

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 APPLICATION** Packet
- \_\_\_\_\_ **COPY OF PHOTO ID(s)** – Valid driver’s license, state ID or passport for all household members over the age of 15.
- \_\_\_\_\_ **COPY OF PROOF OF MEDICAL STATUS** – Test 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.
- \_\_\_\_\_ **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 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.

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

**\* 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:

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

**\*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: \_\_\_\_\_



# 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.

<b>Name of Authorized Persons*</b>	<b>Applicant's Initials</b>	<b>Date</b>
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:

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Print Name of Authorized Individual Relationship

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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:

# Client Participation Agreement

Welcome to the Housing Program. This program is designed to assist you and your family to find and maintain housing stability. As a client you have rights and responsibilities, which ensure the integrity of the program. Please read the following information carefully and don't hesitate to ask your Housing Coordinator if you have questions regarding this information.

## **Your Rights As A Client:**

- To be treated with respect, dignity, consideration, and compassion.
- To receive services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical and/or mental ability.
- To have access to the program policies and procedures.
- To have the opportunity to ask questions and obtain answers related to program requirements.
- To participate in making decisions and creating a plan for maintaining your housing.
- To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.
- To be informed about additional resources available to you.
- To withdraw your voluntary participation in the program at any time.
- To have your personal information and records be treated confidentially.
- To have your information released /shared with other people only with your consent.
- To request a Reasonable Accommodation as described by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.
- To file a complaint or grievance about the services or decisions made by the program.

## **Your Responsibilities As A Client:**

- To provide accurate, honest, comprehensive information/completed forms requested by your Housing Coordinator within the timeframe requested.
- To notify your Housing Coordinator of any changes to your income or the income of the people who live with you within 15 days of the change.
- To notify your Housing Coordinator if any member of your household leaves the household or if a new person comes to live with you within 15 days of the change.
- To maintain current contact information, including a current mailing address, phone number, and emergency contacts with your Housing Coordinator.
- To respect the rights, property, and privacy and/or confidentiality of others and their right to peaceful enjoyment of their homes.
- To comply with your Housing Coordinator and requirements, policies, and procedures as detailed in the Program Policies and Procedures manual. This includes:
  - Cooperating in the development and implementation of a Housing Stability Plan
  - Seeking and applying for other financial assistance and housing programs as identified (i.e. Section 8)
  - Maintaining regular contact with your Housing Coordinator
  - Keeping scheduled appointments
  - Informing your Housing Coordinator of any problems you are having that could affect your housing
  - And asking questions when clarification is needed

- To treat all program staff with respect and courtesy at all times. Physical violence or threats of violence toward staff, landlords or neighbors will result in termination of assistance.
- To abstain from unlawful commission of crimes or possession of illegal drugs on the rental premises.
- To assume full responsibility for the consequences of violating program rules.
- To provide consent for the exchange of information between the program and the case management agency.

**The following section**  **Does**  **Does Not apply to you**

If you receive long-term rental assistance through the program, you have the following additional responsibilities as a client:

- To locate your own rental housing. However, understand that the program must first authorize rental assistance to begin before payments will occur.
- To pay the rent and any utilities on or before the due date. If late fees do accrue you will be responsible for those fees. Program funds will pay part of your rent and utilities, but you are responsible to pay the remaining balance or seek additional assistance if you cannot.
- To never pay a landlord, roommate, or other housing provider more than your portion of the rent as established by your Housing Coordinator.
- To maintain the housing unit in good condition as required by the rental agreement.
- To notify your Housing Coordinator of any problems that you are having with the landlord or rental unit.
- To live in the rental unit as stated in the rental agreement and give the landlord and your Housing Coordinator required notice if you decide to move. **If you wish to move to a new rental unit, you must request authorization to move from your Housing Coordinator 60 days in advance.** If you leave your rental unit for more than 30 days, you may be terminated from the program.
- **To comply with all terms of the lease or rent agreement.**

**I understand that the following actions will result in my immediate termination from the program (please initial next to each):**

\_\_\_\_\_ Committing fraud, bribery or any other corrupt or criminal acts in connection with any federal housing program. This includes lying about or misrepresenting information like my income or my relationship to other people that live with me.

\_\_\_\_\_ Leaving my assisted unit for longer than 30 days except in cases where I am hospitalized or placed into residential substance abuse or mental health treatment.

\_\_\_\_\_ Moving into a new rental unit without approval from my Housing Coordinator.

\_\_\_\_\_ Threatening or abusive behavior toward program staff or other people that help me with my housing, neighbor(s) or my landlord. This can include me making threats out loud or implying threats of violence even if I don't directly say it.

\_\_\_\_\_ Commission by myself, any member of my household, my guests or any person under my control of any violent or drug-related criminal activity that threatens the health, safety or right to peaceful enjoyment of the premises by other residents. This includes making or selling drugs illegally.

\_\_\_\_\_ Causing serious damage to my assisted unit (including damage caused by my guest or a member of my household). This includes vandalism, arson, and breaking or soiling fixtures, floors, walls, windows, doors, or appliances.

I have agreed to the requirements listed on all pages of this form, I understand that it is my responsibility to ask questions that I might have regarding this agreement. I also understand that failure to comply with this agreement may result in loss of my housing assistance and termination from the program.

\_\_\_\_\_  
Client/Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Housing Coordinator Signature

\_\_\_\_\_  
Date