Continuum of Care Program
Rental Assistance Intake Form

NEW YORK STATE
OFFICE OF ALCOHOLISM & SUBSTANCE ABUSE SERVICES

Name: _____ Date: _____

Date of Birth: _____ SS #: _____

Referring Agency: _____ Referral Person: _____

Case Manager: _____ Telephone Number: _____

Current Residence if Any: _____

Telephone Number or Other Means of Contact: _____

Alternate Means of Contact: _____

Current Living Situation (**Note:** Must Meet HUD Definition of Homelessness)

Please check one:

- ☐ Non-housing (street, car, park, etc.)
- ☐ Emergency shelter
- ☐ Transitional housing after having been homeless
- ☐ Fleeing/attempting to flee domestic violence

Note: If the participant came from an institution (such as a mental health/substance abuse treatment facility) but was there less than 90 days and was living on the street or in emergency shelter before entering the treatment facility, he/she should be counted in either the street or shelter category, as appropriate.

☐ Certificate of Homelessness is completed and attached

Can the person be considered chronically homeless (homeless continuously for one year or more or have experienced four episodes of homelessness in the past three years)?

- ☐ Yes (documentation is attached)
- ☐ No

What is the qualifying disability? _____

Is documentation from a professional qualified to make a disability determination attached?

- ☐ Yes
- ☐ No

Other Household Members: *Please list all family members who will be living in the household*

Relationship	Name	Date of Birth	Age	Social Security Number

Demographics:

Please place the total number of household members in each box.

Ethnicity:

	Hispanic or Latino
	Non-Hispanic or Latino

Race:

	American Indian
	Asian
	Black/African American
	Native Hawaiian/ Other Pacific Islander
	White
	American Indian/Alaskan Native & White
	Asian & White
	Black/African American & White
	American Indian/ Alaskan Native & Black/African American
	Other Multi-Racial

Special Needs Program Qualifications: *(For primary program participant only, please check all that apply): Must have a diagnosed Axis I substance use disorder to be eligible for the program*)

- ☐ Mental Illness
- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ HIV/AIDS and related diseases

Other: *(please check all that apply)*

- ☐ Developmental Disability
- ☐ Physical Disability
- ☐ Domestic Violence
- ☐ Other (please specify)

Total Household Monthly Income from EACH of the following sources:

Supplemental Security Income (SSI) _____

Social Security Disability Income (SSDI) _____

Social Security _____

General Public Assistance _____

Temporary Aid to Needy Families (TANF) _____

Child Support _____

Veteran's Benefits _____

Employment Income _____

Unemployment Income _____

Medicare _____

Medicaid _____

Food Stamps _____

Other (please specify) _____

☐ No Financial Resources

Bank Accounts

Type of Account	Bank Name and Address	Amount
☐ Checking		
☐ Savings		

Other Assets: _____

Asset Declaration: I certify that the above listed assets are the only assets of which I am either full or partial owner, that my name does not appear on any other bank accounts, checking accounts, saving certificates, stocks, bonds, or any other kind of asset. I further certified that I have not disposed of any property worth more than $2,000 in the last two year period.

I certify that all of the information included in this application is true and correct.

Applicant Name _____

Signature _____ Date _____

The following documentation should be included with this form:

- Signed Release of Information form
- Birth certificate (or verification of birthplace/date from Social Security, proof of application from HSA/DSS for copy of birth certificate, or driver's license)
- Award letter for SSI/SSDI from Social Security Administration, budget from HSA/DSS, or other documentation of income (pay stubs, etc.)
- Documentation of disability (letter from treatment provider, primary care provider, signed by professional qualified to make the diagnosis)
- Certification of Homelessness