Health
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MFAP

Dear Provider,

We thank you for referring your clients to our Permanent Supportive Housing Program, Moore Place. Enclosed are some policies and procedures that we need to clarify before completing this application. This application should be completed by the referring party **ONLY** and should not be given directly to the client to complete.

Moore Place is a Permanent Supportive Housing Program open to individuals who are currently homeless or in danger and also suffer from one of the following disabilities. (***HIV/AIDS, Mental Illness, SSI/SSDI, or Substance Abuse History***) Client's **DO NOT** have to be chronically homeless in order to apply for Moore Place. There is no limit of stay as long as the Resident adheres to Moore Place's Rules and Regulations. However, the goal of the program is to transition residents to independent living.

- Clients must be employed or have a stable source of income. (SSI, SSDI, Pension, etc.) Individuals without a source of income cannot be considered for Moore Place. Clients' employment or source of income must be established ***before*** applying to Moore Place.

- Moore Place has a monthly program fee of **$400.00**. The program fee includes electricity, gas and Wi-Fi internet access. The first month's program fee is due at the time of intake and every following month no later than the 5th. Cable TV can also be provided in the client's room for an additional monthly fee.

- Clients may only bring two large bags or suitcases of clothing upon admission, and all clothing must complete our delousing procedure. Any clothing or materials brought into the facility after the intake procedure must complete the same process before being allowed into a resident's room.

- No forms of drugs or alcohol are allowed within the premises and residents are expected to remain sober within the facility. Tobacco smoking is only allowed outside the facility. Residents who wish to smoke tobacco must do so within the designated areas. Congregate living requires that we consider the welfare of all residents within the facility.

- Due to the unique nature of our congregate style of living we CANNOT accept applications from clients who are not sober. If a prospective client has a history of substance abuse, we ask for a **MINIMUM AMOUNT OF 90 DAYS DRUG FREE,** before an application can receive consideration. This clean time must be documented and signed by the client's treatment provider and must be included with the application at the time of submission.

- If the referred client has a history of Mental Illness we require documentation of stability, treatment history, and a current medication list. Applicants must also be receiving treatment, and the mental health provider must indicate that a congregative living environment would be conducive for the potential resident.

As a referring provider we ask that you screen your clients accordingly and only submit applications that follow our guidelines. We look forward to collaborating with you and once again thank you for your client referrals.

If you have any questions, please feel free to contact Desmond Cordovez (203) 855-9535 Ext: 104

Sincerely,
Desmond Cordovez
Moore Place Program Director

MFAP
618 West Avenue, Norwalk, CT 06850
203 855-9535 Fax: 203 642-3920 info@mfap.com
www.mfap.org

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**Case Worker's ONLY please submit complete applications to:**

Email: DCordovez@MFAP.COM

Fax: (203) 642-3920

In Person: Mid Fairfield AIDS Project
618 West Avenue
Norwalk, CT 06850

Please Remember:

**INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED**

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# Moore Place
# Pre-Admission Document Checklist

All applications must be accompanied by the following documentation to receive consideration.

All applicants must be verified homeless and be able to present documentation indicating so.
Applicants must also have evidence of a disability, (***SSI, SSDI, Mental Health Diagnosis, Substance Abuse, HIV+***)

**Required Documents**: Case Manager, please include the following documents with your application submission.

## Required Documents

| | | | |
|---|---|---|---|
| Homeless Verification | ☐ | Drivers License | ☐ |
| Disability Verification | ☐ | Medical Insurance Card | ☐ |
| HIV Verification (if appl) | ☐ | Social Security Card | ☐ |
| Medication List | ☐ | Proof of Residency | ☐ |
| Proof of Income | ☐ | TB Test Results | ☐ |

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## SUPPORTIVE HOUSING PROGRAMS

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# MFAP

## MOORE PLACE APPLICATION

DATE OF REFERRAL: _____ TIME OF REFERRAL: _____

APPLICANT NAME: _____ REFERRED BY: _____

CASE MANAGER: PHONE:

1. Applicant Last Name: _ _First Name: _MI:

2. Address: _

3. City: _ State: Zip:

4. Zip Code of Last Permanent Address:_

5. Phone where applicant can be reached with area code: (_

6. Social Security Number: 7. Date of Birth: Age: _

8. Gender: M F _Other (transgender) 8a. Primary Language:

9. Race:

_a. American Indian/Alaskan Native _b. Asian _c. Black/African American

_d. Native Hawaiian/Other Pacific Island _e. White __f. American Indian/Alaskan Native & White

_g. Other multi-Racial _i. Asian & White j. Black/African American & White

k. American Indian/Alaskan Native & Black African American

10. Ethnicity: a. Hispanic or Latino _b. Non Hispanic or Non-Latino

11. Marital Status:

a. Single _c. Separated _e. Widowed/Widower

_b. Married/cohabiting _d. Divorced

12. Veteran Status. A veteran is anyone who has been on active military duty. Is Applicant a Veteran:_ Y N

FAMILY MEMBERS: Enter family members that may live with the client

| Name (Not Applicant) | Relationship to Client | Social Security Number | Gender | Date of Birth |
|---|---|---|---|---|

17. **Chronically homeless person. Definition:** An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for one (1) year or more **OR** has had at least four (4) episodes of homelessness in the past three (3) years. To be considered chronically homeless a person must have been on the streets or in an emergency shelter, (not in transitional housing) during these episodes of homelessness.

a. Is this individual/family chronically homeless? Y N

b. Number of episodes of homelessness in the past three years _

**IF Number 17 is YES:** What was the last date the client lived in the community? _

18. **Homeless Definition:** Person living in an emergency shelter or a place not meant for human habitation i.e. street, car or abandoned building

Is his individual/family Homeless? Y N

19. **At Risk Of Homelessness:** Someone exiting a Treatment Program, Institution, Transitional Living Program, Half-Way House or Jail with no place to live or is in danger of losing their housing or living in an inappropriate housing situation such doubled up, overcrowded or unsafe dwelling

Is this individual/family At Risk of Homeless? _____Y _____ N

20. **Is Applicant Receiving Services from a DMHAS Facility:**

Dubois, Norwalk Hospital, Optimus Healthcare, SWCMHS: _____Y _____ N
***If yes please contact applicant's clinician at the above agency to determine eligibility for DMHAS housing**

21. Estimate the total time homeless in the past three years:

_____a. Not homeless
_____b. Less than 1 month
_____c. At least 1 month but less than 6 months
_____d. At least 6 months but less than 1 year
_____e. At least 1 year but less than 2 years
_____ f. 2 years but less than three
_____ g. 3 years or more

22. Length of homelessness this episode: (How long has this client been homeless?)

_____ a. Not homeless at present
_____ b. Less than one month
_____c. At least 1 month but less than 6 months
_____ d. Three years or more.
_____ e. At least 6 months but less than 1 year
_____ f. At least 1 year but less than 2 years
_____ g. Two years but less than three

*** Did Applicant Experience any Episodes of Homelessness as a Child (17 or under):** _____Y _____ N

23. Current living situation (Enter the one living situation where the client has been the majority of the time)

_____ a. Non-housing (street, park, care, bus station, etc.)
_____ b. Emergency Shelter
_____ c. Transitional Housing for homeless
_____ d. Psychiatric Facility
_____e. Substance Abuse Tx Facility *
_____f. Rental Housing
_____ g. Hospital *
_____ h. Jail/Prison*
_____ i. Domestic Violence Situation
_____j. Living w/Relatives, Friends
_____ k. Other _____

* If a participant or family head(s) of household came from one of these facilities but was there less than 30 days and was living on the street or in emergency shelter before entering the treatment facility, they should be counted in either the street or shelter category, as appropriate.

24. How was this referral with this client initiated? (Check one)

_____ a. Self Referral - Client initiated contact w/program
_____b. Outreach by Shelter + Care Staff/Hot Team Staff
_____ . Shelter staff or staff working in a homeless program
_____d. Inpatient or outpatient health/mental health program
_____e. Other hospital/medical staff
_____f. Alcohol, drug program
_____g. Other social service staff
_____ h. Police
_____ i. PHA waiting list
_____ j. Church Staff
_____ k. Other
_____ l. Unknown

25. Where did the first contact with this client take place? (Check one)

_____ a. Shelter or mission for the homeless
_____ b. Drop in Center
_____c. Hospital
_____d. Street, park, outdoors
_____ e. Mental Health Agency
_____ f. Health Clinic
_____ g. Soup Kitchen
_____ h. Other (Specify) _____

26. What was the date of your (or your agency's) first contact with client? _____

27. Is Applicant currently on a waiting list for any of the following:

Section 8 Public Housing ☐ Bridge Subsidy ☐ Veterans Affairs Supportive Housing (VASH) ☐ Shelter Plus Care

28. Identified Disability (Is this client disabled as defined by HUD and/or DMHAS?) _____Y _____ N

29. If yes, Check ALL those that apply and complete attached disability determination form

_____ a. Mental Illness
_____ b. Drug Abuse
_____ c. Alcohol Abuse
_____ d. Developmental Disability
_____ e. Applicant requires wheelchair accessible unit
_____ f. Physical disability (Sight, Hearing, Mobility)
_____ g. HIV/AIDS and Related Diseases
_____ h. Domestic Violence Survivor
_____ i. Other: _____

30. Alcohol Rating (Indicate your assessment)

_____ a. Abstinence
_____ b. Use without impairment
_____ c. Abuse
_____ d. Dependence
_____ e. Severe dependence

31. Drug Rating (Read the attached clinical rating scale for drugs and indicate your assessment code)

_____ a. Abstinence
_____ b. Use without impairment
_____ c. Abuse
_____ d. Dependence
_____ e. Severe dependence

---

32. Is the applicant willing to participate in the service components of these programs? _____Y _____ N
(Note: For DMHAS RAP Opportunities and some HUD Funded Programs accepting services is not mandatory)

Using the list of services below, indicate which services would address the applicant's current/immediate needs:
In right hand column please prioritize the **THREE** (1, 2, 3) MOST IMPORTANT Services Across all Categories

| HEALTH CARE RELATED NEEDS | YES | NO | PRIORITY # |
|---|---|---|---|
| Psychiatric or Emotional Support Services | | | |
| Medical Services | | | |
| Dental Services | | | |
| Detoxification from Alcohol or Substance Abuse | | | |
| Treatment for Alcohol or Substance Abuse | | | |
| Medication Support (Visiting Nurse or Med Supervision) | | | |

| PERSONAL CARE/GENERAL NEEDS | YES | NO | PRIORITY # |
|---|---|---|---|
| Support with Personal Hygiene ( shower, haircut) | | | |
| Access to Food | | | |
| Access to Clothing | | | |
| Help with Transportation (Tokens, Logisticare) | | | |
| Support Obtaining State Identification or Driver's License | | | |
| Support Obtaining Other Legal/Official Documents | | | |

| HOUSING RELATED NEEDS | YES | NO | PRIORITY # |
|---|---|---|---|
| Immediate/Emergency Shelter | | | |
| Halfway House or Transitional Living Facility | | | |
| Long-Term, Permanent Housing | | | |
| Drop-In Center or Day Program | | | |

| FINACIAL/EMPLOYMENT NEEDS | YES | NO | PRIORITY # |
|---|---|---|---|
| Money Management Support | | | |
| Job Training Services | | | |
| Job Search Services | | | |
| Access to Public Financial Support or Disability Benefits | | | |

33. Does client have a source of income? (e.g. SSI, SSDI, GA etc.) _____Y _____ N

IF #33 is YES, enter the amount of the household's monthly income BY SOURCE TYPE and indicate the person receiving the income. If the household has no income, check item n. If Other, please specify.

| Income Recipient | Name if Other | Source of Income | Start Date | Amount |
|---|---|---|---|---|
| ___ Client | Other _____ | a. Social Security Income (SSI) | _____ | $_____ |
| Client | Other _____ | b. Social Security Disability Income (SSDI) | _____ | $_____ |
| Client | ___ Other _____ | c. Social Security | _____ | $_____ |
| Client | ___ Other _____ | d. General Assistance | _____ | $_____ |
| ___ Client | ___ Other _____ | e. Temporary Aid to Needy Families (TANF) | _____ | $_____ |
| Client | ___ Other _____ | f. Child Support | _____ | $_____ |
| Client | ___ Other _____ | g. Veteran Benefits | _____ | $_____ |
| Client | ___ Other _____ | h. Employment Income | _____ | $_____ |
| Client | ___ Other _____ | i. Unemployment | _____ | $_____ |
| Client | ___ Other _____ | j. Medicare | _____ | $_____ |
| ___ Client | ___ Other _____ | k. Medicaid | _____ | $_____ |
| ___ Client | ___ Other _____ | l. Food Stamps | _____ | $_____ |
| ___ Client | ___ Other _____ | n. Other (specify) _____ | _____ | $_____ |
| ___ Client | ___ Other _____ | n. No financial resources | _____ | $_____ |

**Are there any outstanding debts** Indicate Amount in space provided:

☐ UI electric _____ ☐ Gas _____ ☐ Oil _____ ☐ Cable_____ ☐ Phone _____

☐ Credit Card _____ ☐ Bank _____ ☐ Medical _____ ☐ Other _____

**Education and Employment History:**

Highest Grade Achieved: _____ History of Special Education _____ (y/n)

**State the title of last 3 jobs held and the date of employment:**

1). Title of Job Held: _____ Date of Employment _____

2). Title of Job Held: _____ Date of Employment _____

3). Title of Job Held: _____ Date of Employment _____

**Current/Past Criminal History:**

☐ Criminal charges pending ☐ Probation (if checked provide name and # below)

☐ History of assault/criminal behavior ☐ History of fire-setting

Probation Officer Name: _____ Phone #: ( ) _____

**Contact Information:**

Community Case Manager: _____ Phone #: ( ) _____

Psychiatrist: _____ Phone #: ( ) _____

Therapist: _____ Phone #: ( ) _____

Medical Physician: _____ Phone #: ( ) _____

**Conservator or Payee:** _____ Financial Conservator _____ Conservator of Person _____Payee

**Conservator Name:** _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

**Payee Name:** _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

**EMERGENCY CONTACT INFORMATION:** List person (family member, friend, sponsor, etc.) who should be contacted in case of an emergency

Emergency Contact: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

May the staff leave a message with this person if s/he is trying to reach applicant/tenant? _____Y _____ N

**REQUIRED FORMS FOR APPLICATION SUBMISSION:**

- ☐ **APPLICATION FORM: Be sure you answered all questions, and include your telephone number**
- ☐ **FEDERAL PRIVACY ACT NOTICE**
- ☐ **CONSENT FOR RELEASE OF INFORMATION ..(FORM ATTACHED)**
- ☐ **DOCUMENTED PROOF OF HOMELESSNESS ..(FORM ATTACHED)**
- ☐ **DOCUMENTED PROOF OF DISABILITY ..... ..(FORM ATTACHED)**

***Please submit completed applications directly to the housing program(s): See listing on next page***

**I hereby certify that the above information is true and correct to the best of my knowledge.**

Applicant Signature _____ Date _____

Referring Source Name & Agency _____ Date _____

Referring Source Signature _____ Phone _____

## RELEASE OF INFORMATION:

_____ (initials) The applicant understands that this authorization is voluntary and that information to be released/obtained may include only the information provided within this application. That information pertains to Psychiatric, Medical, HIV/AIDS, Drug/Alcohol, Employment, Entitlements and Legal issues. Agencies needing any further information not included within this application will need to obtain that information utilizing an agency specific release of information between the agency and the applicant.

_____ (initials) The applicant understands that the information provided in this application may be entered into the Homeless Management Information System database and may be used in preparing records pertaining to services provided by any of the following agencies who are licensed HMIS users.

_____ (initials) The applicant agrees for the information contained in this Referral Form to be released to and from any of the following agencies with the applicant's initials in the box provided to help facilitate a referral for housing and/or housing services. Furthermore, this application may be reviewed by a committee of housing providers comprised of representatives from the agencies listed below.

**** Please have the applicant initial in the box next to the agency or agencies where the applicant wishes to submit this form ****

| **Housing for Single Individuals** | | | **Initial** | | | | **Initial** |
|---|---|---|---|---|---|---|---|
| ABRI | Bridgeport | (203)338-0669 | | FCA | Norwalk | (203)604-1230 x335 | |
| RNP | Bridgeport | (203)610-8296 | | Keystone | Norwalk | (203)831-6208 | |
| CASA | Bridgeport | (203)339-4112 | | Norwalk Shelter | Norwalk | (203)866-1057 | |
| Alpha | Bridgeport | (203)366-2809 | | Shelter for the Homeless | Stamford | (203)348-2792 | |
| The Connection | Bridgeport | (203)333-9078 | | Laurel House | Stamford | (203)324-1816 | |
| Hall-Brooke | Bridgeport/Norwalk | (203)362-3929 | | St. Luke's | Stamford | (203)363-7982 | |
| BHFC | Bridgeport | (203)579-3180 | | Family Centers | Stamford | (203)324-3167 | |
| Operation Hope | Fairfield | (203)292-5588 | | Pathways | Greenwich | (203)622-4747 | |
| Homes with Hope | Westport | (203)226-1661 | | | | | |

| **Housing for Families** | | | | | | |
|---|---|---|---|---|---|---|
| The Connection | Bridgeport | (203)333-9078 | | Hall-Brooke | Bridgeport/Norwalk | (203)362-3929 | |
| Catholic Charities | Bridgeport | (203)416-1317 | | Homes with Hope | Westport | (203)226-1661 | |
| Operation Hope | Fairfield | (203)292-5588 | | CTE | Stamford | (203)352-4842 | |
| BHFC | Bridgeport | (203)579-3180 | | | | | |

| **HIV/AIDS (HOPWA/HUD)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| St Luke's McKinney House | Stamford | (203)388-0173 | | MFAP | Norwalk | (203)855-9535 | |
| Family Centers | Stamford | (203)324-3167 | | Catholic Charities | Bridgeport | (203)416-1317 | |

| **Housing for Veterans** | | | |
|---|---|---|---|
| ABRI | Bridgeport | (203)338-0669 | |
| VASH | Regional | (203)479-8056 | |

*I understand that I may withdraw this consent at any time prior to the release of the above information. This consent, if not withdrawn, will expire on _____ or twelve (12) months from the date below, if not otherwise specified. A photocopy of this application and release may be used to substitute as the original.*

_____ _____

Signature of Client or Person Granting Authorization — Date

_____ _____

Witness Signature — Date

_____ _____

Requestor Name — Agency

*The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes as well as Federal Regulations 42 CFR part 2. These laws prohibit any further disclosure of the information by the recipient without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient*

## Disability Verification Form

| | |
|---|---|
| Applicant Name: | |
| Date Form Completed: | |
| Referral Agency: | |
| Contact Name: | Contact Phone No.: |

## Type of Disability/Illness

- ☐ Serious Mental Illness: Please Provide _____ **mGAF Score** or _____ **GAF Score**
- ☐ Chronic Substance Abuse
- ☐ Co-Occurring / Dual Diagnosis
- ☐ Other Impairments
  - ☐ Sight ☐ Hearing ☐ Physical ☐ Applicant Requires Wheelchair Accessible Unit
- ☐ AIDS and Related Diseases
- ☐ TB Test: Date _____ Result: _____ (positive/negative)
- ☐ Hepp C Test: Date _____ Result: _____ (positive/negative)

The following information must be completed and signed by a licensed mental health professional, (e.g. Psychiatrist, Psychologist, Nurse, Social Worker, etc.) or a M.D.

Please attach a statement or an assessment attesting to the current condition (consistent with the Type of Disability checked above) of the applicant to this program. Please be as specific as possible documenting the limiting factors of the condition (i.e. functional deficits):

_____

_____

_____

_____

_____

_____

_____

## Disability Entitlement Status

- ☐ Yes (Currently Receiving SSI/SSDI)
- ☐ No

_____ _____

Signature/License No. Date

## HOMELESS OR RISK OF HOMELESSNESS VERIFICATION FORM

| | |
|---|---|
| Applicant Name: | |
| Date Form Completed: | |
| Referral Agency: | |
| Contact Name: | Contact Phone Number: |

## SUPPORTIVE HOUSING PROGRAMS ELIGIBILITY

- ☐ On the Street
- ☐ Emergency Shelter
- ☐ Transitional if they were homeless at entry
- ☐ Sub-standard housing not fit for human habitation, in car, abandoned building, building w/o utilities, housing that would not meet HUD housing quality standards, etc.
- ☐ Institution: psychiatric hospitalization, substance abuse treatment, Half-Way House or jail w/o identified housing upon discharge or resources, if they were homeless at entry
- ☐ At risk of homelessness, please explain:_____

_____

_____

## Primary Reason for Homelessness:

☐ Mental Health Issues ☐ Substance Abuse ☐ Domestic Violence Incarceration

☐ Job Loss ☐ Low Income ☐ Other _____

## VERIFICATION LETTERS

Attached verification letter of homeless status on agency letterhead signed by agency representative.

☐ Yes ☐ No

Attached verification letter of eviction status signed by agency representative, landlord or family member living in dwelling.

☐ Yes ☐ No

_____ _____

Applicant Signature Date

_____ _____

Staff Signature Date

# HOMELESS OR AT RISK OF HOMELESSNESS VERIFICATION REQUIREMENTS

**Living on the street; sub-standard living, not considered fit for human habitation**

- ☐ Sign and dated statements validating situation on letterhead from outreach workers and/or organizations that assisted the person in the recent past **OR**
- ☐ Applicant should prepare a written narrative of the situation of how they came to be and are residing on the street or substandard housing **OR**
- ☐ Written verification signed and dated on letterhead from referring social service organization or outreach worker providing information regarding where the person has been residing.

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**In an emergency shelter**

- ☐ Verification signed and dated on the emergency shelter letterhead documenting where the person has been residing.

---

**Persons coming from transitional housing**

- ☐ Written verification signed, dated and on letterhead from the transitional facility where the participant has been residing. Must have been homeless at entry.

---

**Persons being discharged from an institution**

- ☐ Written, signed and dated verification on letterhead from the institution's staff that the participant is being discharged with no identified housing upon discharge and/or lacks the resources to obtain housing. Must have been homeless at entry.

---

**Persons being evicted from a private dwelling**

- ☐ Evidence of formal eviction proceedings indicating that the participant is being evicted.
- ☐ If there is no formal eviction and the person is forced out of the housing by circumstances beyond the applicant's control, the applicant must provide a signed and dated narrative explaining the situation.
- ☐ Independent verification by the Property Manager or Property Staff signed and dated confirming validation of the above circumstances attesting to their validity.

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