



MISSOURI DEPARTMENT OF MENTAL HEALTH SHELTER PLUS CARE PROGRAM APPLICATION INFORMATION

GENERAL INFORMATION

- For assistance with this application, contact the DMH Housing Unit at housing@dmh.mo.gov or at 573-526-3125.
- For application processing and wait list information, call 573-751-9206.
- FAX completed applications to the DMH Housing Unit at 573-526-7797.
- Download this form as a PDF file at <http://dmh.mo.gov/housing/ShelterPlusCare.htm#ApplyingforSPCAssistance>.

DETAILED PROGRAM INFORMATION

- For an overview of DMH's Shelter Plus Care programs, visit: <http://dmh.mo.gov/housing/ShelterPlusCare.htm>.
- For very detailed information, see the DMH *Housing Manual* at <http://dmh.mo.gov/housing/ShelterPlusCare.htm#DMHHousingManual>.

NOTICE OF CLIENT RIGHTS (new in this revision)

The *Notice of Client Rights*, located at the end of this application, applies only to Applicants applying for assistance in **non-metropolitan counties** and in the **Springfield** area (which includes Greene, Christian and Webster counties). For those areas, both the Applicant and the Case Manager must sign this form. **Skip this form if** you are applying for assistance in the metro areas of St. Louis City, St. Louis County, Jackson County, St. Joseph, or Joplin.

**An incomplete application slows review time and delays assistance for your client.
For the fastest possible determination of eligibility:**

- ***Be sure you have the most current version of the application before you begin.*** You can check for the latest version by visiting <http://dmh.mo.gov/housing/ShelterPlusCare.htm#ApplyingforSPCAssistance>.
- ***Read the instructions found throughout the application*** to be certain you are filling it out correctly. If you have a question or need help, it's better to contact DMH Housing first than to submit an application you're not certain is complete and correct.
- ***Include documentation*** of the Applicant's homelessness (see Attachment C). ***This is required.*** No Applicant can be found eligible for assistance without this documentation.
- ***Fill out the Service Plan in detail*** (see Attachment B) if you are not submitting a copy of your agency's Service Plan or Treatment Plan. Include the names of all practitioners the applicant sees, how often he or she sees them, and all details relevant to the categories listed—even if they describe future plans of action rather than issues currently being worked on. Do not leave any sections blank unless they do not apply to the Applicant.
- ***Sign the form in all areas where required.*** Both the Case Manager and the applicant must sign in multiple locations.
- ***Make sure the application is legible*** and will remain so after you fax it to us. **Use only dark-colored ink.**
- ***Save time and paper—don't fill out and fax us pages we don't need.*** Don't fax us these instructions or the Application Checklist. If you are a single individual applying, don't fill out or fax us the 'Other Adults' and 'Minors' pages in Sections 5 and 6. If you don't need to sign the ***Notice of Client Rights***, don't fax that page back to us—remove it from the application.



MISSOURI DEPARTMENT OF MENTAL HEALTH SHELTER PLUS CARE PROGRAM

APPLICATION CHECKLIST

*The purpose of this checklist is to assist you in completing an Application for Shelter Plus Care.
Please do not submit this page with the application.*

- Sections 1-13 of the Application are filled out completely. Skip Section 5 if there are no other adults in the household; skip Section 6 if there are no minors in the household.
- The Applicant has signed the Applicant Certification (Section 12).
- Attachment A (Disability Verification) is completely filled out with ONE option checked and is signed by a person with the proper credentials.
- Attachment B (Service Plan) is completely filled out, if you choose not to submit a copy of your agency's original Treatment or Service Plan.
- Attachment C (Homelessness Verification) is completely filled out with ONE option checked and is signed by the Case Manager.
- Complete documentation of the applicant's homelessness is attached (*see Attachment C* for required documentation).
- Attachment D (Chronic Homelessness Verification) is filled out if the Applicant fits the definition of "chronically homeless."
- Documentation of the Applicant's chronic homelessness is attached, if needed (*see Attachment D* for the definition of chronic homelessness).
- Attachment E—Consent for Disclosure of Applicant's Protected Health Information is completely filled out and signed by the Applicant and a witness.
- The **Notice of Client Rights** is signed by the Applicant and the Case Manager, if needed (only Applicants in non-metropolitan counties and the Springfield area need to sign this form; if in doubt, call 573-526-3125 or 573-751-9206).
- A copy of the Applicant's documentation of legal non-citizen status is attached, if applicable.



APPLICATION FOR SHELTER PLUS CARE

DMH Housing Unit | 1706 E. Elm Street | Jefferson City MO 65101
 573-751-9206 | FAX 573-526-7797 | housing@dmh.mo.gov | <http://dmh.mo.gov/housing/>

>SECTION 1. APPLICANT INFORMATION

Applicant Name:

First: _____ Middle _____ Last: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

>SECTION 2. CASE MANAGER CONTACT

Case Manager Name:

Agency: _____ City: _____

Office Phone: (_____) _____ Fax: (_____) _____

Alternate Phone: (_____) _____

>SECTION 3. EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Other Contact Info: _____

For DMH Use Only

DC		EC				LHM					
Metro KC	<input type="checkbox"/>	St. Joseph	<input type="checkbox"/>	St. Louis City	<input type="checkbox"/>	Bootheel	<input type="checkbox"/>	St. Louis Cty Chronic	<input type="checkbox"/>	Branson	<input type="checkbox"/>
KC Chronic	<input type="checkbox"/>	Outer KC Metro	<input type="checkbox"/>	St. Louis County	<input type="checkbox"/>	Poplar Bluff	<input type="checkbox"/>	St. Louis Co. Chronic	<input type="checkbox"/>	Springfield	<input type="checkbox"/>
Joplin	<input type="checkbox"/>	Nevada	<input type="checkbox"/>	Farmington	<input type="checkbox"/>	Jefferson-Franklin	<input type="checkbox"/>	Rolla	<input type="checkbox"/>	West Plains	<input type="checkbox"/>
Joplin Chronic	<input type="checkbox"/>		<input type="checkbox"/>	Hannibal	<input type="checkbox"/>	Central Missouri	<input type="checkbox"/>	Kirkville	<input type="checkbox"/>		<input type="checkbox"/>

Forms:	Disability	<input type="checkbox"/>	Service Plan	<input type="checkbox"/>	Homeless	<input type="checkbox"/>	Chronic	<input type="checkbox"/>	HMIS	<input type="checkbox"/>	HIPAA	<input type="checkbox"/>
Eligibility:	Disabled	<input type="checkbox"/>	Homeless	<input type="checkbox"/>	Income	<input type="checkbox"/>						
Disability:	SMI	<input type="checkbox"/>	CSA	<input type="checkbox"/>	SMI/CSA	<input type="checkbox"/>	PWA	<input type="checkbox"/>	PWOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>								
Referral:				MO								
	<i>Processing Center</i>			<i>Grant Code</i>		<i>HUD Grant Number</i>			<i>Date Referred</i>			

➤SECTION 4. APPLICANT'S INFORMATION

Applicant Name: _____

U.S citizen Eligible non-citizen

Applicant's primary language: _____

If the primary language is not English, can the Applicant speak limited English? Yes No

Country of origin if not U.S.: _____

Race:

- American Indian/Alaska Native
- Asian
- Black/African-American
- Native Hawaiian/Other Pacific Islander
- White
- Multi-Racial (specify by checking additional boxes above)

Ethnicity:

- Hispanic
- Non-Hispanic

Gender:

- Male
- Female
- Transgender, male to female
- Transgender, female to male

Marital Status:

- single
- married
- separated
- widowed
- divorced
- same-sex couple

Veteran Status:

Are you a veteran? Yes No
If yes, please fill out **Section 11, Veteran Status.**

Are you pregnant? Yes No No. of months: _____
Delivery date: _____ / _____ / _____

Temporary Address/Location:

Where do you currently live? Provide at least a city and zip code.

Street address _____ Apt. _____

City _____

Zip Code _____

Telephone _____

Last Permanent Address/Location:

Where did you last live for at least 90 days where you paid rent or had a mortgage? Provide at least a city and zip code.

Street address _____ Apt. _____

City _____

Zip Code _____

Where did you spend the night before filling out this application?

- Emergency shelter (includes a motel or hotel room paid for by an emergency shelter voucher; and a respite bed)
- Transitional housing program
- A place not meant for human habitation (car, park, etc.)
- Jail, prison or juvenile detention center
- Substance abuse treatment facility/detox center
- Safe Haven
- Hospital (non-psychiatric)
- Psychiatric hospital or similar facility
- Other

How long did you stay in the above situation?

- One week or less
- More than one week but less than one month
- 1-3 months
- 4-6 months
- 7-12 months
- 1-2 years
- 2-4 years
- Four or more years
- Don't know

Do you have health insurance? Check all that apply.

- Medicare
- Medicaid (aka Missouri HealthNet)
- VA Medical
- private insurance
- medication assistance
- no insurance

What is the primary reason for your homelessness? Check one.

- | | |
|---|---|
| <input type="checkbox"/> stranded/transient | <input type="checkbox"/> relocating |
| <input type="checkbox"/> physical abuse | <input type="checkbox"/> loss of income |
| <input type="checkbox"/> insufficient income | <input type="checkbox"/> fire |
| <input type="checkbox"/> kicked out of house | <input type="checkbox"/> housing condemned |
| <input type="checkbox"/> substandard housing | <input type="checkbox"/> no power |
| <input type="checkbox"/> no water | <input type="checkbox"/> eviction |
| <input type="checkbox"/> building sold | <input type="checkbox"/> spousal desertion |
| <input type="checkbox"/> mental health issues | <input type="checkbox"/> Section 8 violation |
| <input type="checkbox"/> drug/alcohol issues | <input type="checkbox"/> never lived independently |
| <input type="checkbox"/> high-risk neighborhood | <input type="checkbox"/> 2005 disaster victim (Katrina, etc.) |
| <input type="checkbox"/> marriage/separation | <input type="checkbox"/> victim of crime |
| <input type="checkbox"/> displaced | <input type="checkbox"/> institution discharge |
| <input type="checkbox"/> shelter termination | <input type="checkbox"/> employment situation |
| <input type="checkbox"/> domestic violence | <input type="checkbox"/> disaster |
| <input type="checkbox"/> mental/emotional abuse | |
| <input type="checkbox"/> release from incarceration | |

Have you ever been a victim of domestic violence?

- Yes No Don't Know Refuse to Answer

If yes, how long in the past did this occur?

- Within past three months
- 3-6 months ago
- 6-12 months ago
- More than one year ago
- Don't Know
- Refused to Answer

Are you currently in school and/or working on any degree or certificate? Yes No

Have you received vocational training or been in a trade apprenticeship? Yes No

APPLICANT'S NAME: _____

➤SECTION 4—Continued

What is the highest grade you've completed?

- no school completed
- nursery school to 4th grade
- 5th grade to 6th grade
- 7th grade to 8th grade
- 9th grade
- 10th grade
- 11th grade
- 12th grade, no diploma
- high school diploma
- GED
- Associates degree
- some college, no degree
- Bachelors degree
- Masters degree
- doctorate
- other graduate or post-secondary education
- Certificate of advanced training or skilled artisan
- Don't Know

Are you employed? Yes No

If yes, what type of employment is it?

- Permanent Temporary Seasonal

How many hours did you work last week? _____

If not employed, are you looking for work?

- Yes No

What is your general physical health status?

- Excellent Very good Good Fair Poor

Do you have a mental illness?

- Yes No Don't Know

If yes, is the mental illness a disabling condition?*

- Yes No

[If Attachment A, "Disability Verification," indicates a mental illness or a dual diagnosis, you must answer "yes" to the above.]

Are you receiving services or treatment for the mental illness? Yes No

Do you have a substance abuse disorder?

- yes, alcohol abuse yes, drug abuse
- yes, both alcohol and drug abuse
- No Don't Know

If yes, is the substance abuse disorder a disabling condition?*

- Yes No

[If Attachment A, "Disability Verification," indicates a substance abuse disorder, you must answer "yes" to the above.]

Are you receiving services or treatment for the substance abuse disorder?

- Yes No

Do you have HIV or AIDS?

- Yes No Don't Know

If yes, is this a disabling condition?*

- Yes No

If yes, are you receiving services or treatment for HIV or AIDS?

- Yes No

Do you have a developmental disability?***

- Yes No Don't Know

If yes, is the developmental disability a disabling condition?

- Yes No

If yes, are you receiving services or treatment for the developmental disability?

- Yes No

Do you have a chronic health condition**?**

- Yes No Don't Know

If yes, please specify what the condition is:

If yes, is the chronic health condition a disabling condition?

- Yes No

If yes, are you receiving services or treatment for the chronic health condition?

- Yes No

Do you have a physical disability?

- Yes No Don't Know

If yes, please specify what the disability is:

If yes, is the physical disability a disabling condition?

- Yes No

Are you receiving services or treatment for the physical disability?

- Yes No

* **"Disabling condition"** means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

** **"Developmental disability"** includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and some learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

*** **Chronic health conditions** include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

APPLICANT'S NAME: _____

➤ SECTION 5. INFORMATION ABOUT OTHER ADULTS IN HOUSEHOLD (ANYONE 18+ YEARS OLD)

Use additional copies of Section 5 if the Applicant's household has more than one adult aside from the Applicant. Omit this page if there are no other adults in the household.

Other Adult's Name: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____ / _____ / _____

Race:

- American Indian/Alaska Native
- Asian
- Black/African-American
- Native Hawaiian/Other Pacific Islander
- White
- Multi-Racial (specify by checking additional boxes above)

Ethnicity:

- Hispanic
- Non-Hispanic

Gender:

- Male
- Female
- Transgender, male to female
- Transgender, female to male

What is this adult's relationship to the Applicant?

- spouse
- significant other/partner
- parent
- step-parent
- grandparent
- aunt
- uncle
- brother
- sister
- son
- daughter
- step-child
- niece
- nephew
- roommate
- other

Veteran Status:

Is this adult a veteran? Yes No
If "Yes," please fill out **Section 11, Veteran Status**

Is this adult pregnant? Yes No No. of months: _____

Temporary Address/Location:

Check here if this adult currently lives at the same location as the Applicant; if the location is different, fill it in below. Please provide at least a city and zip code.

Street address _____ Apt. _____

City _____

Zip Code _____

Telephone _____

Last Permanent Address/Location:

Check here if this adult's last permanent address was the same as the Applicant's; if it was different, fill it in below. Please provide at least a city and zip code.

Street address _____ Apt. _____

City _____

Zip Code _____

Where did this adult spend the night before this application was filled out?

- Emergency shelter (includes a motel or hotel room paid for by an emergency shelter voucher; and a respite bed)
- Transitional housing program
- A place not meant for human habitation (car, park, etc.)
- Jail, prison or juvenile detention center
- Substance abuse treatment facility/detox center
- Safe Haven
- Hospital (non-psychiatric)
- Psychiatric hospital or similar facility
- Other

How long did this adult stay in the above situation?

- One week or less
- More than one week but less than one month
- 1-3 months
- 4-6 months
- 7-12 months
- 1-2 years
- 2-4 years
- Four or more years
- Don't know

Has this adult ever been a victim of domestic violence?

- Yes No Don't Know Refuse to Answer

If yes, how long in the past did this occur?

- Within past three months
- 3-6 months ago
- 6-12 months ago
- More than one year ago
- Don't Know
- Refused to Answer

Is this adult currently in school and/or working on any degree or certificate? Yes No

Has this adult received vocational training or been in a trade apprenticeship? Yes No

What is the highest grade completed by this adult?

- no school completed
- nursery school to 4th grade
- 5th grade to 6th grade
- 7th grade to 8th grade
- 9th grade
- 10th grade
- 11th grade
- 12th grade, no diploma
- high school diploma
- GED
- Associates degree
- some college, no degree
- Bachelors degree
- Masters degree
- doctorate
- other graduate or post-secondary education
- Certificate of advanced training or skilled artisan
- Don't Know

APPLICANT'S NAME: _____

➤SECTION 5—Continued

Other Adult's Name: _____

Is this adult employed? Yes No

If yes, what type of employment is it?

Permanent Temporary Seasonal

How many hours did this adult work last week? _____

If not employed, is this adult you looking for work?

Yes No

What is this adult's general physical health status?

Excellent Very good Good Fair Poor

Does this adult have a mental illness?

Yes No Don't Know

If yes, is the mental illness a disabling condition?*

Yes No

[If Attachment A, "Disability Verification," indicates a mental illness or a dual diagnosis, you must answer "yes" to the above.]

If yes, is this adult receiving services or treatment for the mental illness? Yes No

Does this adult have a substance abuse disorder?

yes, alcohol abuse yes, drug abuse

yes, both alcohol and drug abuse

No Don't Know

If yes, is the substance abuse disorder a disabling condition?

Yes No

[If Attachment A, "Disability Verification," indicates a substance abuse disorder, you must answer "yes" to the above.]

If yes, is this adult receiving services or treatment for the substance abuse disorder?

Yes No

Does this adult have HIV or AIDS?

Yes No Don't Know

If yes, is this a disabling condition?

Yes No

If yes, is this adult receiving services or treatment for HIV or AIDS?

Yes No

Does this adult have a developmental disability?**

Yes No Don't Know

If yes, is the developmental disability a disabling condition?

Yes No

If yes, is this adult receiving services or treatment for the developmental disability?

Yes No

Does this adult have a chronic health condition***?

Yes No Don't Know

If yes, please specify what the condition is:

If yes, is the chronic health condition a disabling condition?

Yes No

If yes, is this adult receiving services or treatment for the chronic health condition?

Yes No

Does this adult have a physical disability?

Yes No Don't Know

If yes, please specify what the disability is:

If yes, is the physical disability a disabling condition?

Yes No

If yes, is this adult receiving services or treatment for the physical disability?

Yes No

* "Disabling condition" means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

** "Developmental disability" includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

*** Chronic health conditions include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

APPLICANT'S NAME: _____

>SECTION 6. INFORMATION ABOUT MINORS IN HOUSEHOLD (ANYONE 17 YEARS OLD OR YOUNGER)

Fill out one Section 6 per minor that will live in the Applicant's household. Omit this page if there are no minors in the household.

Minor's Name: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____ / _____ / _____

Does the Applicant have legal custody of this minor?

Yes No

Race:

- American Indian/Alaska Native
- Asian
- Black/African-American
- Native Hawaiian/Other Pacific Islander
- White
- Multi-Racial (specify by checking additional boxes above)

Ethnicity:

- Hispanic
- Non-Hispanic

Gender:

- Male
- Female
- Transgender, male to female
- Transgender, female to male

What is this minor's relationship to the Applicant?

- brother sister
- son daughter step-child
- niece nephew grandchild
- other

Is this minor pregnant? Yes No No. of months: _____

Temporary Address/Location:

Check here if this minor currently lives at the same location as the Applicant; if the location is different, fill it in below. Provide at least a city and zip code.

Street address _____ Apt. _____

City _____

Zip Code _____

Telephone _____

Last Permanent Address/Location:

Check here if this minor's last permanent address was the same as the Applicant's; if it was different, fill it in below. Provide at least a city and zip code.

Street address _____ Apt. _____

City _____

Zip Code _____

Where did this minor spend the night before this application was filled out?

- Emergency shelter (includes a motel or hotel room paid for by an emergency shelter voucher; and a respite bed)
- Transitional housing program
- A place not meant for human habitation (car, park, etc.)
- Jail, prison or juvenile detention center
- Substance abuse treatment facility/detox center
- Safe Haven
- Hospital (non-psychiatric)
- Psychiatric hospital or similar facility
- Other

How long did this minor stay in the above situation?

- One week or less
- More than one week but less than one month
- 1-3 months
- 4-6 months
- 7-12 months
- 1-2 years
- 2-4 years
- Four or more years
- Don't know

Is this minor currently enrolled in school?

- Yes No the minor is not old enough

If yes, please give the name of the school:

If enrolled, is this minor connected with the school district's official homelessness coordinator?

- Yes No don't know

If enrolled, what type of school does the minor attend?

- public (includes charter schools)
- parochial or private
- don't know

If not enrolled, give the most recent date of enrollment:

_____ / _____ / _____

If the minor is old enough to attend school but is not enrolled, please identify any problems or obstacles to enrollment:

- none
- residency requirements
- availability of school records
- birth certificate
- legal guardianship requirements
- transportation
- lack of available preschool programs
- immunization requirements
- physical examination records
- other don't know

Has this minor ever been a victim of domestic violence?

- Yes No Don't Know Refuse to Answer

If yes, how long in the past did this occur?

- Within past three months
- 3-6 months ago 6-12 months ago
- More than one year ago
- Don't Know Refused to Answer

APPLICANT'S NAME: _____

SECTION 6.—Continued

Minor's name: _____

What is the minor's general physical health status?

Excellent Very good Good Fair Poor

Does the minor have a mental illness?

Yes No Don't Know

If yes, is the mental illness a disabling condition?*

Yes No

[If Attachment A, "Disability Verification," indicates a mental illness or a dual diagnosis, you must answer "yes" to the above.]

If yes, is the minor receiving services or treatment for the mental illness? Yes No

Does the minor have a substance abuse disorder?

yes, alcohol abuse yes, drug abuse

yes, both alcohol and drug abuse

No Don't Know

If yes, is the substance abuse disorder a disabling condition?

Yes No

[If Attachment A, "Disability Verification," indicates a substance abuse disorder, you must answer "yes" to the above.]

If yes, is the minor receiving services or treatment for the substance abuse disorder?

Yes No

Does the minor have HIV or AIDS?

Yes No Don't Know

If yes, is this a disabling condition?

Yes No

If yes, is the minor receiving services or treatment for HIV or AIDS?

Yes No

Does the minor have a developmental disability?**

Yes No Don't Know

If yes, is the developmental disability a disabling condition?

Yes No

If yes, is the minor receiving services or treatment for the developmental disability?

Yes No

Does the minor have a chronic health condition*?**

Yes No Don't Know

If yes, please specify what the condition is:

If yes, is the chronic health condition a disabling condition?

Yes No

If yes, is the minor receiving services or treatment for the chronic health condition?

Yes No

Does the minor have a physical disability?

Yes No Don't Know

If yes, please specify what the disability is:

If yes, is the physical disability a disabling condition?

Yes No

If yes, is the minor receiving services or treatment for the physical disability?

Yes No

* **"Disabling condition"** means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

** **"Developmental disability"** includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

*** **Chronic health conditions** include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

APPLICANT'S NAME: _____

➤SECTION 7. INCOME

Have you received cash income from any source in the past 30 days? Yes No

If yes, please check the boxes next to all sources of CASH income in the list below received by all household members (do not include food stamps) and state the amount received per month.

Type	Amount/Month
<input type="checkbox"/> Employment income	\$ _____
<input type="checkbox"/> Child support	\$ _____
<input type="checkbox"/> Social Security Disability (SSDI)	\$ _____
<input type="checkbox"/> Supplemental Security Income (SSI)	\$ _____
<input type="checkbox"/> Social Security retirement	\$ _____
<input type="checkbox"/> TANF	\$ _____
<input type="checkbox"/> Veteran's pension	\$ _____
<input type="checkbox"/> Veteran's disability payment	\$ _____
<input type="checkbox"/> Unemployment Insurance	\$ _____
<input type="checkbox"/> Alimony/other spousal support	\$ _____
<input type="checkbox"/> Pension from a former job	\$ _____
<input type="checkbox"/> Worker's Compensation	\$ _____
<input type="checkbox"/> Private disability insurance	\$ _____
<input type="checkbox"/> Other sources of income	\$ _____

Specify any other sources of cash income and amount below:

If any of the income sources checked above are received by a household member other than the Applicant, please describe here:

Have you received non-cash benefits or services in the past 30 days? Yes No

Please check all sources of NON-CASH benefits and services.

Type	Who receives the assistance/service?
<input type="checkbox"/> Food stamps	_____
<input type="checkbox"/> Medicaid/MO HealthNet	_____
<input type="checkbox"/> Medicare	_____
<input type="checkbox"/> WIC	_____
<input type="checkbox"/> TANF childcare services	_____
<input type="checkbox"/> TANF transportation services	_____
<input type="checkbox"/> Other TANF-funded services	_____
<input type="checkbox"/> Children's Health Insurance Program	_____
<input type="checkbox"/> VA Medical Services	_____
<input type="checkbox"/> Other assistance source	_____

➤SECTION 8. ZERO INCOME DECLARATION

Complete this section only if the Applicant has **NO** cash income.

➤ **APPLICANT:** If you have no cash income, please read the statement below, then print your name, sign your name, and fill in the date. Please be aware that falsification of this statement is grounds for denial or termination of housing assistance.

To the best of my knowledge and belief, I have no income at the time of making this application.

➤ _____
(Print Applicant Name)

➤ _____
(Sign Applicant Name)

➤ _____ / _____ / _____
(Date)

➤ **CASE MANAGER:** If the Applicant has no cash income, please read the statement below, then print your name, sign your name, and fill in the date.

To the best of my knowledge and belief,

_____ (print applicant name) has no income at the time of making this application.

➤ _____
(Print Case Manager Name)

➤ _____
(Sign Case Manager Name)

➤ _____ / _____ / _____
(Date)

APPLICANT'S NAME: _____

➤SECTION 9. ASSETS INFORMATION

Assets: please list all checking, savings, and investment accounts below for all persons that will be living in your household.

Household Member's Name	Bank/Institution Name	Account Number	Type of Account (checking, savings, investment)	Current Balance

List the value of all stocks, bonds, trusts, pension contributions or other assets: _____

Have you sold or given away any real property or assets in the past two years? Yes No

If yes, what is the current market value of the asset: _____

➤SECTION 10. EXPENSES

Expenses: please provide the information requested below. These answers may help reduce the amount of rent for which you'll be responsible in DMH's Shelter Plus Care program.

Do you pay for childcare that enables you or another household member to work or go to school? Yes No

If yes, give the name and address of the childcare provider, weekly cost and the name of the household member working or in school:

Provider Name & Address: _____

Name of household member who works or goes to school: _____

Weekly Cost: _____

Do you pay for a care attendant or for any equipment for a disabled member of the household necessary to permit that person or someone else in the household to work? Yes No

If yes, give the name of the household member who works because of this expense: _____

Do you incur unreimbursed medical expenses on a regular basis? Yes No If yes, amount per month: \$ _____

Do you owe money on back rent? Yes No

If yes, amount: \$ _____

Do you owe money on past utility bills? Yes No

If yes, amount: \$ _____

➤SECTION 11. VETERAN STATUS

Are you a veteran? Yes No Don't Know

If no, skip the rest of this section.

If yes, what date did you begin military service?

_____ / _____ / _____

What branch did you serve in?

Army Air Force Navy Marines
 Other Don't Know

When did you serve? Choose one; if your service dates overlap two choices, choose the one containing most of the service time.

- Post-September 11th (September 11, 2001-present)
- Persian Gulf (August 1991-September 10, 2001)
- Post-Vietnam (May 1975-July 1991)
- Vietnam (August 1964-April 1975)
- Between Korea and Vietnam (Feb. 1955-July 1964)
- Korea (June 1950-January 1955)
- Between WW2 and Korea (August 1947-May 1950)
- WW2 (September 1940-July 1947) Don't know

Duration of Active Duty: _____ Enter months served

Did you serve in a war zone? Yes No Don't Know

If yes, which one?

- Europe North Africa Vietnam
- Laos and Cambodia South China Sea
- China, Burma, India Korea South Pacific
- Persian Gulf Afghanistan Don't know

Number of months in war zone: _____

Did you receive hostile or friendly fire? Yes No
 Don't Know

Discharge Status: Honorable General
 Medical Bad Conduct Dishonorable
 Other Don't Know Refused to Answer

APPLICANT'S NAME: _____

➤SECTION 12. APPLICANT CERTIFICATIONS

Applicant: please read the paragraphs below and then sign to show that you have read the information, understand it and agree to it.

- ✓ I understand that if I am approved to receive assistance from the Department of Mental Health's Shelter Plus Care program, I agree to follow all of the rules of the Shelter Plus Care program.
- ✓ I understand that I must report all increases and decreases in my income to my local processing center agency within 30 days of the change in income;
- ✓ I understand that I must adhere to the Service Plan that I established with the agency that is referring this application to the Department of Mental Health;
- ✓ I understand that if my referring agency can no longer provide case management or supportive services, I will help to identify a new agency of my choice to provide those services.
- ✓ I understand that if I change supportive service agencies I must notify my local processing center agency of the change within 30 days.
- ✓ I understand that as a Shelter Plus Care participant I am required to obey the rules and restrictions of my lease, including paying my share of rent on time, not disturbing fellow tenants, and keeping my unit clean and free of damages.
- ✓ I certify that all information given on this application by me or other parties is accurate and complete to the best of my knowledge and belief. I also understand that making false statements or providing false information is grounds for denial or termination of rental assistance.

➤ _____
(Print Name of Applicant, or of Parent, Guardian or Legal Representative of Applicant)

➤ _____
(Signature of Applicant, or of Parent, Guardian or Legal Representative of Applicant)

➤ _____ / _____ / _____
(Date)

SECTION 13. CASE MANAGER CERTIFICATIONS

CASE MANAGER: please read the following and indicate your understanding and agreement by signing below.

- ✓ I understand that by referring this Applicant to the Shelter Plus Care program, my agency is committing to providing case management and/or other supportive services for the Applicant for as long as the Applicant continues to qualify for such services.
- ✓ I will ensure that all children in this household are properly enrolled in school and are connected to the appropriate services within the community, including early childhood education programs.
- ✓ I will attend the initial Shelter Plus Care orientation with the Applicant at the local housing processing center agency, once the applicant has been approved to receive Shelter Plus Care assistance.
- ✓ I will assist the Applicant in his or her housing search once the Applicant is approved for Shelter Plus Care assistance.
- ✓ I will ensure that this Applicant for Shelter Plus Care receives case management services consistent with the Service Plan included in this application, and that those services will be adequate to help him or her maintain stable independent housing. DMH Housing strongly recommends at least one visit per quarter to the Participant's home.
- ✓ I understand that if I leave my position or if this Applicant is assigned to a different Case Manager, I am responsible for ensuring that DMH Housing and the Applicant's local Shelter Plus Care Processing Center are notified of the change in case management and for facilitating the transfer of services to another person or agency.
- ✓ I understand that making false statements or providing false information is grounds for denial or termination of the Applicant's rental assistance.
- ✓ I certify that all information provided on this application is accurate and complete to the best of my knowledge and belief.

➤ _____
(Print Name of Case Manager)

➤ _____
(Signature of Case Manager)


➤ _____
(Name of Agency Employing Case Manager)

➤ _____ / _____ / _____
(Date)

➤ ATTACHMENT A. VERIFICATION OF DISABILITY

INSTRUCTIONS: This form is used to identify the Applicant's *primary* disability that impedes the Applicant's ability to work and live independently. If the Applicant has multiple disabilities, please choose only the one that most substantially impedes the Applicant's ability to work and live independently.

This form may be signed ONLY by a person with one of the following licenses or credentials and who 1) is authorized by his or her agency to make this type of determination, and 2) maintains appropriate documentation related to the assessment or diagnosis. Please indicate your professional licensure or credential by checking a box below and provide your license or credential number.

 Persons with an MSAPCB-issued credential shown below may indicate an alcohol or drug addiction diagnosis ONLY.

Medical Doctor <input type="checkbox"/>	CADC (Certified Alcohol Drug Counselor) <input type="checkbox"/>
Psychiatrist <input type="checkbox"/>	CRADC (Certified Reciprocal Alcohol Drug Counselor) <input type="checkbox"/>
Psychologist <input type="checkbox"/>	CRAADC (Certified Reciprocal Advanced Alcohol Drug Counselor) <input type="checkbox"/>
Licensed Professional Counselor <input type="checkbox"/>	RSAP-P (Registered Substance Abuse Professional—Provisional) <input type="checkbox"/>
Licensed Clinical Social Worker <input type="checkbox"/>	CCJP (Certified Criminal Justice Addictions Professional) <input type="checkbox"/>
Advanced Practice Nurse <input type="checkbox"/>	CCDP (Co-Occurring Disorders Professional) <input type="checkbox"/>
	CCDP-D (Co-Occurring Disorders Professional—Diplomate) <input type="checkbox"/>

License or credential number (*required*): _____

APPLICANT'S NAME: _____

- The Applicant has been diagnosed with a **serious mental illness**.
- The Applicant has been diagnosed with **both a serious mental illness and a chronic alcohol or drug abuse disorder**.
- The Applicant has a **chronic alcohol abuse disorder and/or a chronic drug abuse disorder**.
- The Applicant has a **severe and chronic developmental disability** that:
 1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
 2. Manifested before the person attained the age of 22;
 3. Is likely to continue indefinitely;
 4. Results in substantial functional limitations in three or more of the following areas of major life activity (*please check three or more of the following*):
 - Self-care
 - Receptive and expressive language
 - Learning
 - Mobility
 - Self-direction
 - Capacity for independent living
 - Economic self-sufficiency; and
 5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.
- The Applicant has a **diagnosis of HIV and/or AIDS**.

I have personally made the diagnosis specified above. The above individual has a disability that is expected to be of long-continued and indefinite duration; is expected to substantially impede this person's ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.

➤ _____ ➤ _____
 (*Print Name of Person Verifying Disability*) (*Signature of Person Verifying Disability*)

➤ _____ / _____ / _____
 (*Date*)

➤ **ATTACHMENT B. SERVICE PLAN**

OPTION 1: Use this form to identify the service plan that will help the Applicant achieve stable housing and increase his or her self-sufficiency and job skills. For all types of services, list both the name of the provider and the frequency with which the Applicant receives or attends the service. Please provide as much detail as possible.

OPTION 2: Attach to this application a copy of your agency's Assessment, Service Plan or Treatment Plan and skip this form.

APPLICANT'S NAME: _____

- Mental Health Services**
 - Doctor, Psychologist or Psychiatrist visits: _____
 - Therapist visits: _____
 - Group therapy: _____
 - Case management: _____

- Substance Abuse Treatment and Aftercare**
 - Treatment services: _____
 - Aftercare: _____
 - Case management: _____
 - AA/NA meetings: _____
 - Relapse plan and sponsor: _____

- Developmental Disability Services**
 - Doctor visits: _____
 - Therapist visits: _____
 - Case management: _____

- HIV/AIDS Services**
 - Doctor visits: _____
 - Case management: _____

- Employment and Training**
 - Vocational rehabilitation: _____
 - Supported employment: _____
 - Case management follow-ups: _____
 - Employment and training goals: _____

- Income and Benefits**
 - Applied for benefits: _____
 - Appeals for benefits: _____
 - Benefits goals: _____
 - Case management follow-ups: _____

- Housing**
 - Other forms of housing assistance applied for:
 - Section 8 Subsidized/project-based rental unit DMH Rental Assistance Program (RAP)
 - DMH Supportive Community Living (SCL) Other rental assistance or voucher program
 - Housing search & moving assistance: _____
 - Furniture & household items: _____
 - Schedule of case management home visits: _____

➤ _____
(Signature of Applicant)

➤ ____/____/____
(Date)

➤ _____
(Signature of Case Manager)

➤ ____/____/____
(Date)

➤ ATTACHMENT C. VERIFICATION OF HOMELESSNESS

INSTRUCTIONS: This form should be used to describe the Applicant's homelessness situation on or about the day that this application is signed by the Applicant. If none of the choices below apply to the Applicant, then that person is not currently eligible for Shelter Plus Care assistance.

Please be sure to attach the documentation described for each choice. Failure to send the required documentation will significantly delay processing.

APPLICANT'S NAME: _____

CHOOSE ONLY ONE: The Applicant is homeless as defined by HUD because he or she:

- Currently lives in places not meant for human habitation.**
 - You must attach a letter from an outreach worker or other homeless services worker or case manager able to personally verify the applicant's street homelessness.
- Currently lives in an emergency shelter or other form of emergency housing.**
 - You must attach a letter from the emergency housing facility verifying the applicant currently resides there; **or** a printout from a Homeless Management Information System (HMIS) showing recorded shelter stays.
- Currently lives in transitional or supportive housing for homeless persons and his or her housing immediately prior was an emergency shelter or a place not meant for human habitation.**
 - You must attach a letter from the transitional housing facility verifying the applicant currently resides in that facility; **and** documentation that the Applicant's housing immediately prior to the transitional facility was either emergency housing or living in a place not meant for human habitation.
- Currently lives in an institution and has lived there for ninety (90) consecutive days or less, and immediately prior to living in the institution lived in an emergency shelter or a place not meant for human habitation.**
 - You must attach a signed and dated verification from the institution staff that the applicant has been residing there for thirty days or less; **and** documentation that the Applicant's housing immediately prior to the transitional facility was either emergency housing or living in a place not meant for human habitation.

➤ _____ ➤ _____
(Print Name of Case Manager) (Signature of Case Manager)

➤ _____ ➤ ____/____/_____
(Name of Agency Employing Case Manager) (Date)

Please Note: Eligibility for Shelter Plus Care cannot be determined without the documentation described above; failure to attach it will significantly delay application processing. The Applicant will not be placed on a wait list until determined to be eligible.

Definitions:

Places not meant for human habitation (a.k.a. street homelessness) include sleeping in cars, in tents located in parks or wilderness, squatting in abandoned, disused or uninhabited buildings, and sleeping in structures without any utilities or sanitation facilities.

Emergency housing includes sleeping in an emergency shelter, staying in a temporary respite setting for up to 30 days such as a respite bed in a residential care facility, or staying in a motel or hotel where the cost is paid by a social services or charitable agency (not by the Applicant him or herself or by family members). Domestic violence shelters are also considered emergency housing unless they specifically self-designate as transitional housing.

Transitional or supportive housing is a residential housing program where the Applicant lives full-time, receives supportive services, and can remain in residence for at least six months but not for more than 24 months.

An **institution** includes a medical or psychiatric hospital, an in-patient treatment program, a nursing home or other congregate setting, and jail or prison.

➤ ATTACHMENT D. VERIFICATION OF CHRONIC HOMELESSNESS

INSTRUCTIONS: "Chronic homelessness" applies to Applicants who are disabled and who experience long-term and/or frequent episodes of homelessness. Several DMH Shelter Plus Care grants are reserved only for people who fit this definition.

APPLICANT'S NAME: _____

To be considered chronically homeless, the Applicant must:

- have experienced four (4) separate, distinct and sustained episodes of homelessness over the past three (3) years; or
- have been continually homeless for one full year.

"Homelessness" as used above means only staying a form of emergency housing such as a shelter, or sleeping in places not meant for human habitation. A person currently residing in a transitional housing program is not considered chronically homeless.

If neither choice above describes the Applicant, check this box and skip the rest of this form:

A. Please list in chronological order below the Applicant's four most recent episodes of homelessness within the past three years. For each episode, attach documentation of the homelessness episode (see Attachment C for valid forms of documentation).

Date	to	Date	Location
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OR (If you filled out A. completely above, leave B. blank.)

B. Please describe below how the Applicant lived for one full year continuously in a place not meant for human habitation or in an emergency shelter. Attach documentation verifying the full year of homelessness.

Date	to	Date	Location
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

➤ _____
(Print Name of Case Manager)

➤ _____
(Signature of Case Manager)

➤ _____
(Name of Referring Agency)

➤ ____/____/____
(Date)

➤ **ATTACHMENT E. CONSENT FOR DISCLOSURE OF APPLICANT'S PROTECTED HEALTH INFORMATION**

I, (full name): _____,

Social Security Number: _____ - _____ - _____

Date of Birth: _____ / _____ / _____

hereby authorize the MISSOURI **DEPARTMENT OF MENTAL HEALTH (DMH)** and the programs, agencies and persons listed below to communicate and disclose to one another written and verbal information regarding my protected health information:

- DMH rent subsidy processing center
- Homeless management information data system (HMIS)
- U.S. Department of Housing and Urban Development (HUD)
- local housing authority
- rental property owner or manager

The purpose of the disclosure is to obtain information used to secure and/or maintain rental assistance and housing through DMH's rent subsidy programs Shelter Plus Care and/or Rental Assistance Program, or through a local housing authority.

DMH does not have my permission to disclose the following items: _____

I understand that my medical/health information records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and cannot be disclosed without written consent unless otherwise provided for in the regulations. I understand that by signing this authorization, I am allowing the release of my protected health information. The protected health information in my record may include mental/behavioral health information, information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol/drug abuse, and/or a developmental disability.

I understand that I may revoke this consent at any time, except to the extent that disclosures have already been made in reliance on this or any other consent. Revocation may be accomplished by written request and may be for specific items or the entire release. To revoke this consent, mail a signed written request to revoke consent to: Missouri Department of Mental Health, Housing Director, 1706 East Elm Street, Jefferson City, MO, 65101.

I understand that this consent remains effective until I am no longer a participant in the DMH rent subsidy program, unless I specify expiration on the following date, or based on the following event or special condition: _____

I understand that while signing this consent form is not a precondition to being declared eligible for housing assistance, DMH cannot complete the process of delivering such assistance to me unless I sign this consent form. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Would you like a copy of this consent form? Please initial: () **YES** () **NO**

Signature of Consumer: _____ **Date:** _____ / _____ / _____

Signature of Witness: _____ **Date:** _____ / _____ / _____

Signature of Parent/Guardian/Representative: _____ **Date:** _____ / _____ / _____

Guardian/Representative: please include a description of authority to act on Consumer's behalf: _____

HOMELESS MISSOURIANS INFORMATION SYSTEM**Notice of Client Rights**

The information that is collected in the HMIS database is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with applicable federal and state laws. Every person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights terminated and may be subject to further penalties.

FOR DATA BEING ENTERED INTO THE HMIS I UNDERSTAND THAT:

- Staff of other agencies who will see my information have promised to protect it.
- Others using HMIS will protect my information.
- Information I give about physical or mental health problems will not be shared with others.
- Partner Agencies may share information that does not identify me to others.
- I have the right to request who has looked at my file.
- I understand I have the right to ask, "Can I refuse to answer that question," and how my refusal might affect my receipt of services.
- I have the right to view confidentiality policies used by HMIS.
- If I decide at a later date that I no longer want my information in HMIS, I can request that it be removed.

 Client Name (*please print*)

 Client Signature

 Date

 Agency Personnel Name (*please print*)

 Agency Personnel Signature

 Date