

NEW MEXICO SPECIAL NEEDS HOUSING PROGRAM REFERRAL

& PRE- APPLICATION FORM

(REVISED 10/2015)

Receipt of
Complete
Application:
Date and Time Stamp:

Consumer/Applicant and Household Information

1. Consumer/Applicant name: _____

2. Date of Birth: _____ Last 4 digits of SSN: XXX-XX-_____

3. Contact Information: *Must be up to date at all times. Required for immediate communication*

Applicant Contact Information	Must Provide Emergency Contact Information for Applicant
Address:	Address:
Phone:	Phone:
Cell Phone:	Cell Phone:
Email:	Email:

Note: The Services Provider/Agency is responsible for providing the services needed by the Applicant and to assist Applicant in completing this form:

The Information below is required for purposes of processing Special Needs Housing Unit referrals.

Provider/Agency Name:	Date Completed:
Referral Agency Point or Back-up person Printed Name:	Phonenumber:
Referral Agency Point or Back-up person <i>Signature</i> required:	Email

Referring Person (if not Services Provider/Agency)

Agency Name: _____

Contact Name: _____

Phone No: _____

Email: _____

4. Documentation of Disability or Homelessness must be provided by a licensed professional (caseworker, social worker, physician, etc.) that the Applicant qualifies for Special Needs housing unit based upon the following qualifying Special Needs disability:

Part 1: Eligible Target Populations for LIHTC Special Needs Set Aside Units (check one or more)

Homeless or Precariously Housed

A Household/individual is considered homeless or precariously housed if, without this assistance, he/she/ they would have to spend the night in a homeless shelter or in a place not meant for human habitation. This includes:

- Persons living on the street, in emergency shelters, or in transitional housing programs for the homeless;
- Persons with a legal eviction notice, or other similar legal circumstances in which they are to lose their housing imminently; and
- People with disabilities who are inappropriately living in an institution or other facility may be considered homeless if no other housing placement is available or appropriate.

Serious Mental Illness

Addictive Disorder (i.e., individuals in treatment and demonstrated recovery from a substance abuse disorder);

Developmental Disability (i.e., mental retardation, autism, or other disability acquired before the age of 22);

Physical, sensory, or cognitive disability occurring after the age of 22;

Disability caused by chronic illness (i.e., people with HIV/AIDS, who are no longer able to work);

Age related Disability (i.e., frail elderly, or, young adults with other special needs who have been in the foster care or juvenile services system).

Part 2: Eligible Target Populations for Section 811 PRA Units (check one or more)

Persons who are:

Serious Mental Illness

OR

Young adults between ages of 18 and 21 that meet the criteria for SMI and have been emancipated from foster care or are transitioning from the juvenile justice system.

AND

Homeless or **At risk of institutionalization**

Documented evidence of the Special Need, i.e. Diagnosis, SSI Disability Letter, etc. Documentation must attached and be from an individual or organization licensed or authorized to provide said documentation.

NOTICE: IF YOU HAVE A DISABILITY and need modifications that would help you live in the apartment unit, use the facilities, or, take part in programs on-site, you can request a Reasonable Accommodation or Modification from Property Management personnel. If you can show that you have a disability and the request is directly connected to that disability, we will try to make the changes you request.

You can get a **Reasonable Accommodation/Modification Request Form** in the property management office.

5. Disclosure of Criminal History

Have you /the Applicant ever been **convicted** of a Felony? Yes No If yes, what year? _____

Do you have either current, or pending criminal charges against any member of your household?

Yes No If yes, name of household member: _____

Note: The Applicant's household includes any member (also applies to persons under age 18 years) who has been arrested, or charged.

Where records reflect a past arrest without a final disposition and the crime would be a basis for rejecting the application, the applicant must provide proof the charge was dismissed for lack of evidence, adjudicated not guilty, or an alternative treatment was part of the adjudication process.

6. Total Number of household members (do not include live-in aides): _____ Number of live-in aides: _____

List all household members: including Sex, Age and relationship of each household member to the Applicant.

Name	Age	Sex	Relationship to Head of Household

Number of bedrooms desired: _____

Number of bedrooms required: _____

7. Household Income (list a sources of income)

A. **Cash Income:** please check all applicable sources of income and include the amount per month. Provide a description if appropriate; if the income belongs to a household member other than the Applicant, please note that in the Description field (Note: documentation will be required for all income sources) .

Have you received income from any source in the past 30 days?

Yes No Don't Know Refuse to Answer

Type Please provide a description where appropriate and Amount per Month

- Employment Income \$ _____
- Child Support Income \$ _____
- Social Security Disability \$ _____
- Supplemental Security Income \$ _____
- Social Security Retirement Income \$ _____
- TANF \$ _____
- Veteran's Pension \$ _____
- Veteran's disability payment \$ _____
- Unemployment Insurance \$ _____
- Alimony/other spousal support \$ _____
- Pension from a former job \$ _____
- Worker's Compensation \$ _____
- Private disability Insurance \$ _____
- Other sources on income \$ _____

B. Non-cash benefits: please check all applicable sources of non-cash benefits and services and include the amount per month. Provide a description if appropriate; if the assistance belongs to a household member other than the Applicant, please note that in the Description field.

Have you received non-cash benefits or services in the past 30 days?

- Yes No Don't Know Refuse to Answer

Type Description *(list names of each household member receiving the assistance)*

- Food Stamps (aka: SNAP) _____
- Medicaid _____
- Medicare _____
- WIC _____
- TANF child care services _____
- TANF Transportation services _____

- Other TANF funded services _____
- Children's Health Insurance Program _____
- VA Medical services _____
- Other Assistance source _____

8. What is the total Annual gross household income from all sources and all persons living in the household (earned income, social security, SSDI, retirement, government benefits, unearned income, etc.)?

9. Monthly \$ _____ ANNUAL \$ _____
 (Monthly Income must total Annual).

10. Indicate whether or not the household needs the following type of apartment:

- a. Handicapped Unit (wider doors, grab bars) Yes No
- b. Fully Accessible Unit (curb less shower) Yes No
- c. Visual/Audio Accessible Unit Yes No
- d. Ground floor unit necessary, if no elevator Yes No
- e. Does household has medical reasons for an extra bedroom Yes No

11. Applicant Acknowledgement

I have read the **Tenant Responsibility and Participation Agreement** and the **Pre-Tenancy Overview Information** and understand the expectations of being a good tenant and participant in the Special Needs Housing Program. I understand that my housing is contingent upon my compliance with these rules and regulations.

 Applicant's Signature Date

 Advocate/Provider Signature Date

 Participant Printed Name Date

 Provider Printed Name Date

**NEW MEXICO SPECIAL NEEDS HOUSING PROGRAM REFERRAL
COMMITMENT OF SUPPORT SERVICES PROVISION**

I, Services Agency Caseworker Services Contact, herein certify that Applicant:

Name of applicant

- a) meets the target population eligibility of the current Qualified Action Plan (QAP) for the Low Income Housing Tax Credit (LIHTC) program;
 - b) is in need of permanent supportive housing,
- The Referring Agency agrees that:
- c) required support services will be available as needed and requested by this applicant by the Referring Services Agency,
 - d) Agency will be available for Monthly Housing Site Visits in the consumer's apartment,
 - e) Agency will coordinate services with the property manager and Local Lead Agency as needed to ensure success of the consumer in their Special Needs Housing;

As a result of this Applicant's homeless or disability status, the household requires the following types of support services to maintain stable tenancy. Please briefly describe:

- a) the support services that are necessary; and,
- b) how the Agency will assist the applicant to live successfully in their own housing in the community:

Primary Case Manager/Services Contact Name: _____

Email: _____

Office Phone: _____ Cell Phone: _____

Signature of Support Services Worker Print Name Date

Signature of Supervisor Print Name Date

This information is requested from records whose confidentiality is protected. The receiving agency is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for the request of medical or other information is not sufficient for this purpose. This information is protected both by the State (Section 34-2A-18 NMSA 1953) and Federal (42 CFR Part 2) Regulations.

You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to the: Help New Mexico main office at 5101 Copper NE, Albuquerque, NM 87108. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my protected health information have already acted in reliance on this authorization.

Revocation Section

I hereby revoke this authorization.

Client Signature

Client Printed Name

Date

Crisis Response Plan and Contact Numbers

Date of Plan: _____

<u>TENANT INFORMATION</u>

Tenant Name _____

Apartment Name _____ Apartment No. _____

Apartment Address _____ City _____ Zip _____

<u>RESOURCE PHONE NUMBERS</u>

For Property Manager and Consumer in the event of Crisis

Referring Agency or Advocate Contact Person Name: _____ **(Print)**

Office Phone: _____ Emergency Cell Phone: _____

Personal /Family Member Name: _____ **(Print)**

Office Phone: _____ Cell Phone: _____

Local Lead Agency: _____

LLA Staff Name: _____ **(Print)**

Staff Office Phone: _____ Cell Phone: _____

TENANT RESPONSIBILITY AND PARTICIPATION AGREEMENT

Dated: 5.2.2012

CLIENT/APPLICANT NAME: _____ (Please Print)

REFERRING AGENCY NAME: _____

PROPERTY NAME: _____

I, _____, understand that if I am determined eligible for the Special Needs Housing program by the information I presented, and also selected via the Special Needs lottery process to be referred to a housing unit:

I will commit to meet my obligations as a tenant under New Mexico Uniform Owner-Resident Relations Act. I understand the Property Manager can establish their own property rules in addition to the rental lease provisions and that I as the Tenant must abide by those.

I will make Rent Payments on time: Rent is due the 1st of each month. If the Tenant does not pay the rent and the utilities for the property, the property manager will provide the appropriate notices and if I have not complied, the property manager will have the right to begin eviction by giving the tenant notice as outlined in New Mexico Owner-Resident Relations Act.

I will allow Monthly In-Home Apartment Visits: by my advocate or staff member of _____ (Referring Services Agency), or, the Local Lead Agency for the purposes of identifying any risks to my housing stability. During this site visit the tenant will participate in completing the Supportive Housing Monthly checklist (see attachment) and discuss any necessary follow up actions on the part of the tenant, advocate, provider or other partners.

I will keep my Crisis Response Plan and Contact Numbers (see attachment) up to date.

I will abide by the following tenant rules and regulations:

1. **Occupant:** Only the persons whose names appear on the lease agreement may live in this apartment or housing unit.
2. **Pets:** Pets may be allowed if this is consistent with the policy of the landlord.
3. **Damages:** The tenant is to notify property manager immediately of any repairs that are needed and will be required to pay for repairs of all damages (other than normal wear) they or their guests have caused, including, but not limited to windows, furniture, walls, appliances, bathroom fixtures, carpet, counters, light fixtures, etc.
4. **Cleanliness:** Participant will maintain the apartment at a level of cleanliness that meets health, safety and fire hazard standards.
5. **Violent Behavior:** Any violent behavior will be grounds for immediate termination from the program.

6. **Disturbing the Peace:** The Tenant agrees not to cause or allow on the premises any excessive nuisance, noise or other activity which disturbs the peace and quiet enjoyment of neighbors or other tenants in the building or violates any state law or local ordinance. The tenant is fully responsible for all guest actions and behavior.
7. **Prohibited Use Of Premises:** The premises will not be used for any unlawful purpose whatsoever, including the manufacture or distribution of illegal drugs. Participants shall not bring or permit any other person to bring any weapon of any type, including, without limitation, guns and knives, (other than normal kitchen knives), into the dwelling.
8. **Building and Property Rules:** Tenant agrees to follow the terms and conditions of the Lease or Rental Agreement between the Landlord and Tenant. Tenant also agrees to abide by all Property rules and guidelines set by manager/owner of the building.

I acknowledge and understand the terms of this Agreement between _____ (Referring Services Provider Agency) and myself and that my housing and my continued participation in the Special Needs program are contingent upon my compliance with this Agreement.

Applicant's Signature

Referring Services Agency Staff Signature

Applicant's Printed Name

Referring Services Staff Printed Name

DATE

DATE

Cc: Local Lead Agency
Special Needs Applicant
Referring Services Agency

Attachments: Supportive Housing Site Visit Checklist
Crisis Response Plan and Contact Numbers

MONTHLY SUPPORTIVE HOUSING CHECKLIST

Month/Year of Visit: _____ / _____ / _____

Tenant/Consumer Printed Name: _____

Address of Rental Unit _____ City: _____

Printed Name of Support Services Staff: _____

Provider/Agency: _____ Phone: _____

<input type="checkbox"/> YES <input type="checkbox"/> NO	1. Is the unit in a reasonably clean state? (e.g. are there any health or safety issues?)																								
Corrective Action Due Date _____	If no, what are next steps for consumer?																								
<input type="checkbox"/> YES <input type="checkbox"/> NO	2. Is there anything in the housing unit not in good working condition , or in need of repair or replacement? Please review the list of the following items: <table style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 60%;">Stove</td> <td>Yes___ No___</td> </tr> <tr> <td>Refrigerator</td> <td>Yes___ No___</td> </tr> <tr> <td>Heating and Cooling Systems</td> <td>Yes___ No___</td> </tr> <tr> <td>Lighting</td> <td>Yes___ No___</td> </tr> <tr> <td>Hot and Cold Water</td> <td>Yes___ No___</td> </tr> <tr> <td>Smoke Detectors</td> <td>Yes___ No___</td> </tr> <tr> <td>Toilets</td> <td>Yes___ No___</td> </tr> <tr> <td>Water leaks</td> <td>Yes___ No___</td> </tr> <tr> <td>Doors</td> <td>Yes___ No___</td> </tr> <tr> <td>Windows</td> <td>Yes___ No___</td> </tr> <tr> <td>Electrical fixtures, electrical outlets</td> <td>Yes___ No___</td> </tr> <tr> <td>Any other items ? _____</td> <td></td> </tr> </table>	Stove	Yes___ No___	Refrigerator	Yes___ No___	Heating and Cooling Systems	Yes___ No___	Lighting	Yes___ No___	Hot and Cold Water	Yes___ No___	Smoke Detectors	Yes___ No___	Toilets	Yes___ No___	Water leaks	Yes___ No___	Doors	Yes___ No___	Windows	Yes___ No___	Electrical fixtures, electrical outlets	Yes___ No___	Any other items ? _____	
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Any other items ? _____																									
Corrective Action Due Date _____	Has the landlord or property manager been notified of needed repairs <u>via official letter</u> , and if yes, are they making repairs in a timely fashion? Yes___ No___ Issue: _____ Date Notified: _____ Issue: _____ Date Notified: _____ Issue: _____ Date Notified: _____ If no, Corrective Action to be taken:																								
<input type="checkbox"/> YES <input type="checkbox"/> NO	3. Does the tenant have the necessary amenities for their home: refrigerator, stove, fan (if no air conditioning), basic furniture (bed, pillow, dresser, chair/couch, lamps, table and chairs), basic kitchen set-up (plates, glasses, utensils, pots and pans); and, basic linens (bath, hand and dish towels, wash cloths, sheets, blankets, pillowcases).																								

By When: Date_____	If no, what are next steps: For consumer? For CSW (community support worker or case manager) ?
<input type="checkbox"/> YES <input type="checkbox"/> NO	4. Is there a record or evidence [receipts, money order stub, etc.] of tenant's monthly rent and other related utilities [if not included with rent] being paid in a timely manner?
By When: Date_____	If no, what are next steps: For consumer? For CSW?
<input type="checkbox"/> YES <input type="checkbox"/> NO	5. Consumer Well Being: Does the tenant appear to be in good physical and mental health.
By When: Date_____	If no, what are next steps: For consumer? For CSW?
<input type="checkbox"/> YES <input type="checkbox"/> NO	6. Are there any tenancy-related issues that may become a problem for the tenant? e.g. problems with other tenants/neighbors; lease violations; issues with the landlord or apartment manager.
By When: Date_____	If no, what are next steps: For consumer? For CSW?
<input type="checkbox"/> YES <input type="checkbox"/> NO	7. Has a complete Section 8 Voucher application been submitted to local housing authority(s) ?
By When: Date_____	If no, what are next steps: For consumer? For CSW? If yes, what is current status on Section 8 waiting list(s)? _____ Has consumer received a Housing Authority Section 8 waiting list purge/address update notice? <input type="checkbox"/> YES <input type="checkbox"/> NO

	When is next Section 8 waiting list purge anticipated by the housing authority? Date: _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	8. Are there any changes or new challenges since the last month's visit? Transportation Yes___ No___ Food Yes___ No___ Amenities Yes___ No___ Purchases/Losses Yes___ No___ Social Activities Yes___ No___ Unusual Events Yes___ No___ Police/Landlord visits Yes___ No___ Other Yes___ No___
By When: Date _____	If yes, what are next steps: For consumer? For CSW?
<input type="checkbox"/> YES <input type="checkbox"/> NO	9. Service or Treatment Plan Update: What progress has been made, or, new challenges developed (per above questions) that need to be addressed in the consumer's Service or Treatment Plan? 9a. Are there any changes to the names or phone numbers for Crisis Plan?
By When: Date _____	If yes, what are next steps: For consumer? For CSW? Crisis Plan Changes: Name: Phone Number:

Signatures:

Support Services Staff: _____

Printed Name: _____

Date: _____

Consumer: _____

Printed Name: _____

Date: _____

Forms for Local Lead Agency's Special Needs Applicant Files

- Applicant File Checklist (Note: Applicant files shall include items on this list)
- Attestation of Confirmed Special Needs Applicant Identity (Note: used to verify Social Security card and Drivers License (or Photo ID) presented by Applicant)
- Attestation of Homelessness (Note: for clients whose Special Needs Housing eligibility is based ONLY upon homelessness)

SPECIAL NEEDS HOUSING PROGRAM

APPLICANT FILE CHECKLIST (Dated 8.21.2013)

For SN Applicant:

- Special Needs (SN) Application Form** (all items completed and signed by Applicant and Referring Provider/Agency)
- Attestation of Confirmed Identity**
- Attestation of Homelessness** (for Applicants whose Special Needs Housing eligibility is based ONLY upon Homelessness)
- Proof of Special Needs Disability** (Documented evidence of the Special Need, i.e. Diagnosis, SSI Disability Letter, etc. from an individual or organization licensed or authorized to provide said documentation)
- Proof of Income Amount and Sources**
 - Employment Check Stubs (6 months)
 - Social Security Award Letter (Supplemental Security Income/SSI or Social Security Admin /SSA)
 - Other: _____
- Release of Information** (signed by Applicant)
- Tenant Participation and Responsibility Agreement** (signed by Applicant)
- Commitment of Services Provision** (signed by Services Provider/Agency -- within the Special Needs Application form)
- Crisis Response Plan with Contact Numbers**
- Applicant Data Entered into LLA Spreadsheet** (for all LIHTC properties qualified for)

After SN Applicant Accepted as Qualified:

- Client Data Input/Entered into LLA Spreadsheet**
 - Enter Date Qualified; Enter Lottery Number
- SN Letter of Referral sent to Property Manager**
- Proof of required monthly visits:**
 - i.e. Copies of Monthly Supportive Housing Checklists for each month

LETTER OF ATTESTATION OF CONFIRMED SPECIAL NEEDS APPLICANT IDENTITY

(Letter is to be placed on Local Lead Agency or Services Provider Letterhead)

Date of Attestation: _____

To Whom It May Concern

Re: Attestation of Confirmed Identity

By this Letter of Attestation, I am attesting that the identity of this Applicant named: _____ (Person's full name),

who was born on: _____/_____/_____ (birth day/month/year), and he/she has presented to me **two** of the following valid and official documents of which one must be a current picture identification document:

- ____ Government Issued Birth Certificate (original or certified copy)
- ____ U.S. Social Security Card issued by Social Security Administration
- ____ Drivers License or ID Card issued by a State with Photo
- ____ Voter's Registration Card
- ____ Native American Tribal Document with birth date (e.g. Certificate of Indian Blood)

This Attestation document will remain part of the Applicants file and will be considered proof of the Applicant's identity for which the Local Lead Agency staff is responsible for in the determination of eligibility of a Special Needs Applicant.

Signature of Local Lead Agency or Services Provider Staff Person

Print Name

Date

Contact Information for Local Lead Agency or Services Provider:

Name of Local Lead Agency or Services Provider (Printed)

Address

City, State, Zip

Phone Number (area code/ number)

LETTER OF ATTESTATION OF HOMELESSNESS OF SPECIAL NEEDS APPLICANT

(For Applicants whose Special Needs Housing eligibility is based *SOLELY* upon homelessness)

Letter is to be placed on Services Provider or Local Lead Agency Letterhead

Date of Attestation: _____

To Whom It May Concern

Re: Attestation of Homelessness or Precariously Housed

By this Letter of Attestation, I am attesting that this Applicant named:
_____ (Person's full name),

and that he/she has demonstrated to me they meet at least one of the following conditions of being Homeless or Precariously Housed:

A Household/individual is considered homeless or precariously housed if, without this assistance, he/she/ they would have to spend the night in a homeless shelter or in a place not meant for human habitation. This includes:

- a) an individual or family which lacks a fixed, regular, and adequate nighttime residence;
- b) an individual or family which has a primary nighttime residence that: 1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelter, and transitional housing for persons with mental illness); 2) an institution that provides a temporary residence for individuals intended to be institutionalized, or previously institutionalized; 3) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings; or 4) individuals who are certified by their case manager as "doubling up", "couch surfing" or staying with another household of a relative or friend. The term does not include any individual imprisoned or otherwise detained pursuant to an Act of the Congress or State law.

This Attestation document will remain part of the Applicants file and will be considered proof of the Applicant's homelessness status for which the Local Lead Agency staff is responsible for in the determination of eligibility of a Special Needs Applicant.

Signature of Local Lead Agency or Services Provider Staff Person

Print Name

Date

Contact Information for Local Lead Agency or Services Provider:

Name of Local Lead Agency or Services Provider (Printed)

Address: _____

City, State, Zip: _____

Phone Number (area code/ number) _____