**Combined Application for Housing**

The mission of Clare Housing is to provide a continuum of affordable and supportive housing options that create healing communities and optimize the health of people living with HIV/AIDS in the Twin Cities. Clare Housing seeks to house a population consisting of single adults, couples and families who are living with and affected by HIV and cannot afford the cost of market rate housing.

*The purpose of this application is to provide initial information to determine eligibility and to prioritize applicants for residency. Additional forms and signatures will be required later in the application process.*

**PLEASE EMAIL COMPLETED Applications to:** **HousingApplication@clarehousing.org**

**OR FAX TO: (612) 236-9520**

**Please indicate which program(s) you are applying to:**

[ ]  **Clare Apartments**  [ ]  **Clare Midtown**

[ ]  Homecare Program (CADI waiver) [ ]  Homecare Program (CADI waiver)

[ ]  **Clare Terrace** (GRH only) [ ]  **Scattered Site Housing Program**

[ ]  Single

 [ ]  Family

[ ]  **Marshall Flats(**GRH only) [ ]  **Bloom Lake Flats**

[ ]  CADI 55+

 [ ]  Family

**Personal Information:**

First Name: **\_\_\_\_\_\_\_\_\_\_\_\_** Last Name: **\_\_\_\_\_\_\_\_\_\_\_\_** Social Security #: **\_\_\_\_\_\_\_\_\_\_\_\_** DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: [ ]  Female [ ]  Male [ ]  Non-binary

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Phone: \_\_\_\_\_\_\_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you require an apartment with special accommodations for a physical disability? [ ]  Yes [ ]  No

**If yes,** what type accommodations do you need?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any family members who will be living with applicant:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Relationship to Applicant** | **Date of Birth** | **Income** |
| 1  | Head of Household |   |   |
| 2.  |  |   |   |
| 3.  |  |   |   |
| 4.  |  |   |   |
| 5.  |  |   |   |

**Income Information**

Primary source of income:

[ ]  GA Amt. per month: \_\_\_\_\_\_

[ ]  SSI/SSDI Amt. per month: \_\_\_\_\_\_

[ ]  Employment Amt. per month: \_\_\_\_\_\_ Employer (name, address, phone, length of employment): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Child Support Amt. per month: \_\_\_\_\_\_

[ ]  Other \_\_\_\_\_\_\_\_ Amt. per month: \_\_\_\_\_\_

**Case Management Information**

Name of Primary manager/Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#/ email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of HIV manager/Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#/email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Mental Health Case manager/Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#/email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Housing Case manager/Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#/email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CADI**

Do you have a CADI waiver? [ ]  Yes [ ]  No

Do you have MA-Dx? [ ]  Yes [ ]  No

Have you completed a SMRT process? [ ]  Yes [ ]  No [ ]  Unsure

**IF yes,** name/email/ phone of CADI case manager \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you have been assessed for a CADI waiver? [ ]  Yes [ ]  No [ ]  Unsure

If yes, where are you in the process? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, do you think you are eligible and would like more information? [ ]  Yes [ ]  No

**HIV/AIDS Status**

[ ]  HIV [ ]  AIDS

Name of Provider and Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A copy of the HIV/AIDS Status Verification **(Form A)** signed by your primary medical provider must be included. **Be sure to sign the release of information on the form.**

**History of Criminal or Violent Behavior**

We understand that applicants to Clare Housing may have a criminal background. This background check is not designed to eliminate individuals, but to obtain a complete history. Please describe your criminal history including misdemeanor and felony charges. Please include date of charge, location, sentence, incarceration, parole, etc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on parole, probation or community supervision? [ ]  Yes [ ]  No

If so, list the name of the worker, agency, phone number, and dates of supervision:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Housing Status**

Please be specific and include all dates for the past three years. ***Incomplete applications*** *with lack of housing history will be returned for additional information.*

Please describe your housing history for the past three years, including explanation of any evictions:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list addresses **for the past three years** with dates of residency, whether there was a lease, whether rent was paid, and reason for leaving.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Address** | **Dates of residency** | **Lease Amt?** | **Rent Amt?** | **Reason for leaving?** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**A copy of the Homelessness Verification (Form C-1 and/or C-2) signed by your service provider must be included if you are considered homeless under the HUD or State of Minnesota definition found on the verification form. Be sure to sign the release of information on the form**

**Nondiscrimination Policy**

Clare Housing will not discriminate on the grounds of age, race, color, creed, religion, sex, disability, national origin, familial status, sexual orientation, the presence of any sensory, mental, or physical handicap, or the use of a trained dog guide and/or companion animal by a blind or deaf person.

When requested, reasonable accommodations will be provided to ensure equal opportunity for a person with a disability to use and enjoy a dwelling at Clare Housings.

(FORM A)

HIV/AIDS Status Verification Form

I\_\_\_\_\_\_\_\_\_\_\_\_(applicant name) hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_ (Provider’s name) to release, disclose, and provide the results of HIV testing information requested hereunder, to the Clare Housing to determine eligibility for housing. This release of information will become invalid following tenancy at the Clare Housing or 1 year from the date it is signed.

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

**-------------------------------------To be completed by medical professional-----------------------------------**

I certify and say that\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Patient) has HIV infection or AIDS.

Date of: HIV diagnosis \_\_\_\_\_\_\_\_\_ AIDS diagnosis \_\_\_\_\_\_\_\_ Recent Viral Load: \_\_\_\_\_

CD4 Count: \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Clinic Phone Number

# A picture containing text  Description automatically generatedWARNING: SECTION 1001 OF TITLE 18 OF THE UNITED STATES CODE MAKES IT A CRIMINAL OFFENSE TO MAKE WILLFUL FALSE STATEMENTS OR MISREPRESENTATION OF ANY MATERIAL FACT INVOLVING THE USE OF OR OBTAINING OF FEDERAL FUNDS.

## SIGNATURES

I/We understand that Property Solutions & Services, Inc. and its employees are agents of the owner of the property to which I/we are applying and as such represent only the interests of the owner and are in no way acting as my/our agent.

I/We understand that the information in this application will be screened by Rental Research Services Inc., 7525 Mitchell Road #301, Eden Prairie, MN 55344, (952) 935-5700, and Property Solutions & Services, Inc. to determine eligibility for housing and that this information will be verified. I/We certify that all information given in this application is true, complete and accurate. I/We understand that if any of this information is false, misleading or incomplete, management may decline our application or, if move-in has occurred, terminate our lease agreement.

I/We authorize Property solutions & Services, Inc. to make any and all inquiries to verify this information, directly or through information exchanged now or later with rental and credit screening services. Inquiries may include but are not limited to: previous & current landlords, past & present employers, banks and other financial institutions, government agencies providing income to the household, credit providers and credit bureaus, and utility companies. This instrument also serves as your consent to obtain this information from the entities mentioned herein. This authorization is for this transaction only and continues for (1) year unless limited by state law.

If my/our application is approved, and move-in occurs, I/we certify that only those persons listed in this application will occupy the unit, that it will be my/our only residence, and that there are no other persons for whom I/we have, or expect to have, responsibility to provide housing.

I/We agree to notify management immediately in writing regarding any changes in household address, telephone numbers, income and household composition. I/We also agree that I/we have been offered the resident selection criteria.

**All household members age 18 or older sign below:**

|  |  |  |
| --- | --- | --- |
| Applicant's Signature |   | Date  |
| Applicant's Signature |   | Date  |
| Applicant's Signature |   | Date  |
| Applicant's Signature |   | Date  |

(FORM C-1)

Homelessness Verification

Dear Service Provider:

This form is to verify that the person named below is either homeless or at imminent risk of homelessness. Please make sure that the applicant has signed the release of information and complete this form.

**APPLICANT RELEASE OF INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Applicant), do hereby authorize you to disclose all information to Clare Housing as requested below to determine eligibility for housing. This release of information will become invalid following tenancy at Clare Housing (Clare Apartment, Clare Midtown and Project Cornerstone) OR 1 year from the date it is signed.

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

**According to HUD, a homeless individual is someone who is living on the street or in an emergency shelter, or who was living on the street or in an emergency shelter prior to entering a short-term institution or a transitional housing project.**

**Please review the attached checklist to determine if your client fits HUD criteria for homeless status.**

Is the applicant homeless? [ ]  Yes [ ]  No

Is the applicant at imminent risk of homelessness? [ ]  Yes [ ]  No

Please describe the current housing situation of the applicant as it is known to you. **(Please be specific, especially if you answered yes to either question above):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Professional Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency/Organization \_\_\_\_\_\_\_\_\_\_\_\_\_

Agency/Organization Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(FORM C-1)
Checklist for Eligibility for Permanent Housing**

Thisfor is for those with HUD McKinney Vento Funds under The Supportive Housing Program, the Section 8 Single Room Occupancy Program, or Shelter Plus Care Programs. **Include this checklist in each household’s file with third party evidence—*do not use other funder’s definitions for compliance with HUD funded households*).** A homeless person is someone *who is living on the street or in an emergency shelter, or who was living on the street or in an emergency shelter prior to entering a short-term institution or a transitional housing project*

|  |  |
| --- | --- |
| [ ]  \*\* | \*\*Lacks the resources to obtain housing and one of the following situations on the night before the household entered the program. Explain: |
| [ ]  \* | In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, camps, on the street, etc. *with third party verification attached (see instructions attached if unavailable)* |
| [ ]  \* | In an emergency shelter *with third party verification attached* |
| [ ]  \* | In transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters *with third party verification attached from transitional housing program and previous stay on the streets or in an emergency shelter* |
| [ ]  \* | Is being discharged from an institution, such as a mental health or substance abuse treatment facility or a jail/prison, in which the person has been a resident for less than 30 consecutive days and originally came from a place unfit for human habitation or an emergency shelter. *Third party verification attached from a hospital, treatment facility or jail and verification of the previous stay on the streets or in an emergency shelter*  |
| [ ]  \*\* | *Written evidence* of a severe or significant disabling condition for those entering (a household member of an SHP or an adult entering the Shelter Plus Care funded program) or client is exempt because the project is funded under the Sect. 8 SRO Mod. Rehab. Program). |

**A person is considered homeless only when they/he/she resides in one of the places described below:**

*\* One of these boxes must be checked \*\* All these boxes must be checked*

**Applicant Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Attached Third party verification** of being homeless and having a qualifying severe disability (SHP requires a member of the household to have a severe disability and S+C grant programs require an adult member of the household have a severe disability. **And /or** Case Note or grant recipient agency’s written determination or observation to support the claim the applicant was *homeless on the night before entering the program, lacks the resources to obtain housing, and has a disabling condition* and qualifies for this McKinney Vento fund program of HUD.

**Agency Employee Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_**

**If needed, See Form C-2**

(FORM C-2)

**Long-Term Homelessness Eligibility Form**

**This form is required to verify eligibility for Long-Term Homelessness (LTH) and must be kept in the tenant file of the housing provider.**

**VERIFICATION STEPS**

**The service provider/assessor who completes this form should:**

* **List two to four years of all housing history below, starting with the most recent date. Approximate dates (month/year) may be used, and intermittent shelter stays (e.g., within one month) may be grouped together. If necessary, continue to list living situations on page three.**
* **For type of living situation, choose from: emergency shelter, transitional housing, psychiatric facility, substance abuse treatment, hospital, jail/prison, staying with friends/family, rental housing, a place not meant for human habitation, or other (specify).**
* **The agency documenting LTH eligibility must attempt to verify each homeless episode and attach a paper copy of the evidence to this form. Verification may be via: letter, Third Party Verification Form, email, phone conversation (include date, name and number of the person you talked to), or evidence in HMIS or another database.**
	+ **If third party verification is not feasible for one or more of the homeless episodes, the applicant may self-certify. List “self-cert” in the verification type, and explain in the comments section why third party verification is not possible.**

**Print Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Start/End Dates** | **Type of Living Situation** | **City and State AND Facility Name OR Address** | **Reason for Leaving** | **Verification Type** | **# Months Homeless** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Comments/Notes/Reason For Self-Certification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Important! Eligibility requirements for homeless status depend on the type of program.*

**Households Experiencing Long-Term Homelessness: Persons, including individuals, unaccompanied youth, and families with children who lack a permanent place to live continuously for a year or more or at least four times in the past three years. Exclude any period of institutionalization, incarceration, or transitional housing when determining the length of time a household has been homeless.**

**Households at Significant Risk of Long-Term Homelessness: Includes (a) households that are homeless or recently homeless that have members who were previously homeless for extended periods of time and are faced with a situation or a set of circumstances likely to cause the household to become homeless in the near future, or (b) previously homeless persons who will be discharged from correctional, medical, mental health or treatment centers who lack sufficient resources to pay for housing and who do not have a permanent place to live.**

**For more information, please read:** [**LTH Definition Eligibility Common Questions**](https://www.mnhousing.gov/idc/groups/public/documents/document/mhfa_011066.pdf) **found at mnhousing.gov.**

**Applicant Verification**

**I verify the information provided on this form is accurate and true.**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

**Service Provider Determination**

**I have determined that the applicant:**

[ ] **Meets the definition of long-term homelessness**

[ ] **Meets the definition of significant risk of long-term homelessness**

[ ] **Does not meet either definition**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title of Professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Company/Agency Name and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

**(FORM D)**

**Application Form for Clare Housing Assisted Living**

**(FOR Homecare Applicants interested in Midtown or NE apartments ONLY).** To qualify for the program, a client must be **CADI eligible** and at risk for being placed in a nursing home. The Clare Housing Homecare Program offers services that enable people living with HIV/AIDS and/or other disabilities to live independently.

Please check the support services that your client needs:

[ ]  24 -hour RN supervision
[ ]  24 -hour coverage by trained resident assistants
[ ]  Medication management
[ ]  Medication reminders
[ ]  Medication set-ups
[ ]  Weekly housekeeping
[ ]  Weekly laundry
[ ]  Activities and social events
[ ]  Scheduled transportation
[ ]  Safety checks
[ ]  Assistance with ADL’s
[ ]  Appointment reminders
[ ]  Wound care
[ ]  Diabetic care

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

Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Checklist for Completed application**

(**Case Managers, PLEASE make sure all information is included before submitting application. The application WILL NOT be considered if it is incomplete)**

[ ]  Completed Combined Application for Housing, with all information requested and signatures of the applicant and the case manager.

[ ]  HIV/AIDS Status Verification form signed by applicant and medical doctor. (Form A)

[ ]  Criminal Background Check form signed by applicant.

[ ]  Homelessness Verification form signed by applicant and service provider (Form C-1) and/or (Form C-2): MN Housing Long-term Homelessness Eligibility Form

[ ]  Homecare Program Initial Application (Form D) (FOR HOMECARE APPLICATIONS ONLY)