HealthChoices Housing Program Pre-Screening

Please review the following information and ensure that you meet ALL of the criteria below before completing the housing application.

- ☐ Enrolled in Medical Assistance
- ☐ Current resident of York or Adams County for at least the last six months
- ☐ Have a current documented serious and persistent mental illness and is involved with behavioral health services
- ☐ Current recipient of Supplemental Security Income/Social Security Disability Income of a limited amount or is able to provide verification these benefits are in the process of being reinstated. Individuals receiving only employment income may be eligible after review of all other eligibility criteria.

AND must also meet at least one of the following target population requirements:

- ☐ **Target Population 1** – Adults living with a serious mental illness, who are currently residing at one of the following facilities: Extended Acute Care (EAC), State Hospital, Community Residential Rehabilitation (CRR), or the Community Hospitalization Integration Project Program (CHIPP) Apartments
- ☐ **Target Population 2** – Youth and Young Adults with serious mental illness who are 18 through 29 years of age and having accessed some form of high intensity behavioral health treatment within the previous twelve (12) months leading up to the date of application
- ☐ **Target Population 3** – Adults with serious mental illness currently involved in the criminal justice system and attending behavioral health treatment. Must have evidence that symptoms of the serious mental illness are linked to the reason for recent charges or for being on probation. **Some charges will prevent individuals from being approved for certain openings in the HealthChoices Housing program**

OR

Meets U.S. Department of Housing and Urban Development's (HUD) definition and has eligible verification of "Homeless".

According to the U.S. Department of Housing and Urban Development, a person is considered homeless only when he/she resides in one of the following places:

- In places not meant for human habitation, such as cars, parks, abandoned buildings, on the street;
- In an emergency shelter (requires documentation from the shelter including dates of stay and signed by shelter staff. The date of the housing application must coincide with the individual's stay at the shelter.)
- In any of the above places, but spending a short time (up to 30 consecutive days) in a hospital or other institution.

Please note all applicants will be screened by the HCMU in order to assess past rental history, independent living skills, and the ability to uphold the terms of a lease. **Therefore, not all applicants who meet the criteria listed above will be approved.**

You or your referral source will be contacted by the HealthChoices Housing Specialist either by phone, email, or letter within 4 business days of receiving a completed application. Information will be provided explaining denial or next steps in the application process.

Applications and Questions may be directed to the attention of:

Amy Hampson, Housing Specialist
York/Adams HealthChoices Management Unit
100 West Market St., Suite B-01
York, PA 17401
Phone: (717) 771-9900
Fax: (717) 771-9590

York/Adams HealthChoices Management Unit
100 W. Market Street, Suite B-01
York, PA 17401
Ph: 717-771-9900 Fax: 717-771-9590

Permanent Supportive Housing Program
Pre-Application Form

Agency Name: ______________________________ Date: ______________

Staff making referral: ______________________________ Phone: ______________

____

Consumer's Last Name First M.I. DOB

____

Current Address Phone

____

Previous Address

How long at previous address? ______________ Reason for Leaving ______________

____

Marital Status: single married informally separated legally separated
divorced widowed

Are you a domestic violence survivor? ________

Are you a Veteran? ________

Are you currently residing in any of the following facilities?

- ☐ CRR/Group Home
- ☐ Extended Acute Care
- ☐ Prison/Jail.
- ☐ CHIPP Apartments
- ☐ State Hospital

What area do you prefer to live in? (Check all that apply)

Gettysburg	☐	City of York	☐
Dillsburg	☐	Windsor	☐
Dover	☐	Red Lion	☐
Manchester	☐	Dallastown	☐
North York	☐	Shrewsbury	☐
East York	☐	Stewartstown	☐
West York	☐	Hanover	☐
Other (Please Specify)	☐		

Are you looking to have anyone else living permanently in the household? ________

- If yes, what is the relationship? ____________________

Which of the following eligibility criteria is met? (Check all that apply):

- ❖ Enrolled/Eligible for Medical Assistance ____ Medical Assistance # ______________
- ❖ Mental Illness ____ Specify Diagnosis ____
  ____
- ❖ Currently Homeless? _____ Have you stayed at a Shelter? ____________________
  If yes, Name of Shelter and Dates of Stay ____________________________
- ❖ Chronically Homeless ____ {HUD Def.: *An individual with a disabling condition who has been either continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years.*}
  - When was most recent episode of homelessness__________
  - Main cause of homelessness ______________________________
- ❖ Substance Use History ____ In Recovery? ____yes ____no
  Drug of Choice ______________________ Age at first use _____
- ❖ Transitional Age (18-29) ____
- ❖ Criminal History ____
  - What were charges and/or convictions? ______________________
  - Prison/Jail Time? (Specify dates of sentence): ____________________
  - On Probation or Parole?(Specify Dates): ________________________

Do you have any medical problems/concerns? ______ If so, please explain ______________

____

____

Are you taking any medications for the above problems? _____ If so, please list ______________

____

Do you have any physical handicaps that require special assistance or accommodations? __________

If yes, please explain ______________________________________

____

Source of income: ________________ Amount per month: ________

Which supportive services have been utilized in the past 6 months? (Check all that apply):

- Case Management ☐
- CTT/ACT ☐
- Substance Abuse Services ☐
- Individual or Group Therapy ☐
- Medication Assistance/Management ☐
- Mental Health Court ☐
- Compeer ☐
- Helpline ☐
- Psychiatric Rehab ☐
- Drop In Center ☐
- Other (Please specify) ☐
- Social Rehab ☐
- Crisis Intervention ☐
- Family ☐
- Friends ☐
- Peer Support ☐
- Housing Assistance ☐
- Employment Assistance ☐
- Education ☐
- Rep Payee ☐
- Life Skills ☐
- Probation ☐

____

____

What supportive services are currently being used regularly?

Reason for Request (How will placement in this Permanent Supportive Housing Program be a benefit?)

What do you see as being the greatest challenge in transitioning to & maintaining independent living?

Please describe your strengths and support network that is in place to help you have success in the Permanent Supportive Housing Program.

What activities would you need support/assistance doing in order to live successfully in a permanent supportive housing unit? (Check all that apply)

Bathing/Showering	☐	Scheduling Needed Appointments	☐
Grooming	☐	Getting to Appointments	☐
Meal Preparation	☐	Laundry	☐
Food Shopping/Menu Planning	☐	Money Management/Budgeting	☐
Medication Management	☐	Cleaning Apartment	☐
Other (please list below)	☐		

HOUSING AUTHORITY OF THE CITY OF YORK
31 SOUTH BROAD STREET, P O BOX 1963
YORK, PENNSYLVANIA 17405
(717) 854-7846
(717) 846-9157 (TDD Only)
(717) 845-9251 FAX

OFFICE USE ONLY

CLIENT #______________

DATE:________ TIME:______

SHELTER + CARE APPLICATION

Are you homeless?: ☐ YES ☐ NO Chronically Homeless?: ☐ YES ☐ NO

Full Name:______________________________ AKA: ______________________________

Caseworker Contact Name:__________________________ Agency:______________________

MARITAL STATUS: Single ________ Married ________ Separated________ Divorced________ Widowed________

CURRENT ADDRESS Street______________________________City____________________County__________

State ______________Zip Code __________Telephone__________________ Check one: Own______Rent________

ADDRESS CHANGES MUST BE REPORTED IN WRITING WHEN THE CHANGE OCCURS. RETURNED MAIL WILL RESULT IN YOUR APPLICATION BEING REMOVED FROM THE WAIT LIST <u>WITHOUT NOTICE.</u>

Please select <u>ethnicity code</u> from the following options: 1-Hispanic or Latino 2-Not Hispanic or Latino

Please select <u>race code(s)</u> from the following options: 1-White 2-Black or African American 3-American Indian/Alaskan Native 4-Asian 5-Native Hawaiian or Other Pacific Islander

Is English your primary language? ☐ YES ☐ NO If no, what language is your first language______________?

Do you need help understanding English? ☐ YES ☐ NO

Relationship	Last Name	First Name	Middle Initial	Ethnicity	Sex	Race	Age	Birth Date	Social Security #
SELF					M / F			/ /	- -

IS THE HEAD OF HOUSEHOLD DISABLED OR HANDICAPPED? ☐ YES ☐ NO
DO YOU EXPECT A CHANGE IN YOUR HOUSEHOLD SIZE? ☐ YES ☐ NO
INCOME FOR ALL PERSONS LISTED ABOVE (Indicate amount before deductions):

Employment $__________per__________ (How many hours per week?)

Social Security /SSI (Supplemental Security Income) $__________per Month

TANF (Welfare)......... $_______per Month Case Record #: 67-__________________
EBT(green Access card) #________________________________

Unemployment .... $_______per Month

Pension.................. $_______per Month From: __________________

Other Source of Income $_______per Month From: ________________

ASSETS: NAME OF BANK OR CREDIT UNION______________________________________

Checking $___________Savings $__________Stocks $_________Bonds $_________ Other Investments $___________

HOUSEHOLD SIZE	1
Shelter + Care	$23,500

Do you have a DISABILITY or HANDICAP that we need to be aware of because you require an apartment with specific special features such as HEARING/VISUAL IMPAIRMENT, MOBILITY, OR WHEELCHAIR ACCOMMODATIONS?

If YES, please indicate if you require any of the following:

☐ I require a dwelling with special features for the VISUALLY impaired.
☐ I require a dwelling with special features for the HEARING impaired.
☐ I require a dwelling with special features for the VISUALLY AND HEARING impaired.
☐ I require a dwelling with special features for the MOBILITY impaired. Explain_______________
☐ I require a dwelling with special features for a WHEELCHAIR USER person. Explain_______________
☐ OTHER (Please explain)_______________

ADDITIONAL INFORMATION:

1. Are you a full time student? ☐ YES ☐ NO

   If yes, name and address of the school attending_______________

2. Have you ever:

- A) been a tenant with the Public Housing Program of the Housing Authority of the City of York ☐ YES ☐ NO
- B) been a participant in the Section 8 Program of the Housing Authority of the City of York ☐ YES ☐ NO
- C) been a participant in the Section 8 Program or Public Housing Resident of another Housing Authority ☐ YES ☐ NO.
  If so, name and address of the Housing Authority_______________
- D) been or are a participant in an assisted unit ☐ YES ☐ NO. If so, indicate the name and address of the dwelling
  ____

If YES, please indicate the dates you were assisted by the Program: FROM_______________TO_______________

3. Were you ever evicted from a Public Housing dwelling or Section 8 dwelling? ☐ YES ☐ NO.
   If YES, YEAR?__________ REASON_______________

4. Have you ever been convicted of a crime? ☐ YES ☐ NO, (only omit minor Traffic Violations, DUI is considered a crime)

5. Have you been released from jail in the past five (5) years? ☐ YES ☐ NO
   Please list the reason for being in jail_______________

6. Are you now charged with an unresolved crime which has not yet resulted in a plea of guilty, a Court trial or the dropping of charges? ☐ YES ☐ NO

7. Have you been arrested for any activity related to the abuse of alcohol? ☐ YES ☐ NO.

8. Are you subject to a lifetime sex offender registration requirement under a State Sex Offender Registration Program? ☐ YES ☐ NO If yes, in what state did the offense occur? __________

If you have answered YES to questions 4, 5, 6, 7 or 8 please explain the nature of the offense_______________
_______________and when it occurred? _______________
____

9. If you live outside of York County, are you currently working within York County or have you been hired to work within York County ☐ YES ☐ NO

I UNDERSTAND MY APPLICATION WILL NOT BE PROCESSED UNLESS ALL ITEMS ON THE FRONT AND BACK OF THE APPLICATION ARE COMPLETED AND SIGNED. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HAVE NO OBJECTION TO INQUIRIES FOR THE PURPOSE OF VERIFYING THE FACTS HEREIN STATED. I AUTHORIZE THE RELEASE TO THE HOUSING AUTHORITY OF THE CITY OF YORK INFORMATION RELATIVE TO MY APPLICATION FORM. THIS AUTHORIZATION WILL CONTINUE IN FORCE AND EFFECT UNTIL TERMINATED IN WRITING BY THE UNDERSIGNED.

ADDRESS CHANGES MUST BE REPORTED IN WRITING WHEN THE CHANGE OCCURS, RETURNED MAIL WILL RESULT IN YOUR APPLICATION BEING REMOVED FROM THE WAIT LIST WITHOUT NOTICE.
INITIAL HERE THAT THIS IS UNDERSTOOD ______________.

I UNDERSTAND FALSE STATEMENTS ARE A VIOLATION OF FEDERAL LAW. I ALSO UNDERSTAND IT IS A FEDERAL OFFENSE TO GIVE FALSE INFORMATION TO ANY GOVERNMENT AGENCY. I UNDERSTAND GIVING FALSE INFORMATION WILL RESULT IN AN APPLICATION BEING DETERMINED INELIGIBLE.

I HEREBY AUTHORIZE THE HOUSING AUTHORITY TO OBTAIN ANY RECORD OF ANY CRIMINAL HISTORY OR PRECEEDING WHERE I HAVE PENDING CHARGES OR PRIOR CONVICTIONS OF A CRIME IN ANY COURT OR JURISDICTON.

SIGNED____ DATE________________________

IF someone helped complete this application, please have them sign & date also.

SIGNED____ DATE________________________

WE ENCOURAGE YOU TO CONTACT US REGARDING ANY CONCERNS YOU HAVE ABOUT THE ADMINISTRATION OF THIS PROGRAM. IF WE ARE UNABLE TO ADDRESS YOUR QUESTIONS, YOU MAY CONTACT HUD'S PUBLIC HOUSING INFORMATION AND RESOURCE CENTER AT 1-800-955-2232.

REVISED 09/08

Housing Application (attachment)
Financial Resource Evaluation Worksheet
Please complete worksheet with MONTHLY Average Costs

Applicant's Name:

# of People Living In Household:

Date Completed:

MONTHLY Income and Expenses:		
Income (family)		
Earnings (net)		
SSI		
SSDI		
Child Support		
Food Stamps		
Other		
Total Income		
Expenses	*Monthly Payment*	Outstanding Balances (If Any)
Rent/Mortgage		
Real Estate Taxes		
Utility Gas		
Utility Electric		
Utility Water		
Utility Telephone		
Utility Cable TV		
Utility Internet Services		
Utility - Sewer, trash collection, etc.		
Clothing		
Food/Groceries		
Auto payment (# of vehicles ____)		
Auto repairs/maintenance		
Auto insurance		
Auto - gas		
Insurances (other)		
Medications / health care		
Credit card (consumer debt pay)		
Entertainment Expenses		
Other expenses: Please specify...		
Total Expenses:		
Total Income minus Expenses:		

Asset Evaluation	
Savings	
Investments	
Capital Equity (net)	
Total Assets	
Total Assets Available to Utilize:	

Additional Comments:

Housing Worksheet updated Dec 2007 - KLW

YORK COUNTY HUMAN SERVICES DEPARTMENTS
INFORMATION RELEASE FORM

I hereby authorize the following to release information to: and/or to receive information from:

York/Adams HealthChoices Management Unit ______________________

100 W. Market St., Suite B-01 York, PA 17401 ______________________
(Name and complete address of Agency/Individual) (Name and complete address of Agency/Individual)

Regarding the Record of Name: ______________________ DOB: __________

Address: ______________________

The information released will be limited to any and all records requested below for the date range: __________
Please have consumer over 14 or person authorizing release of information sign their initials next to any requested information.

____ Evaluation-Select: ☐ Psychological ☐ Psychiatric ☐ Drug and Alcohol ☐ Offender ☐ __________

____	Report Card/Attendance	____	Behavior reports	____	IEP/Evaluation Report	____	Birth Certificate (copy)
____	Medical/Hospitalization Records	____	Physical Exams	____	Immunizations	____	Dental Exams
____	Treatment Plan/Recommendations	____	Progress Reports	____	Attendance/Participation	____	Discharge Summary
____	Probation/Parole Conditions	____	Childline	____	Drug Test Results	____	Accurint/Family Finding
____	County Assistance/Welfare	____	Pay Stub(s)	____	Social Security Benefits	____	Insurance Information

____ Residency Confirmation-Rent Payment, Lease or Mortgage __________

____ (Financial Release explanation) financial information & ongoing income updates

____ (Other) Contact Updates application paperwork, Ind. Liv. skills, mental & physical health info for eligibility & ongoing

The information will be used for the following purpose(s): ☒ Assessment ☒ Provision of Service ☐ __________

This release automatically expires 1 year from date of signature or when the above-named person ceases to be a consumer of the agencies selected, whichever occurs sooner. The authorization for the release of information may be revoked at anytime. To revoke this authorization, please notify the York County Human Services Agency identified at the top of the release in writing.

I understand that I do not have to consent to the release of information. I understand that treatment, payment, enrollment or eligibility for services are *not* subject to signing this release, except as required to initiate County services. If health information is needed to initiate County services and I do not sign this release, I understand that I may not receive services.

I understand that there may be a risk that the person/organization receiving my information could possibly redisclose it without my authorization and then the confidentiality of the information might not be protected. I have read this form carefully and I voluntarily choose to release the information. I acknowledge that I fully and completely understand the content of this form.

Please read carefully:

- I have the right to receive a copy of this signed release form.
- If the consumer is 14 years of age or older, the consumer must sign and date the form.
- If the consumer is 14 years of age or younger, the consumer's parent or legal guardian must sign and date the form unless an exception exists under state or federal law.
- If the consumer is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship. ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

__________ Printed name | X__________ Signature of client/parent/guardian | __________ Relationship | __________ Date

__________ Printed name of staff | X__________ Signature of staff | __________ Date

Notice to the recipient of these records

This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Regulations limit your ability to make any further disclosure of this information without the prior written authorization of the person to whom it pertains.

YORK COUNTY HUMAN SERVICES DEPARTMENTS
INFORMATION RELEASE FORM

I hereby authorize the following to release information to: York/Adams HealthChoices Management Unit, 100 W. Market St., Suite B-01 York, PA 17401
(Name and complete address of Agency/Individual)

and/or to receive information from: Housing Authority of York, 31 S. Broad St., York, PA 17403
(Name and complete address of Agency/Individual)

Regarding the Record of Name: ______________________ DOB: __________

Address: ______________________

The information released will be limited to any and all records requested below for the date range: __________
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_____ Evaluation-Select: ☐ Psychological ☐ Psychiatric ☐ Drug and Alcohol ☐ Offender ☐ __________

_____ Report Card/Attendance	_____ Behavior reports	_____ IEP/Evaluation Report	_____ Birth Certificate (copy)
_____ Medical/Hospitalization Records	_____ Physical Exams	_____ Immunizations	_____ Dental Exams
_____ Treatment Plan/Recommendations	_____ Progress Reports	_____ Attendance/Participation	_____ Discharge Summary
_____ Probation/Parole Conditions	_____ Childline	_____ Drug Test Results	_____ Account/Family Finding
_____ (County Assistance/Welfare)	_____ Pay Stub(s)	_____ (Social Security Benefit(s))	_____ Insurance Information

_____ Residency Confirmation-Rent Payment, Lease or Mortgage __________

_____ (Financial Release-explanation) financial information & income changes

_____ (Other) reporting requirements behavioral health services used & supports received by housing staff; ongoing eligibility

The information will be used for the following purpose(s): ☒ Assessment ☒ Provision of Service ☐ __________

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__________ Printed name   X__________ Signature of client/parent/guardian   __________ Relationship   __________ Date

__________ Printed name of staff   X__________ Signature of staff   __________ Date

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(Name and complete address of Agency/Individual)

and/or to receive information from: Bell Socialization Services, 160 S. George St., York, PA 17401
(Name and complete address of Agency/Individual)

Regarding the Record of Name: ______________________ DOB: __________

Address: ______________________

The information released will be limited to any and all records requested below for the date range: __________

Please have consumer over 14 or person authorizing release of information sign their initials next to any requested information.

____ Evaluation-Select: ☐ Psychological ☐ Psychiatric ☐ Drug and Alcohol ☐ Offender ☐ __________

____ Report Card/Attendance	____ Behavior reports	____ IEP/Evaluation Report	____ Birth Certificate (copy)
____ Medical/Hospitalization Records	____ Physical Exams	____ Immunizations	____ Dental Exams
____ Treatment Plan/Recommendations	____ Progress Reports	____ Attendance/Participation	____ Discharge Summary
____ Probation/Parole Conditions	____ Childline	____ Drug Test Results	____ Accurint/Family Finding
____ County Assistance/Welfare	____ Pay Stub(s)	____ Social Security Benefits	____ Insurance Information

____ Residency Confirmation-Rent Payment, Lease or Mortgage __________

____ Financial Release-explanation: financial information & income changes

____ (other) Contact Updates — Information via a shared database, application paperwork, ongoing eligibility for the program

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______________	X______________	self	______
Printed name	Signature of client/parent/guardian	Relationship	Date
______________	X______________		______
Printed name of staff	Signature of staff		Date

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INFORMATION RELEASE FORM

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(Name and complete address of Agency/Individual)

and/or to receive information from: True North Wellness Services(Housing Support Staff), 1195 Roosevelt Ave., York, PA 17404
(Name and complete address of Agency/Individual)

Regarding the Record of Name: ______________________ **DOB:** __________

Address: ______________________________

The information released will be limited to any and all records requested below for the date range: __________
Please have consumer over 14 or person authorizing release of information sign their initials next to any requested information.

____ Evaluation-Select: ☐ Psychological ☐ Psychiatric ☐ Drug and Alcohol ☐ Offender ☐ __________

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__________ Printed name   X__________ Signature of client/parent/guardian   __________ Relationship   __________ Date

__________ Printed name of staff   X__________ Signature of staff   __________ Date

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