

Section 1

Tenant Selection

FORMS IN THIS SECTION

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RELEVANT STANDARDS OF CARE

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- Confidentiality
- Residents' Records
- Protecting Residents' Rights

Introduction to Section 1

SECTION DESCRIPTION

This section includes a set of sample documents typically used during the tenant selection process in a provider's first contact with applicants to a housing program.

Residents of HIV/AIDS supportive housing have the unique status of being program participants as well as lease holding tenants. Residents and program staff must understand and abide by the laws that govern tenancies - - laws which can be federal, state, or local in jurisdiction.

In making tenant selection decisions, the desired outcome is that all applicants have equal access to HIV/AIDS housing. Programs are obliged to create admissions procedures that are systematic and fair for all applicants. Furthermore, the spirit and practice of fair housing laws should be integrated into admission procedures such that screening of potential applicants include questions related only to eligibility and suitability for housing.

MORE INFORMATION ABOUT SELECTED FORMS:

Universal Preliminary Application for HIV/AIDS Housing

This form is intended for HIV/AIDS housing programs to utilize as an application form for admission to their housing program. [A Massachusetts specific version of the form may also be downloaded from our website at www.ahc.org.] This application enables applicants to apply to multiple programs

using a single application. It facilitate the verification of basic eligibility for most HIV/AIDS housing programs.

Initial Referral Form

This form may serve multiple purposes:

- Some programs may find it useful to have referring socials workers, nurses, or advocates complete this form before scheduling a face-to-face meeting with the applicant.
- This short screening form may identify obviously ineligible individuals whose valuable time and energy would be wasted by sitting through an intake appointment.
- The form may also be used by housing programs that have no vacancies to develop a waiting list for applicants. As names come to the top of the list, applicants are invited to a more comprehensive intake meeting.

Authorizations for Release of HIV Test Results and other Relevant Information

Verification of an applicant's HIV and income status may be required by the agency's funding sources.

MORE INFORMATION ABOUT KEY ELEMENTS OF THE STANDARDS OF CARE:

The Standards of Care are recommended best practices that have been established in every area of the provision of housing and supportive services. Standards that are particularly relevant to the topics in this section are identified and explained below.

STANDARD: Tenant Selection

- Federal, state, and local fair housing laws apply to supportive housing providers regardless of whether they

identify themselves as “housing” or a “program”. Providers must understand and abide by these laws.

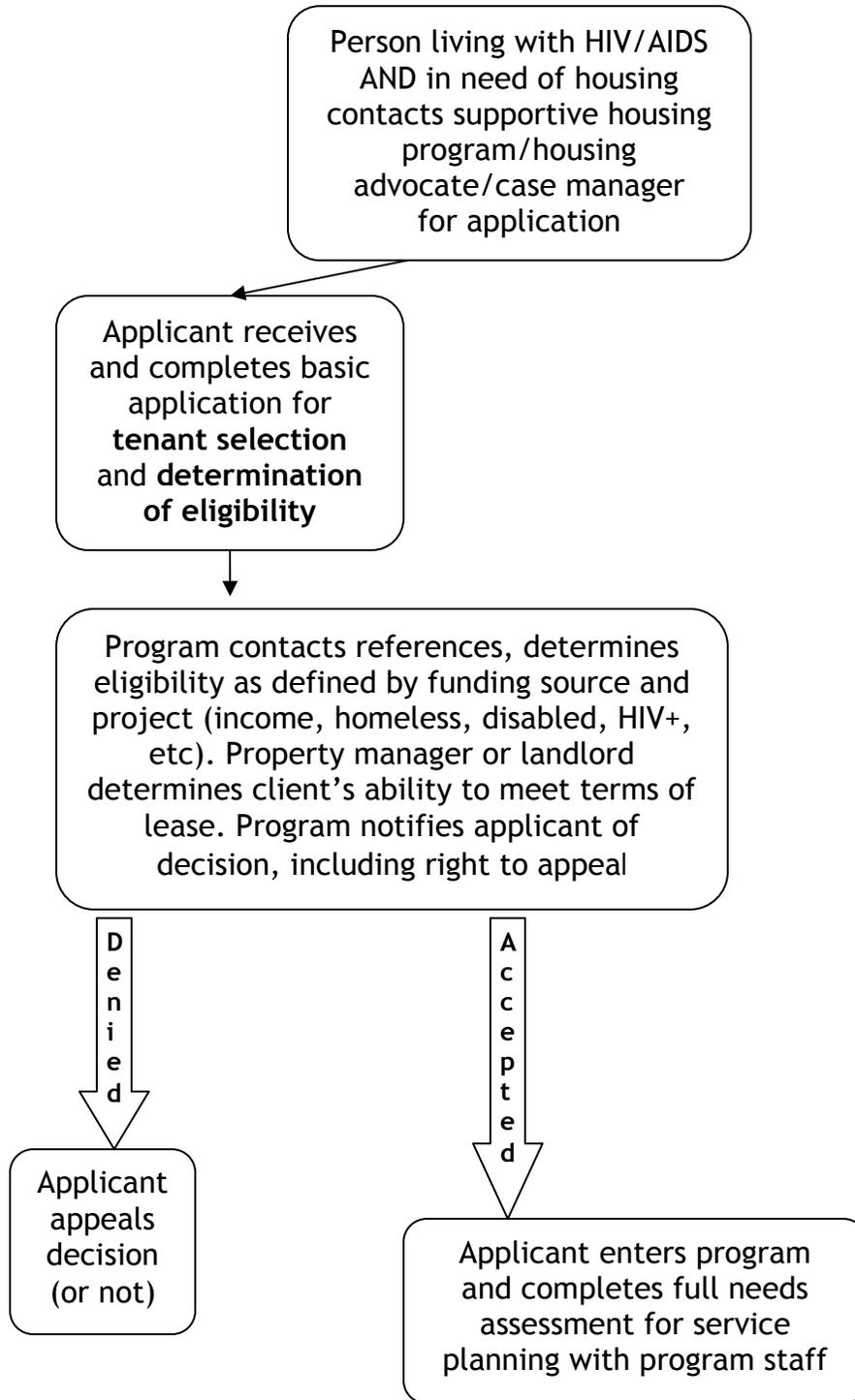
- ☑ The Standards of Care on Tenant Selection encourage programs to devise a set of clear policies regarding the spectrum of issues, from eviction history to drug use, on which it will base its decisions regarding applicants to its housing program.
- ☑ Providers are encouraged to develop an equal opportunity statement that is used in all advertisements and literature related to marketing the housing resource and in tenant selection.
- ☑ The standards encourage programs to divide the steps of an application process into two distinct phases: 1) tenant selection (limited to legally appropriate questions regarding eligibility and suitability, see below) and 2) needs assessment (a more extensive exploration of significant issues, not appropriate for tenant selection, but necessary for the provider to understand case management needs.
- ☑ The standard emphasizes that the landlord/owner must devise a set of clear, written tenant selection criteria concerning (1) eligibility, which is determined by the funding source and is limited to programmatic requirements (e.g. income and HIV status): and (2) suitability, the ability to comply with the terms of the lease.
- ☑ The Standard suggests checking background information only as it relates specifically to eligibility and suitability. The provider may ask for authorization from multiple sources to assess the applicant’s ability to uphold essential obligations of the lease agreement.

- ☑ The standards encourage programs to include questions related to HIV/AIDS only insofar as eligibility is determined. Additional information (related to medical, psychiatric, and substance use history) may be asked in the needs assessment stage, after the tenant selection process has concluded.
- ☑ The standards state that a program may ask an applicant if they have been convicted of the illegal manufacture or distribution of drugs during the selection process.
- ☑ The standards encourage programs to provide applicants who are not selected to be residents with a written explanation as to why they were denied housing, as well as means to appeal a denial.
- ☑ The following forms are appropriate for the tenant selection process: The Universal Application for HIV/AIDS Housing, an initial referral form, and a homeless verification form.

STANDARD: Confidentiality

- ☑ The standards suggest that providers obtain signed releases of information before discussing individual residents and sharing any personal information about them with outside service contacts or any other party.
- ☑ Information related to HIV/AIDS and substance use history should be shared only after a special authorization of disclosure of information pertaining to these issues has been signed. Releases should be time-limited, specific in scope, and not automatically renewed.

Overview of the Tenant Selection Process



Please indicate family status of applicant:

- Married/Long Term Partner
- Unmarried
- Divorced
- Separated
- Widowed
- Other: _____

Does applicant have any children under the age of 18? yes no

If yes, what are their ages? _____

Do the children live with the applicant? yes no partial or part-time custody

Is applicant already receiving case management and/or other assistance related to his/her HIV status?

- no
- yes.....Where? _____

Is applicant willing to work with program staff around service planning and have regular meetings? yes no

Do you believe the applicant is in need of supportive housing to enhance his/her safety, well being personal dignity, survival, and functioning? yes no

If yes, please explain

Does applicant have any pets? yes no

Outcome (housing staff only):

- Invited in for eligibility determination.
- Appointment scheduled for eligibility determination.
- Put on waiting list for services, application passed along for property management assessment.
- Determined not eligible for program and letter mailed to provider.

Person completing this form:

Signature: _____

Date: _____

UNIVERSAL PRELIMINARY APPLICATION FOR HIV/AIDS HOUSING

(Revised September, 2004)
COVER PAGE

CHECK LIST:

This application requires the following to be complete. Applicant should retain a copy.
Complete Forthcoming

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. UNIVERSAL PRELIMINARY APPLICATION – 4 pages. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. FIVE YEAR HOUSING HISTORY form |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. MEDICAL CERTIFICATION form |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. CERTIFICATE OF HOMELESSNESS (if required) |

Presumptive Eligibility Information (For Housing Providers use Only)

Date on which
found eligible: M ____ D ____ Y ____

Reason/s off list:

Date removed
from waitlist: M ____ D ____ Y ____

- 1= Accepted into program
- 2= Found ineligible before intake
- 3= Withdrew application
- 4= Died
- 99= Unknown/lost to follow up

Additional comments:

UNIVERSAL PRELIMINARY APPLICATION FOR HIV/AIDS HOUSING

(Revised June, 2004)

Name of the HIV HOUSING PROVIDER to which applicant is applying: _____

Date mailed: ___/___/___ Referring Person: _____

Agency: _____ Phone: _____

Client code of head
of household:

_ _ _	_ _ - _ _ - _ _	_ _ _ _
1 st 3 letter of mother's first name	Birth (MM-DD-YY)	Last 4 digits of SSN

A) BASIC INFORMATION

Applicant: _____ DOB: ___/___/___

Primary Language: _____ Social Security #: _____ - _____ - _____

Phone # where applicant accepts calls (if any): () _____

Pager: () _____

Cell Phone: () _____

Address: _____ City/Town: _____ ZIP: _____

Place to send mail (if different): _____

City/Town: _____ ZIP: _____

Gender: Male ___ Female ___ Transgender ___

Race: Hispanic/Latino ___ Caucasian ___ African American ___ Haitian ___ Asian ___ Native American ___
 Other _____

Existing Case Managers (other than referring person) assisting with HIV-related issues (*optional*):

Name/Agency: _____ Phone: _____

Name/Agency: _____ Phone: _____

B.) HOUSEHOLD COMPOSITION/ INCOME:

Most HIV housing programs require that residents meet low income requirements set by the U.S. Department of Housing and Urban Development. List all persons in the planned household with any form of income including live-in boyfriends/ girlfriends. List children who are certain to live with applicant from move-in date. *(Continue in section K)*

<i>Names of individuals who will live with the applicant</i>	<i>Relationship to applicant</i>	<i>Age</i>	<i>Source(S) of income * (Wages, SSI, AFDC, etc.)</i>	<i>Monthly Income*</i>	<i>Annual Income*</i>
Applicant	Self			\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
Total Household Income:				\$	\$

** Leave blank for official Personal Care Attendant for whom medical documentation can be supplied evidencing this role.*

C.) MEDICAL ELIGIBILITY:

Please have applicant’s physician complete attached MEDICAL CERTIFICATION form and submit with this application to verify positive HIV status or diagnosis of AIDS for applicant and/or household members (see page 6).

Note to housing managers: HUD has deemed this medical eligibility form as an acceptable form of documentation of HIV status. However, they do suggest that once an applicant has been accepted into your program, a letter from their medical provider on stationary should be placed into the resident’s file.

D.) HOUSING STATUS:

Please check the box below that best describes the applicant’s housing situation for which supporting documentation can be supplied. Check only one box and be certain documentation from a third party on letterhead stationary can be produced at a later date to verify this status. Some HIV Housing Providers will have precise requirements as to the source and content of such supporting documentation.

<input type="checkbox"/>	Living in a shelter.
<input type="checkbox"/>	Living on the street (having no fixed, regular, nighttime residence).
<input type="checkbox"/>	Living in Department of Transitional Assistance Program.
<input type="checkbox"/>	Living in a transitional program (i.e. provides services on site designed to prepare the individual to move into more independent permanent housing) and homeless immediately prior.

<input type="checkbox"/>	Living in and receiving care from an institution not designed for long term residence (e.g. hospital, rehabilitation facility etc.)
<input type="checkbox"/>	Doubled up (living temporarily with friends or relatives)
<input type="checkbox"/>	In imminent danger of losing housing through no fault* of own and has received “summary process summons” from the court to proceed with an eviction (applicant need not have actually been to housing court).
<input type="checkbox"/>	Renting an apartment using a transitional subsidy such as AHVP or DMH.
<input type="checkbox"/>	Renting an apartment using a 2-year HOPWA certificate or a 2 year TBRA HOME certificate and was homeless immediately just prior to using 2 year subsidy.
<input type="checkbox"/>	Living in substandard housing (i.e. living in a unit that endangers the health, safety, or well being of the household due to being dilapidated, or due to inadequate source of heat or inadequate indoor plumbing (including toilet, and bathing facilities, or lack of electricity).
<input type="checkbox"/>	Rent burdened - paying between 50% or more of gross income toward rent and utility costs for at least 90 days (based on average monthly utility payment, excluding phone, over 12 months).
<input type="checkbox"/>	Rent burdened - paying 75% or more ...
<input type="checkbox"/>	Other (briefly describe):

E.) CERTIFICATE OF HOMELESSNESS:

Some HIV housing programs require that applicants submit an official CERTIFICATE OF HOMELESSNESS form to be in compliance with requirements of their funding sources.

F.) HOUSING HISTORY:

FIVE YEAR HOUSING HISTORY form. Provide as much detail as possible.

Has the applicant ever lived in subsidized housing? No Yes If yes, where? _____

When (from – to): _____ In whose name was the apartment? _____

H. ADDITIONAL ELIGIBILITY:

Some HIV housing programs require, in addition HIV verification, that applicants belong to other specific population groups. A signature below indicates that the applicant belongs to the target population, in every respect, for this housing resource.

The applicant certifies that he/she qualifies as a member of the special target population for the HIV housing program to which this application is being. The applicant can supply supporting documentation upon request to demonstrate such eligibility.

Applicant Signature: _____

Date: _____

MEDICAL CERTIFICATION FORM

Instructions to applicant: You should fill out Sections A and B and have your physician complete Section C and send to the HIV housing providers to which you are applying.

Section A. Request for Physicians Certification of HIV Status

Dear Medical Provider,

Your patient, _____, is applying for subsidized housing for persons living with HIV/AIDS. These programs may only consider persons with a diagnosis of AIDS or who are HIV+. By signing in Section B below, the individual named authorizes you to release to us the information requested on this page.

Section B. Authorization for Release of Information

I, _____, an applicant for subsidized housing for persons with HIV/AIDS hereby authorize _____, my health care provider, to release the information requested on this form to the program staff of the entities listed above:

Applicant/Date

Witness/Date

Section C. Physician's Certification

I, _____ (please print name), provide primary medical care for _____. For the purpose of his/her application for housing for persons with HIV/AIDS, I hereby certify that he/she:

_____ has a diagnosis of AIDS

_____ does not have an AIDS diagnosis but is HIV symptomatic or has (any) conditions arising from the virus.

_____ is disabled due to HIV

_____ none of the above

Medical Provider Signature

Date

Medical Provider Name Printed

Phone Number

Clinic Name and Address

CERTIFICATION OF HOMELESSNESS

To be eligible for **Shelter Plus Care** and/or **Supported Housing Programs**, an applicant must be homeless, as defined by HUD. Homeless is defined as living in a shelter or on the streets. An applicant who is residing in transitional housing for less than 2 years is also eligible as long as she/he was homeless according to the above definition immediately prior to entering the transitional housing program. An applicant is also eligible after a stay at a hospital or other inpatient setting as long as s/he was homeless according to the above definition immediately prior to the inpatient stay. If the inpatient stay was less than 30 days, the applicant should be counted as coming from his/her immediate prior place of stay (street or shelter).

This form must be filled out by the individual or social service agency that can verify the individual's presence at the checked-off program/setting/institution/shelter

I hereby verify that the referred applicant, _____ (Name)
is currently: (check only one, and complete related information)

- In an emergency shelter.**
- In a transitional housing program for less than 2 years and was homeless (in a shelter or on the streets) immediately prior to the transitional housing stay.**
- In an inpatient setting (for less than 31 days) and was living on the streets or in an emergency shelter immediately prior to the inpatient stay.**
- In an institution (for more than 31 days) and no subsequent residence has been identified and lacks the resources and support network necessary to obtain housing.**
- In a public/ private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, such as cars, parks, sidewalks, and abandoned buildings. *This form may be signed and dated by collateral contacts or by client requesting supportive housing. Other verifying documentation may be presented.***
- Being evicted within a week from a private dwelling unit and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing. *Please attach a signed and dated letter verifying the eviction proceedings and unsuccessful attempts to secure other housing options.***

This must be completed except when individual is being evicted

Name or location of program/institution/setting/shelter: _____
Date entered program/setting/institution/shelter: ____ / ____ / ____
Location prior to this stay: _____

I understand that false statements or information are punishable under Federal Law.

Signature of Authorized Program Staff	Print Name of Authorized Program Staff
Program/Agency Name	____ / ____ / ____ Date

FIVE YEAR HOUSING HISTORY

(Make multiple copies of this page as needed)

Please list the following information about where the applicant has lived for the past five years. Please note: A lack of rental history does not necessarily disqualify the applicant. Substitute a contact person when no landlord was involved (e.g. shelter social worker, transitional program case manager etc.)

Applicant's current address: _____ Lived here from _____ to present.

Type of residence: ___ rented apartment ___ doubled up ___ transitional program ___ shelter ___ other: _____

Landlord/other contact name: _____ Phone: _____

May we call this person for a reference? Yes ___ No ___

Applicant's address: _____ Lived here from _____ to _____.

Type of residence: ___ rented apartment ___ doubled up ___ transitional program ___ shelter ___

other: _____

Landlord/other contact name: _____ Phone: _____

May we call this person for a reference? Yes ___ No ___

Applicant's address: _____ Lived here from _____ to _____.

Type of residence: ___ rented apartment ___ doubled up ___ transitional program ___ shelter ___ other: _____

Landlord/other contact name: _____ Phone: _____

May we call this person for a reference? Yes ___ No ___

Applicant's address: _____ Lived here from _____ to _____.

Type of residence: ___ rented apartment ___ doubled up ___ transitional program ___ shelter ___ other: _____

Landlord/other contact name: _____ Phone: _____

May we call this person for a reference? Yes ___ No ___

Applicant's address: _____ Lived here from _____ to _____.

Type of residence: ___ rented apartment ___ doubled up ___ transitional program ___ shelter ___ other: _____

Landlord/other contact name: _____ Phone: _____

May we call this person for a reference? Yes ___ No ___

(Use additional page if necessary)

Authorization for Release of Information

I _____(name) hereby authorize the release of information pertaining to my case record, history, and status to staff representatives of the _____(program) from the following agencies:

My signature below acknowledges my understanding and authorization and consent for the following:

1. This authorization for release of information is valid for one year;
2. This authorization covers both the release of that information specified above and information to be compiled during the course of clients involvement with the Program;
3. This authorization is subject to my revocation at any time except for information already released;
4. I understand that I have a right to receive a copy of this authorization;
5. A copy of this form is as valid as the original.

Name of Client/Parent/Guardian:

Relationship to Client:

Signature of Client/Parent/Guardian: X

Date:

Witness to above signature (spell out name):

Witness signature:

Date:

Written Revocation of Authorization for Release of Information

I hereby revoke my authorization for the above specified information.

Signature of Client/Parent/Guardian: X

Date:

Oral Revocation of Authorization for Release of Information

Client/Parent/Guardian revoked authorization for the above specified client.

Name of person receiving revocation:

Signature:

Date:

Authorization for Release of HIV Test Results

I _____(name) hereby authorize _____ to release my HIV anti-body test results [and the results of my child's test] to:

(name)

(agency)

For the following purpose:

This authorization is valid until (date should not be more than one year from date of signature):

Signature of Client/Parent/Guardian

Name of Client/Patient

Witness

Date of Birth

Date

Authorization for Release of Alcohol or Drug Related Records

I _____ (name) hereby authorize _____ to release my alcohol or drug related records to:

(name)

(agency)

For the following purpose:

This authorization is valid until (date should not be more than one year from date of signature):

Signature of Client/Parent/Guardian

Name of Client/Patient

Witness

Date of Birth

_____/_____/_____
Date

Sample Acceptance Letter

Dear Applicant:

Congratulations. You have been accepted as a participant in our housing program. As a participant you will receive housing as well as case management services from our staff.

As a participant in this program, you will be paying rent based upon your income. Your rent will be calculated prior to signing a lease agreement with us. In order to prepare for this, please gather up-to-date income verifications for all members of your household who will be living with you.

The next step is for you to meet with our staff to complete a needs assessment. This process will allow us to understand what your particular needs are and how we may best serve you. At that time, we will also go over the services that our program offers and any program guidelines and expectations.

Please call us as soon as possible to let us know that you would like to be a participant in our program. Please call us at () if you have any questions.

Once again, congratulations!

Sincerely,

Program Director
Housing Program

Sample Rejection Letter

Dear Applicant:

This letter is in regards to your application for housing services through the housing program. After reviewing your application and speaking with the persons you provided to us as references, we are unable to offer you our housing services at this time.

Specifically **(state the reason why the applicant is not eligible for services)**.

If you do not agree with this decision, you have a right to appeal. Through an appeals process, mitigating circumstances will be considered and reasonable accommodations will be made as appropriate. Please write to us within seven days of receiving this letter stating specifically why you believe our decision was made in error. Please send your letter to the following address (xxxxxxxxxxxxxxxxxxxxxxxxxxxx).

If you think that your rights have been violated, you may contact one or all of the following organizations to seek action: **(provide phone numbers and addresses for the organizations relevant to your area)**.

- local legal aid at ()
- local fair housing organization at ()
- HUD at ()

We are sorry that we will be unable to serve you at this time. If you have any questions, please do not hesitate to call me at ().

Sincerely,

Program Director
Housing Program

Request for Program Eligibility Appeal Hearing

Any applicant who is found ineligible for this program may appeal the decision by meeting with the program director or the owner/manager of the building. To request an appeal, the form below must be filled out by the applicant or a proxy and must be submitted no more than fourteen days after receiving written notice of program ineligibility. Upon receiving the request the program director or the owner/manager of the building will schedule an appeal meeting with the applicant and any other interested parties at which the applicant will have an opportunity to present his/her opinion on his/her eligibility for the program. A final decision will be mailed to the applicant within one week of the appeal hearing.

REQUEST FOR APPEAL TO PROGRAM DIRECTOR

Name:

I hereby request a meeting with the program director to appeal the decision that I am ineligible for program participation.

I intend to bring the following person(s) with me to this hearing:

- 1. _____
- 2. _____
- 3. _____

I can be reached at the following phone number or can have messages left for me at this number for the next week: (_____) _____

Signature: **X**

Date:

Proxy Name:

Proxy Signature:

Date: