would be of benefit to me, or my permission is needed in the future to authorize additional services for this program, my signature below authorizes the named individual to sign for assistance for me in my absence after receiving my verbal permission. Finally, if I am unable to make decisions, the person listed below is hereby authorized to represent me:

Print Name of Authorized Individual | Relationship

Address of Authorized Individual | Phone/Fax

Client Signature | Date

Witness Signature | Date

NOTES: _____

_____

_____

STATEMENT OF HIV VERIFICATION

HOUSING OPPORTUNITIIES FOR PERSONS WITH AIDS

Note: This form may be filled out by a physician, certified health care worker, or HIV testing site representative.

Applicant's Name: _____

Social Security Number: _____

I certify that _____ has

tested positive for the Human Immunodeficiency Virus.

Printed Name: _____

Signature: _____

License #: _____ State Issued: _____

Date: _____

Telephone: (____) ____ - _____

Fax: (____) ____ - _____

Address: _____

City _____ State_____ Zip _____

NOTES:

_____

FOR HOPWA USE ONLY:

This information was verified on _____ by _____.
[mm/dd/year] [print name]

HOPWA Representative Signature: _____ Date: _____

ZERO INCOME AFFIDAVIT
HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS

I, _____, have applied for emergency or rental assistance through the HUD Housing Opportunities for Persons with AIDS (HOPWA) program. Program regulations require verification of all income from participating households.

Income includes but is not limited to:

- Gross wages, salaries, overtime pay, commissions, fees, tips and bonuses
- Net income from operation of a business or from rental or real personal property
- Interest, dividends and other net income of any kind for real personal property
- Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of period receipts
- Lump sum payment(s) for the delayed start of a periodic payment (except as provided in 24 CFR 5.609 (b)(5))
- Payments in lieu of earnings, such as unemployment and disability compensation, worker's compensation, and severance pay
- Public assistance
- Alimony and child support payments (whether through the court system or not)
- Regular pay, special pay and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling)
- Regular monetary gifts from family and/or friends

I have stated during this verification process that I have no income at this time. I have not received income since _____. I do not expect to receive any income until _____. I applied for _____ (other financial assistance) on _____ (date).

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in the HOPWA program, and may be grounds for termination of assistance. WARNING: It is unlawful to provide false information to the government when applying for federal public benefit programs per the Program Fraud Civil Remedies Act of 1986, 31 U.S.C. §§ 3801-3812.

I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes to my household composition or income in writing to within ten (10) business days of such change.

Signature: _____ Date: _____

Witness: _____ Date: _____

Case Manager/Care Coordinator's Notes: