



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 congregate 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



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 | <input type="checkbox"/> | Drivers License | <input type="checkbox"/> |
| Disability Verification | <input type="checkbox"/> | Medical Insurance Card | <input type="checkbox"/> |
| HIV Verification (if appl) | <input type="checkbox"/> | Social Security Card | <input type="checkbox"/> |
| Medication List | <input type="checkbox"/> | Proof of Residency | <input type="checkbox"/> |
| Proof of Income | <input type="checkbox"/> | TB Test Results | <input type="checkbox"/> |

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SOUTHWEST REGION CONTINUUM OF CARE
(Bridgeport /Norwalk/ Stamford)

SCREENING AND REFERRAL FORM

FOR

PERMANENT SUPPORTIVE HOUSING PROGRAMS



HOPWA APPLICATION ☐

MOORE PLACE APPLICATION ☐

DATE OF REFERRAL: _____ TIME OF REFERRAL: _____

APPLICANT NAME: _____ REFERRED BY: _____

CASE MANAGER: _____ PHONE: _____

SOUTHWEST REGION CoC SCREENING AND REFERRAL FORM
PERMANENT SUPPORTIVE HOUSING PROGRAMS

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 this individual/family Homeless? _____ Y _____ N

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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 as 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 | _____ e. At least 1 year but less than 2 years |
| _____ b. Less than 1 month | _____ f. 2 years but less than three |
| _____ c. At least 1 month but less than 6 months | _____ g. 3 years or more |
| _____ d. At least 6 months but less than 1 year | |

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

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

*** 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.) | _____ g. Hospital * |
| _____ b. Emergency Shelter | _____ h. Jail/Prison* |
| _____ c. Transitional Housing for homeless | _____ i. Domestic Violence Situation |
| _____ d. Psychiatric Facility * | _____ j. Living w/Relatives, Friends |
| _____ e. Substance Abuse Tx Facility * | _____ k. Other _____ |
| _____ f. Rental Housing | |

* 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 | _____ g. Other social service staff |
| _____ b. Outreach by Shelter + Care Staff/Hot Team Staff | _____ h. Police |
| _____ c. Shelter staff or staff working in a homeless program | _____ i. PHA waiting list |
| _____ d. Inpatient or outpatient health/mental health program | _____ j. Church Staff |
| _____ e. Other hospital/medical staff | _____ k. Other |
| _____ f. Alcohol, drug program | _____ 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

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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

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

30. Alcohol Rating (Indicate your assessment)

- | | | |
|--|---|---|
| <input type="checkbox"/> a. Abstinence
<input type="checkbox"/> b. Use without impairment | <input type="checkbox"/> c. Abuse
<input type="checkbox"/> d. Dependence | <input type="checkbox"/> e. Severe dependence |
|--|---|---|

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

- | | | |
|--|---|---|
| <input type="checkbox"/> a. Abstinence
<input type="checkbox"/> b. Use without impairment | <input type="checkbox"/> c. Abuse
<input type="checkbox"/> d. Dependence | <input type="checkbox"/> 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			

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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.

<u>Income Recipient</u>	<u>Name if Other</u>	<u>Source of Income</u>	<u>Start Date</u>	<u>Amount</u>
___ 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 _____	m. 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 #: () _____

SOUTHWEST REGION CoC SCREENING AND REFERRAL FORM
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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** _____

SOUTHWEST REGION CoC SCREENING AND REFERRAL FORM
PERMANENT SUPPORTIVE HOUSING PROGRAMS

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.

SOUTHWEST REGION CoC SCREENING AND REFERRAL FORM
PERMANENT SUPPORTIVE HOUSING PROGRAMS

Disability Verification Form

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

Type of Disability/Illness

<input type="checkbox"/> Serious Mental Illness: Please Provide _____ mGAF Score or _____ GAF Score	
<input type="checkbox"/> Chronic Substance Abuse	
<input type="checkbox"/> Co-Occurring / Dual Diagnosis	
<input type="checkbox"/> Other Impairments	
<input type="checkbox"/> Sight <input type="checkbox"/> Hearing <input type="checkbox"/> Physical <input type="checkbox"/> Applicant Requires Wheelchair Accessible Unit	
<input type="checkbox"/> AIDS and Related Diseases	
<input type="checkbox"/> TB Test:	Date _____ Result: _____ (positive/negative)
<input type="checkbox"/> 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

SOUTHWEST REGION CoC SCREENING AND REFERRAL FORM
PERMANENT SUPPORTIVE HOUSING PROGRAMS

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

SOUTHWEST REGION CoC SCREENING AND REFERRAL FORM
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**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.
-

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.
-