No Limits Incorporated
PROSPERITY HOUSE APPLICATION

Permanent Supportive Housing Application

Please complete the entire application as fully as possible. The application will not be considered complete unless all of the questions that have an asterisk * are completed.

Date of Application: ______________________________________

APPLICANT (Head of Household) Information ***Please Print Clearly***

____

First Name ***MI*** ****Last***

____

**Street (address at which you receive your mail)*

____

**City* **State* *Zip Code*

It is important that we can get in touch with you. Please provide as many phone numbers as possible.

*Primary: (_____)________–_ *Secondary: (______)________–_

Email: ________________________________ Additional: (______)________–_

_ – –_ ______/______/_______ ________________________

**Social Security Number* ** Birth Date* *Medicaid Number*

DEMOGRAPHIC INFORMATION

1. **Are you homeless**? ☐Yes ☐No

2. **Are you chronically homeless**? ☐Yes ☐No

3. What is your housing situation? (Housing Status): ☐ Literally Homeless ☐ imminently losing their housing ☐ Unstably Housed and at risk of losing their housing ☐ stably house ☐ Don't know ☐ Refused

4. If Homeless, have you been continuously homeless for a year or more?
☐ Yes ☐ No ☐ Don’t Know ☐ Refused

5. Number of Times Homeless within the Past Three Years (*INCLUDING THIS TIME -* *choose one):*
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 to 7 ☐ 8 to 10 ☐ 11 or More ☐ Don’t Know ☐ Refused

6. **Race** *(**Voluntary** – Please select one or more):*
☐White ☐Black or African American
☐American Indian/Alaskan Native ☐Asian
☐Native Hawaiian/Other Pacific Islander ☐American Indian/Alaskan Native and White
☐Asian and White ☐Black/African American and White
☐American Indian/Alaskan Native and Black ☐Other

7. Ethnicity *(**Voluntary –** Please select “yes” or “no” for Hispanic Origin.)*
Hispanic: ☐Yes ☐No

8. Citizenship *(please check)* Are you a citizen of the United States? ☐Yes ☐No
(Some noncitizens are eligible for this program)

9. Gender *(please check)* ☐Male ☐ Female

10. Veteran *(please check)* ☐Yes ☐No

11. Near Elderly - *Defined as a head of household 55 to 61 years of age*
(please check) ☐Yes ☐No

12. Elderly -*Defined as a head of household over 62 years of age*
(please check) ☐Yes ☐No

13. Aging Out Youth: You are aging out of the state Foster Care system
(please check) ☐Yes ☐No

14. Accessibility: Does a member of your household require any of the following? *(If so please check yes and below which accommodation(s) you need)* ☐Yes ☐No

☐Wheelchair ☐Handicapped Accessible Parking ☐Grab bars and Handrails ☐No Steps
☐Few Steps ☐Hearing Disability ☐Modification for vision or hearing impairment
☐Roll in shower

Please explain

___

___

___

Household Information

List **all** other persons who will be living in the unit and their relationship to the Head of Household. Complete the information in the chart for all members of the household. (This can include unrelated people.) When unrelated persons with disabilities are living together sharing supports, one person should be designated as applicant and head of household. Other persons should be listed in the chart, with relationship as "roommate."

First Name	Last Name	Relation to Head	Birth Date	Age	Sex	Social Security #
		Head				

Do you require 24-hour care by a caretaker or live-in aide? ☐Yes ☐No

Disability

In order to help you access any needed supports it is helpful for us to know what type of disability you have. Please check all that apply.

☐ Developmental Disability - defined as a disability that occurred before the age of 22.

a. Acquired age birth – 3 yrs
b. Acquired age 3 – 21 yrs

☐ Serious Mental Illness;

c. Mental Illness
d. Mental Illness with Substance Abuse

☐ Disability Acquired after the age of 22 (e.g., physical disability, sensory disability, disability caused by chronic illness, disability caused by HIV/AIDS); or
☐ Age-related disability (i.e., “frail elderly”).
☐ Other

INCOME ELIGIBILITY

Do you have Very Low income? (Defined as 50% of Area Median Income) Please refer to chart below

☐ Yes ☐ No

FY 2016 Income Limits Summary

FY 2016 Income Limit Area	Median Income Explanation	FY 2016 Income Limit Category	Persons in Family							
			1	2	3	4	5	6	7	8
Fairbanks North Star Borough	$93,800	Very Low (50%) Income Limits ($) Explanation	30,050	34,350	38,650	**42,900**	46,350	49,800	53,200	56,650
		Extremely Low Income Limits ($)* Explanation	18,050	20,600	25,200	**30,380**	35,560	40,740	45,920	51,120
		Low (80%) Income Limits ($) Explanation	46,000	52,600	59,150	**65,700**	71,000	76,250	81,500	86,750

Source of Income: ____

Employer if applicable: ____

Provide proof of income by way of Paystubs or SSI/ATAP benefits printout.

AUTHORIZATION FOR RELEASE OF INFORMATION

No Limits Incorporated
253 Romans Way, Fairbanks, AK 99701
907-310-1377

Name: ______________________________ **Date of Birth:** ____________________

Social Security #: ____________________ **P.O. Name (if applicable):** ____________________

☐ **OCS Involvement (if applicable):** ____________________

PURPOSE: The information released will be used to evaluate my situation and to plan for and coordinate services for me, or for other purposes as specified.

I authorize:

(Name & Address)	
Phone:	Fax:

and (Name & Address)	
Phone:	Fax:

To provide information to the following individuals/agencies:

Initial	Release To:		Purpose:
	(Name & Address)		
	Phone:	Fax:	
	(Name & Address)		
	Phone:	Fax:	

Check the box and initial after each type of record for which you are authorizing release:

		Initial			Initial
☐	Family History Record	________	☐	Educational	________
☐	Employment/Work Records	________	☐	Alcohol/Drug	________
☐	Treatment/Medical Records	________	☐	Mental Health	________

☐ Services* Information/records as specified: ______________________________

Educational reports include both behavioral and progress reports. Alcohol/drug Treatment, Mental Health Services and medical/psychiatric records include all aspects of diagnosis, treatment and prognosis.

This permission is good for **six (6) months** from the date of your signature.

I can cancel this at any time. I understand the cancellation will not affect any information that was released before the cancellation. I approve the release of this information. I understand that information about my case is confidential and protected by state and federal law. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

______________________________ ____________________

Signature Date

______________________________ ____________________

Witness Signature Date

To those receiving information under this authorization: **The information disclosed to you is protected by State and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.**

PERMANENT SUPPORTIVE HOUSING ELIGIBILITY

This portion of the form (pages 7 & 8) needs to be completed by you and a service professional, that can attest to your need for supportive services. Examples of a professional can include a social worker, a support coordinator, a nurse, or a doctor.

Printed Name of Professional completing ____
Contact Information (email/ phone) ________________________________
Agency Address ____

Need for Housing supports
Housing History:

Has the Applicant:

1. Lived for a period of more than 90 days in an institution (public or private Intermediate Care Facility/Developmental Disability, nursing home, psychiatric hospital, other facility)?
   Yes ☐ No ☐ Approximate term of institutionalization: _________________________

2. Lived at some point independently in his/her own apartment or home? ☐ Yes ☐ No

3. Ever been evicted? ☐ Yes ☐ No
   Reason(s) for eviction (*number of evictions and reason*):
   ____
   ____

Housing needs:

Rate the following support areas per the needs of the Applicant

☐ Never ☐ Sometimes ☐ Often 1. Needs support to identify preferences related to housing (location, accommodations needed, feasibility of accessing other needed supports or activities)

☐ Never ☐ Sometimes ☐ Often 2. Needs support to maintain housing, including assistance to access appropriate housing options, obtaining necessary documents and records to complete housing application or lease, obtain/access sources of income necessary to pay rent, home management, establish credit, and understand and meet obligations of tenancy as defined in lease terms

☐ Never ☐ Sometimes ☐ Often 3. Needs assistance to communicate with the landlord or property manager regarding the Applicant's disability , accommodations needed (wheelchair ramp, bath grab bars, etc.), needed repairs, or other unit concerns

☐ Never ☐ Sometimes ☐ Often 4. Needs assistance to communicate with neighbors (For example, resolving disputes in a calm manner)

☐ Never ☐ Sometimes ☐ Often 5. Needs assistance with household budgeting to ensure payment of rent and avoid utility disconnection

☐ Never ☐ Sometimes ☐ Often 6. Needs assistance keeping appointments and providing paperwork necessary to maintain access to income/benefits.

Does the applicant or member of the household have a substantial, long-term disability including but not limited to serious mental illness, Co-occurring disorder (mental illness and substance use disorder), developmental disability, physical or sensory disability, disability due to aging (i.e. "frail elder") or disability due to HIV/AIDS?

Yes ☐ No ☐

Does the applicant or member of the household need the Supportive Services provided by the PSH program to allow you to live in the community and not become evicted or homeless?

Yes ☐ No ☐

Attestation:

I attest that I have assessed this individual and/or their household member and I believe the person and/or household meets the criteria of being in need of permanent supportive housing services.

____________________________________ ____________________________________

Signature of Professional Completing **Date**