Rapid Re-Housing (RRH) Program Application

Dear Applicant:

The Health Council of South Florida Rapid Rehousing Program provides housing placement assistance (application fees, rent deposits, utility fees) and rental assistance based on need to persons who can verify that they are (a) HIV+; (b) homeless; and (c) low income.

Applicants may receive up to 12 months of rental assistance. The Applicant's need for rental assistance will be assessed every three months. Applicants must work towards meeting their housing obligations without financial assistance. A good faith effort to do so will be part of the 3-month assessment for continued assistance. Program participants will receive assistance with locating a rental unit and ongoing support of a housing specialist to assist them in accomplishing their housing self-sufficiency goals.

Staff will perform a preliminary determination of your eligibility based on the information you provide in the RRH Program Application, including all required documentation. Documents will be required for every household member. You will be contacted by a Housing Specialist within 48 hours of submission to go over your application and for a final determination of eligibility. There are limited RRH funds available, therefore, assistance will be provided to eligible persons on first-come, first-serve basis until funds are exhausted.

In order to qualify for assistance, applicants must meet the following criteria:

1. Applicant must be HIV+.
2. Currently homeless.
3. Total household income cannot exceed 80% of Area Medium Income.

Family Size	1	2	3	4	5	6
80% of AMI	$50,650	$57,850	$65,100	$72,300	$78,100	$83,900

5. Miami-Dade County resident.
6. There is a reasonable expectation that the Applicant will be able to assume responsibility for their housing obligations after assistance ends based on the Applicant's preliminary housing self-sufficiency goals shared with the HCSF Housing Specialist during an eligibility determination meeting conducted by phone.
7. Applicant is not receiving housing assistance from another program.
8. Not otherwise excluded from participation under HUD or Florida Department of Health rules.

The applicant must submit a fully completed RRH Program Application with all required documentation, preferably online at bit.ly/healthcouncilrrh

If unable to apply online, applicants can request a paper copy, which may be scanned and emailed to: housing@healthcouncil.org or hand-delivered to: Health Council of South Florida, Inc. Attn: Francia Alcala, 7875 NW 12th Street, Suite 118, Miami, Florida 33126.

Rapid Re-Housing (RRH) Program Application

Applicant must attach the following documents to their RRH Application:

- Notice of Eligibility for Ryan White Program given to you by your Ryan White Provider
  - ➢ If you are not receiving Ryan White Services at this time, you must provide documentation of HIV status (one of the following documents):
    - Medical Certification of HIV/AIDS Status Form signed by the applicant's physician, certified healthcare worker such as a physician's assistant, or advanced nurse practitioner, or HIV testing site representative.
    - A laboratory report indicating a positive serologic test (Western Blot confirmed).
    - Social Security Administration records indicating the nature of a disability determination.
    - A hospital discharge summary that documents the HIV positive status.
- Verification of Homelessness
  (HCSF Housing Specialist can assist you with documentation needed based on your individual circumstances).

  - Miami-Dade County Homeless Verification Form or certification from another provider serving the applicant;
  - Documentation that the applicant is losing their primary nighttime residence within 14 days because of:
    a. Final court order of eviction
    b. Residing in a motel or hotel or in a doubled up situation where they have been asked to leave immediately and lack resources or support networks to remain where they are housing (applicant will be required to sign a self-certification and the Program will seek independent verification).

- Applicant Certification of No Other Housing or Utility Assistance Form (*this form is in the application below to complete and sign*)
- Participant Rights and Responsibilities Form (*this form is in the application below to complete and sign*)
- Consent Form. If referred to this housing program by another agency, please add the agency's name to the form. (*this form is in the application below to complete and sign*).
- Identification
  - Picture ID for all adults in the household
  - Social Security Cards for EVERYONE in the household
    - If applicant is a minor and head of household is legal guardian of minor: if parent, attach birth certificate or school records or if legal guardian, attach court order.
- Income Documentation
  - Bank Statements for all household members (all pages including child accounts)
  - Recent check stubs for all employed household members
  - Proof of SSI/SSDI benefits or other disability benefits for all recipients in household (if applicable)
  - Proof of veterans benefits for all recipients in household (if applicable)
  - Proof of other household income and assets (i.e. child support, alimony, other benefits, real estate, stock)
  - If applicable, Certification of No Income Form (*this form is in the application below to complete and sign if applicable to you*).

If you have any questions or require assistance with this application, please contact:
Francia Alcala, Housing Coordinator
HCSF Housing Assistance Program
(786) 535-4372
falcala@healthcouncil.org

Rapid Re-Housing (RRH) Program Application

Applicant

Name: _____ **Social Security #.:**_____

Address: _____ **Phone:** _____

City: _____ **State:**_____ **Zip:**_____ **Email:** _____

HIV Status	**Are you HIV+?** Yes ☐ No ☐ ***If no***, please stop completing the application. Assistance is limited to persons who are HIV+.

Demographics for Applicant and Household Members: (*HUD-Required**)

Use one of the following race, gender, ethnicity codes and family member relation to fill in chart below:

***Gender:** **M** – Male **F** – Female **TM** – Transmasculine/Transgender Man/FTM **TF** – Transfeminine/Transgender Woman/MTF
N – Non-binary **T**-Two-Spirit **GN** –– **A** - Agender
PS - Prefer to Self-Describe (please describe in gender column) **P** – Prefer Not To Say

*** Sexual Orientation:** **H** - Heterosexual/straight **G** –Gay **L**- Lesbian **B/P** - Bisexual or Pansexual **Q** - Queer
A – Asexual **NQ** - Not sure/Questioning **PS** - Prefer to Self-Describe (please describe in sexual orientation column) **P** - Prefer Not To Say

***Race:** **A** – Asian
AI/AN – American Indian/Alaskan Native
AI/AN/B/AA - American Indian/Alaska Native/Black/African American
AI/AN/W - American Indian/Alaska Native/White
A/W – Asian White

B/AA – Black/African American
B/AA/W - Black/African American/White
MENA – Middle Eastern/North African
NH/PI - Native Hawaiian/Pacific Islander
O/MR - Other/Multi-racial
W – White

***Ethnicity:** **H** - Hispanic **NH** - Non-Hispanic

***Relationship:** Husband, Wife, Domestic Partner, Mother, Father, Sibling, Daughter, Son, Grandparent, Grandchild, Aunt, Uncle, Cousin, Roommate, Other

Name	HIV+ Yes / No	Gender	Age	Sexual Orientation	Race	Ethnicity	Relationship	$ Income
							SELF (Applicant)	

HCSF
Health Council of South Florida, Inc.

Rapid Re-Housing (RRH) Program Application

Current Housing

1. Are you currently homeless living on the street or other place not meant for habitation? Yes ☐ No ☐
2. Are you currently living in an emergency shelter? Yes ☐ No ☐
3. If yes, please which emergency shelter? _____
   Please provide the name and contact information for your case manager:
   Name_____ Phone Number_____ Email_____
4. How long have you been homeless or living at the shelter? _____
5. When you last rented or owned a home, how long did you live at that address? _____

Back Rent or Utilities and Eviction History

1. Do you owe back rent? Yes ☐ No ☐ How much: _____
2. Do you owe utility in arrears? Yes ☐ No ☐ How much:_____
3. Have you ever been evicted? Yes ☐ No ☐ Year of last eviction: _____

Housing Plan

1. Have you identified steps you can take to manage your housing expenses after assistance? Yes ☐ No ☐
2. Have you developed a Housing or Case Management Plan with your current case manager? Yes ☐ No ☐
3. Are you receiving, or requested, credit counseling? Yes ☐ No ☐
4. Have you had contact with a benefit counselor/case manager within the last 3 months? Yes ☐ No ☐
   If yes, name of the agency and contact information for the benefits counselor/case manager:
   Agency Name_____
   Benefits Counselor/Case Manager: _____

Employment

1. Are you now employed? Yes ☐ No ☐ Self-Employed Yes ☐ No ☐
2. Your Title/Type of work you do:_____

If unemployed:

3. Date of last employment: _____
4. Reason for unemployment:_____
5. Your last title/type of work you last did:_____
6. Are you now able to work? Yes ☐ No ☐ If no, explain: _____
7. Have you been seeking employment? Yes ☐ No ☐ If yes, for how long?_____
8. Are you receiving unemployment assistance? Yes ☐ No ☐ If yes, how much?_____/month

Social Security

1. Are you now receiving Social Security Income? Yes ☐ No ☐ If yes, amount $_____
2. Have you applied for Social Security? Yes ☐ No ☐
3. When will you receive your first SSI check? Approximate Date:_____
4. Have you been denied Social Security? Yes ☐ No ☐
5. If yes, are you appealing? Yes ☐ No ☐ Date of Last Appeal: _____
6. Do you have an appeal hearing date? Yes ☐ No ☐ Hearing date:_____

Medical Assistance and Insurance

1. Are you receiving Ryan White medical care and/or other services? Yes ☐ No ☐
2. Do you have medical insurance (check all that apply)?
   - ☐ Medicaid
   - ☐ Medicare
   - ☐ Private Insurance
   - ☐ Other:_____
   - ☐ None
3. Do you have a medical case manager? Yes ☐ No ☐
   If yes, name the agency and the contact information for the medical case manager:
   _____

Support Services

1. What supportive services are you receiving at this time?
   _____
2. What supportive services will you need of after moving into permanent housing?
   _____

Is there anything else you would like to share with us regarding your current situation?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Monthly Household Income of All Household Members *(subject to independent verification)*	
Source of Income	**Total Household Income Per Month**
Employment PT/FT	
Unemployment	
SSI/SSDI	
Other Disability	
AFDC (TANF)	
VA Benefits	
Military	
Child Support	
Alimony	
Foster Care	
Pension	
Business Income	
Educational Assistance	
Other: _____	
Other: _____	
Total Monthly Income	
Assets	**Current Amount/Value**
Stocks, Bonds	
Savings Account	
Pension/Retirement Account	
Property	

Emergency Contact

I authorize Health Council of South Florida, Inc. to contact the following individual(s) in case of an emergency or for receiving program notices and communications in the event that they have difficulty locating me.

Name:_____ **Relationship:** _____
Email:_____ **Phone:** _____

Applicant Certification

- I understand that the HCSF RRH Program is need based and may provide rent assistance up to twelve (12) months . My need for rental assistance will be assessed every three months and demonstration of a good faith on my part to assume responsibility for my housing obligations will be part of the assessment.

- I understand that as a condition of RRH assistance I must work with my Housing Specialist to develop and commit to a RRH housing plan as well as household budget to assist me in achieving the ability to pay my own housing costs after assistance ends.

- I certify that the information provided by me to determine my eligibility for RRH assistance is true and correct to the best of my knowledge. I acknowledge that it is my responsibility to report any and all changes in the income of my household within ten days of the change. I, the applicant, further understand that any false information provided in connection with this application may be grounds for termination from the program if deemed eligible. I hereby

  acknowledge that I am applying for assistance under a U.S. HUD-funded program and that Title 18 Section 1001 of the United States Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States. False statements also are criminally punishable under state law.

Applicant Signature: _____ Date: _____
(or Legal Guardian if Applicant is a minor)

Print Name: _____

If applicant was assisted in the completion of this application, please complete:

I, the applicant, certify that I allowed my current Case Manager or HCSF Housing Specialist, _____ (name), to assist me in completing this application form and that I have fully reviewed the information entered in this RRH application and any and all supporting documentation and to the best of my knowledge and belief, the information is true, correct, and completed.

Applicant Signature: _____ Date: _____

Print Name: _____

HCSF Determination

☐ Approved for Assistance ☐ Denied for Assistance

Reason for Denial:
_____
_____
_____

HCSF Housing Coordinator
Signature: _____
Print Name: _____
Date: _____

Health Council of South Florida, Inc.
HOPWA Rapid Rehousing Program

Applicant Certification of No Other Source of Housing or Utility Assistance

I, _____, am submitting an application as an individual or as eligible head of household for assistance under the federally-funded HOPWA Rapid Rehousing Program, which is locally administered by the Health Council of South Florida, Inc. Federal regulations prohibit rent, mortgage and/or utility assistance to persons or households who are receiving such assistance from another federal, state, local or other program.

Place your initials next to the statement(s) that are true:

Rent/Mortgage Assistance

____ At this time, neither I nor a member of my household is receiving rent/mortgage assistance from another program.

Utility Assistance

____ At this time, neither I nor a member of my household is receiving utility assistance from another program.

I hereby acknowledge that this certification is related to administration of a U.S. HUD-funded program and that Title 18 Section 1001 of the United States Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States. Furthermore, I acknowledge that Chapter 837 of the Florida Statutes subjects persons to criminal prosecution for knowingly making false statement(s).

I hereby certify, under penalty of perjury, that all statements contained herein are true.

_____ _____

Applicant Signature Date

_____

Applicant Printed Name

FLORIDA STATE HOPWA PROGRAM
PARTICIPANT RIGHTS AND RESPONSIBILITIES
(Form 4)

I am applying for assistance through the State HOPWA Program. I understand there are multiple components in the application process that I agree to complete to the best of my ability.

I authorize my Housing Specialist to obtain the information needed to determine my meeting program qualifications for HOPWA services and to develop a personalized plan of care.

Persons applying for assistance through the State HOPWA Program have rights and responsibilities.

RIGHTS

- You have the right to choose whether or not to apply for assistance through this program.
- You have the right to receive the HOPWA services you need; these may or may not include all the services you desire.
- You have the right to receive timely, respectful, high quality services from the staff of all providers without regard to age, ethnicity, gender, gender identity, disability, religion, sexual orientation, values and beliefs, and marital status.
- You have the right to request copies of all signed documents and have access to your service record.
- You have the right to develop your own housing plan with the assistance of your Housing Specialist.
- You have the right to receive current information and education about housing services and resources.
- You have the right to file a complaint, grievance, and appeal for decisions with which you do not agree.
- You have the right to request an interpreter to enhance communication.

RESPONSIBILITIES

- You are responsible for working with your Housing Specialist to develop a housing plan, and actively work toward assuming responsibility for your housing obligations.
- You are responsible for keeping scheduled appointments, responding in a timely manner to all appointments, and requests for information. Appointments may be at Program offices, home-based or virtual to ensure your safety during the COVID-19 Pandemic.
- You are responsible for notifying your Housing Specialist if any illness interferes with scheduled appointments.
- You are responsible for providing all documentation needed to acquire or maintain housing services in a timely fashion.
- You are responsible for notifying your Housing Specialist when you have problems in obtaining housing services or when you are dissatisfied with services you are receiving.
- You are responsible for maintaining your HIV/AIDS care and treatment through your health provider.
- You may be responsible for a portion of the costs of your housing services.

FLORIDA STATE HOPWA PROGRAM
PARTICIPANT RIGHTS AND RESPONSIBILITIES
(continued)

- You are responsible for notifying your Housing Specialist of any changes such as income or proposed household composition. You must request approval of a new household member in advance and their income will be counted towards the total household income.
- You are responsible for informing your Housing Specialist if you are having difficulties with your landlord or meeting your lease obligations.
- You are responsible to conduct yourself in a courteous, cooperative, assertive, and respectful manner.

CLIENT COMPLAINT, GRIEVANCE, AND APPEAL PROCEDURES

- You have the right to file a complaint, grievance, and/or an appeal with the HOPWA Housing Coordinator. If dissatisfied with the outcome, you may request review of the outcome by the Executive Director of the Health Council of South Florida, Inc.
- You have the responsibility to initiate these actions.

I have had the opportunity to discuss, and I am fully aware of the Participants Rights and Responsibilities outlined above. The Housing Specialist will provide me a signed copy of this document.

I hereby acknowledge that my Certification above is true and is related to administration of a U.S. HUD-funded program and that Title 18 Section 1001 of the United States Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States. Furthermore, I acknowledge that Chapter 837 of the Florida Statutes subjects persons to criminal prosecution for knowingly making false statement(s).

_____ _____
Client Signature Date

_____ _____
Housing Specialist Signature Date

Form 4

HEALTH COUNCIL OF SOUTH FLORIDA, INC. (HCSF)
HOPWA PROGRAM
CLIENT CONSENT TO RELEASE AND EXCHANGE OF INFORMATION

I, _____ (print name), hereby consent to the release and exchange among and between the agencies listed below the following information: my complete name, date of birth, gender, race/ethnicity, my HIV test results and HIV/AIDS status, medical and behavioral health history and records, HOPWA provider site and housing specialist, HOPWA-funded service information and records, case management site and case manager and service delivery history. I understand that this information is necessary to (a) determine my eligibility for, and the provision of, HOPWA funded-assistance; (b) coordinate my HOPWA assistance with the HIV/AIDS-related medical and support services that I may be or may become eligible for and receive and (c) ensure the integrity of, and allow the evaluation, of the

HOPWA Program.
Health Council of South Florida, Inc.
Florida Department of Health
Apple Tree Perspectives, Inc.
Referral Agency/Organization: _____
Ryan White Medical Case Management Provider: _____
Other (Insert Name) _____
Other (Insert Name) _____

This consent may be revoked at any time by signing the revocation line below, or by informing the agency holding this original form in writing. I understand that any entity receiving information as a result of this release is bound by the following statement:

> "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose."

I also understand that the HCSF HOPWA Program is funded with federal Housing Opportunities for Persons with AIDS funds and that my participation in the program is based, in part, on my HIV/AIDS status. I further understand that while all participating agencies will adhere to all legal requirements to protect my confidentiality, my participation in the program may cause my HIV status to be inferred by others who become aware of my participation.

X_____ _____
Client's Signature Date

Revocation of Consent:
I wish to revoke this release of information. I understand that I am entitled to a copy of this canceled release.

X_____ _____
Client's Signature Date

Form 1 (2021)

Health Council of South Florida, Inc.
Housing Assistance Program

CERTIFICATION OF NO INCOME

I, _____, Social Security Number _____, have applied or am seeking additional assistance, as an individual or as a member of a household, for assistance through a federally funded housing assistance program funded by US HUD and locally administered by the Health Council of South Florida, Inc. US HUD requires verification of all household income for the purposes of applying for and/or receiving housing assistance. I have stated during this application/verification process that I have no income. At this time, I do not have any source of income.

□ I do expect to receive income from _____ (source of income) in the amount of $_____ (circle monthly, annually or one-time)) by _____ (date expected).

□ I applied for unemployment on _____ (date).

□ I applied for SSD or SSI on _____ (date).

□ I will apply for unemployment (circle), SSD or SSI (circle) and any other benefits to which I may be entitled within thirty days of the date of this affidavit.

□ I am ineligible for government assistance because _____.

I hereby acknowledge that this certification is related to administration of a U.S. HUD-funded program and that Title 18 Section 1001 of the United States Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department or agency of the United States. Furthermore, I acknowledge that Chapter 837 of the Florida Statutes subjects persons to criminal prosecution for knowingly making false statement(s).

I hereby swear, under penalty of perjury, that all statements contained herein are true.

Signature:_____ Date: _____

Print Name: _____

Form 6