Supportive Living, INC.
BRAIN INJURY PROGRAMS

APPLICATION FOR HOUSING AND SERVICES

at

Warren House	McLaughlin House	Douglas House	Murphy House
Woburn, MA	North Reading, MA	Lexington, MA	Rockport, MA

Introduction

Supportive Living, Inc.'s (SLI) affordable housing properties are designed to meet the needs of people with brain injury who would benefit from the supportive services available.

Warren House is home to 16 individuals and consists of 11 apartments, 5 double occupancy units and 6 single occupancy units. There is a kitchen and living room in each apartment. Each person living at Warren House has their own bedroom and bathroom. Common areas include a large common living room, laundry room, and an outside patio.

McLaughlin House is home to 8 individuals who each have a bedroom and bathroom. There is a large common living room, dining room, kitchen, laundry room and an outside patio.

Douglas House is home to 15 individuals each with their own private bedroom, bathroom, and an option for a mini kitchen. Common areas include a dining room, kitchen, laundry room, TV room, sitting area, and an outside patio and deck. This property has three private pay - market rate units.

Murphy House in Rockport is home to 3 individuals. There are two studio bedroom units on the first floor and a one bedroom apartment on the second floor-stair access only.

SLI has entered into an agreement with Advocates, Inc. of Framingham, MA to provide supportive services. This document contains applications for both housing and services.

Accordingly, each individual who desires to become a resident must complete the following:

1. Application for Housing
2. Application for Services
3. Authorization to release Medical Record information

The instructions, on the next page, are for both applications and authorization forms.

Instructions

Your application is not considered complete without the following documents. Documents will not be returned; please submit copies only. SLI reserves the right to request additional documentation as necessary.

Documentation required for each applicant include:

-Copies of Birth Certificate, social security card, and MassHealth card
-Current Social Security benefits letter
-If applicable, SIX week's worth of most recent pay stubs
-If applicable, documentation of all other sources of income you have declared (such as copies of child support, alimony, social security, or pension payments)
-If applicable, a letter and supporting documentation explaining any unusual employment or household circumstances and any other income received since the beginning of the current year (for example: bonus, inheritance, etc.)
-If applicable, copies of pertinent trust documents
-A no-income-statement, signed and notarized, for any household member over 18 who has no source of income

Please send your completed application and supporting documents to:

Supportive Living, Inc.
Att: Mikayla Jenny
7 Oakland Street
Lexington, MA 02420

Or scan to:
mjenny@supportivelivinginc.org

When your application is added to our wait list, it is your responsibility to contact us regarding any changes in your address, telephone number, income situation, care needs, or any other changes in your housing status that might affect your application. In addition, you must respond to yearly mailings in which you declare your continued interest in housing so that you may keep your spot on our wait list.

After we review your application with our team, we will make a preliminary determination of eligibility. If you appear to be eligible for housing and services, your application will be placed on a Waiting List. Having your name on the Waiting List does not guarantee that you will be offered housing. If later evaluation determines that you are not qualified for housing and/or services, your application will be rejected and you will be notified. We will process your application according to our standard procedures, which are summarized in the Tenant Selection Plan and is available to view upon request.

Please note that many of the forms below are from Barkan Management Company. They provide compliance services for SLI. All forms should still be submitted directly to SLI as mentioned above.

WARNING

Section 1001 of Title 18 of US Code makes it a criminal offense to make willful, false statements or misrepresentations of any material facts involving the use of or obtaining Federal funds.

Rental Application

PROPERTY: Supportive Living

PRELIMINARY RENTAL APPLICATION
Please fill out each item as completely as possible.

No. of Bedrooms Desired: ____
Do you own a car? ___ Yes ___ No

FOR OFFICE USE ONLY
Date Received: _____Time: _____
Interview Date: _____
EVI/L/VL: _____ Imputed Assets: _____
Assets Disposition Date: _____
Special Needs:_____
Refused Unit:_____

1. Your Name: _____ Home Telephone: _____

Present Address: _____

Street & Apt. Number City State Zip

Mailing Address (if different): _____

Email: _____

How did you hear about this complex? _____

2. Please complete the following information about every person to occupy the apartment (including applicant and unborn children):

Name	Sex	Relationship	Date of Birth	Place of Birth	US Citizen?	Eligible Immigrant?	Social Security #

**As of January 31, 2010, all individuals, including those under the age of six, must now disclose a valid SSN. The only exceptions to this requirement are for tenants age 62 or older as of January 31, 2010, whose initial determination of eligibility was begun prior to January 31, 2010, and individuals who have not claimed eligible immigration status.*

3. Are you, your spouse, or any member of your household a full-time student 18 years of age or older?
Yes _____ No _____
If YES, explain _____

4. Is the Head of Household 62 years of age or older? Yes _____ No _____

5. Is the Head of Household between 51 and 61 years of age? Yes _____ No _____

6. Is the Head of Household under 51 years of age and disabled? Yes _____ No _____

7. Please list all landlords for the past five years. If more space is needed, please attach a separate piece of paper.

Name and Address of Current Landlord: _____

Apt. Size: _____ Date From: _____ To: _____

Monthly Rent: _____ Utility Cost/Month: _____ Reason for leaving: _____

Name and Address of Current Landlord: _____

Apt. Size: _____ Date From: _____ To: _____

Monthly Rent: _____ Utility Cost/Month: _____ Reason for leaving: _____

Name and Address of Current Landlord: _____

Apt. Size: _____ Date From: _____ To: _____

Monthly Rent: _____ Utility Cost/Month: _____ Reason for leaving: _____

8. EMPLOYMENT
(Please include employment of all persons to occupy apartment. Attach a separate piece of paper if needed)

Applicant 1

Name of Employer: _____ Tel. No: _____

Business Address: _____

Length of Employment: _____ Annual Gross Wages: _____

Applicant 2

Name of Employer: _____ Tel. No: _____

Business Address: _____

Length of Employment: _____ Annual Gross Wages: _____

9. OTHER SOURCES OF INCOME (please include income of all persons to occupy apartment):

		Applicant 1	Applicant 2	Applicant 3
Social Security:	Gross Monthly Amount: $	_____	_____	_____
SSI:	Gross Monthly Amount: $	_____	_____	_____
Veterans Benefits:	Gross Monthly Amount: $	_____	_____	_____
Pension:	Gross Monthly Amount: $	_____	_____	_____
Alimony:	Monthly Amount: $	_____	_____	_____
Child Support:	Monthly Amount: $	_____	_____	_____

Other – $_____ Please explain_____

10. ASSETS (list all accounts for all family members including: savings, checking, CD's, etc.)

Account Type (checking, savings, CD's, etc) _____Amount: $_____

Bank Name and Address: _____

Account Type (checking, savings, CD's, etc) _____Amount: $_____

Bank Name and Address: _____

Account Type (checking, savings, CD's, etc) _____Amount: $_____

Bank Name and Address: _____

Stocks – Name: _____ Value: $_____

Bonds – Name: _____ Value: $_____

Annuities: _____ Value: $_____

Trusts: _____ Value: $_____

Whole Life Insurance Policy: _____ Cash Value: $_____

Property Owned: _____ Net Sales Value: $_____

Street City State

11. During the past two years have you given away more than $1,000 or disposed of other assets for less than market value? ___ Yes ___ No If yes, please explain: _____

_____

_____

12. CRIMINAL RECORD – Have you or any person who will occupy the unit ever been convicted of a misdemeanor in the last ten years? ___ Yes ___ No

If yes, please explain the circumstances, docket number, charge, date and court: _____

_____

13. Does any person who will occupy the unit currently use a controlled substance illegally? ___ Yes ___ No

If yes, please explain: _____

14. Does any person who will occupy the unit currently abuse alcohol? ___ Yes ___ No

15. Have you or any person who will occupy the unit ever been convicted of a methamphetamine production on federally assisted properties? ___ Yes ___ No

If yes, please explain the circumstances, docket number, charge, date and court: _____

_____

16. Are you or any person who will occupy is subject to a state lifetime sex offender registration in any state? ___ Yes ___ No
If yes, what states are you a registered as a sex offender: _____

17. Has your family's assistance or tenancy in a subsidized housing program ever been terminated for fraud, non-payment of rent, or failure to cooperate with management? ___ Yes ___ No
If yes, please explain: _____

18. Have you or any person who will occupy the unit ever received housing assistance from any housing agency or other landlord, including rental assistance programs? ___ Yes ___ No
If yes, list the Head of household at that time: _____
Name of Housing Agency/Landlord: _____
Date Moved Out: _____ Reason for Moving: _____

19. Have you or any person who will occupy the unit been evicted from housing? ___ Yes ___ No
If yes, please explain: _____

20. Have you or any person who will occupy the unit been evicted from federally or state assisted housing for drug related criminal activity? ___ Yes ___ No
If yes, please explain: _____

21. Have you or any person who will occupy the unit been denied housing in the past 5 years? ___ Yes ___ No
If yes, please explain: _____

22. RACE (Please note that this section is optional. This information will be used only for Fair Housing Programs as required by federal and state laws). **Please complete the attached Race and Ethnic Data Reporting Form.**

23. ELIGIBILITY REQUIREMENT FOR HOUSING FOR PERSONS WITH DISABILITIES - For purposes of determining project eligibility with HUD regulations only. If this applies to any individuals on this application, **please complete the attached Disabilities Form.**

24. SPECIAL HOUSING NEEDS – (This section is optional and is used only to determine any reasonable accommodations for applicants)
Does any applicant family member have any special housing needs? ___ Yes ___ No
Does any applicant family member require a handicap accessible unit? ___ Yes ___ No
If yes, **please complete the attached Reasonable Accommodation Form.**

25. List all of the cities and sates where you have lived in the past. (Add a sheet if necessary).
_____
_____
_____

Instructions for the Race and Ethnic Data Reporting (Form HUD-27061-H)

A. General Instructions:

This form is to be completed by individuals wishing to be served (applicants) and those that are currently served (tenants) in housing assisted by the Department of Housing and Urban Development.

Owner and agents are required to offer the applicant/tenant the option to complete the form. The form is to be completed at initial application or at lease signing. In-place tenants must also be offered the opportunity to complete the form as part of the next interim or annual recertification. Once the form is completed it need not be completed again unless the head of household or household composition changes. There is no penalty for persons who do not complete the form. However, the owner or agent may place a note in the tenant file stating the applicant/tenant refused to complete the form. **Parents or guardians are to complete the form for children under the age of 18.**

The Office of Housing has been given permission to use this form for gathering race and ethnic data in assisted housing programs. Completed documents for the entire household should be stapled together and placed in the household's file.

1. The two ethnic categories you should choose from are defined below. You should check one of the two categories.

1. **Hispanic or Latino.** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic" or "Latino."
2. **Not Hispanic or Latino.** A person not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

2. The five racial categories to choose from are defined below: You should check as many as apply to you.

1. **American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
2. **Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
3. **Black or African American.** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or "African American."
4. **Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
5. **White.** A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

Race and Ethnic Data Reporting Form

U.S. Department of Housing and Urban Development
Office of Housing

OMB Approval No. 2502-0204
(Exp. 06/30/2017)

Name of Property | **Project No.** | **Address of Property**

Name of Owner/Managing Agent | **Type of Assistance or Program Title:**

Name of Head of Household | **Name of Household Member**

Date (mm/dd/yyyy): _____

Ethnic Categories*	Select One
Hispanic or Latino	
Not-Hispanic or Latino	
Racial Categories*	**Select All that Apply**
American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or Other Pacific Islander	
White	
Other	

***Definitions of these categories may be found on the reverse side.**

There is no penalty for persons who do not complete the form.

_____ _____
Signature **Date**

Public reporting burden for this collection is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. This information is required to obtain benefits and voluntary. HUD may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number.
This information is authorized by the U.S. Housing Act of 1937 as amended, the Housing and Urban Rural Recovery Act of 1983 and Housing and Community Development Technical Amendments of 1984. This information is needed to be incompliance with OMB-mandated changes to Ethnicity and Race categories for recording the 50059 Data Requirements to HUD. Owners/agents must offer the opportunity to the head and co-head of each household to "self certify' during the application interview or lease signing. In-place tenants must complete the format as part of their next interim or annual re-certification. This process will allow the owner/agent to collect the needed information on all members of the household. Completed documents should be stapled together for each household and placed in the household's file. Parents or guardians are to complete the self-certification for children under the age of 18. Once system development funds are provide and the appropriate system upgrades have been implemented, owners/agents will be required to report the race and ethnicity data electronically to the TRACS (Tenant Rental Assistance Certification System). This information is considered non-sensitive and does no require any special protection.

SECTION 8 Claim of Disability Form (Optional)

For the purposes of determining project eligibility with U.S. Department of Housing and Urban Development regulations only.

Name of Applicant: _____

Property: _____

If you are applying to Supportive Living, Inc. and claiming a disability, please check the applicable category below. (Definitions from the Code of Federal Regulations.)

Disabled (handicapped) family means:

____ Families of two or more persons the head of which (or his or her spouse) is a person with disabilities (handicapped);

____ The surviving member or members of any family described in paragraph (1) of this definition living in a unit assisted under subpart E of this part (Section 202 loans) with the deceased member of the family at the time of his or her death;

____ A single person with disabilities (handicapped person) over the age of 18; or

____ Two or more persons with disabilities (handicapped persons) living together, or one or more such persons living with another person who is determined by HUD, based upon a licensed physician's certificate provided by the family, to be essential to their care or well-being.

A person with disabilities means:

____ Any adult having a physical, mental, or emotional impairment that is expected to be of long-continued and indefinite duration, substantially impedes his or her ability to live independently, and is of a nature that such ability could be improved by more suitable housing conditions.

____ A person with a developmental disability, as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001(8)), i.e., a person with a severe chronic disability that:

(i) Is attributable to a mental or physical impairment or combination of mental and physical impairments;
(ii) Is manifested before the person attains age 22;
(iii) Is likely to continue indefinitely;
(iv) Results in substantial functional limitation in three or more of the following areas of major life activity:
  (A) Self-care,
  (B) Receptive and expressive language,
  (C) Learning,
  (D) Mobility,
  (E) Self-direction,
  (F) Capacity for independent living, and
  (G) Economic self-sufficiency; and

(v) 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.

____ A person with a chronic mental illness, i.e., a person who has a severe and persistent mental or emotional impairment that seriously limits his or her ability to live independently, and whose impairment could be improved by more suitable housing conditions.

____ Persons infected with the human acquired immunodeficiency virus (HIV) who are disabled as a result of infection with the HIV are eligible for occupancy in the Section 202 projects designed for the physically disabled, developmentally disabled, or chronically mentally ill depending upon the nature of the person's disability. (24 CFR 891.505)

Note: A person whose sole impairment is alcoholism or drug addiction (i.e., who does not have a developmental disability, chronic mental illness, or physical disability that is the disabling condition required for eligibility in a particular project) will not be considered to be disabled for the purposes of the Section 202 program.

____ A person infected with the human acquired immunodeficiency virus (HIV) and a person who suffers with alcoholism or drug addition, provided they meet the definition of "person with disabilities" in Section 811 (42 U.S.C) 8013(k)(2). A person whose sole impairment is a diagnosis of HIV positive or alcoholism or drug addiction (i.e., does not meet the qualifying criteria in Section 811will not be eligible for occupancy in a section 811 project. (24 CFR 891.305)

A nonelderly disabled (handicapped) family means:

____ A disabled family in which the head of the family (and spouse, if any) is less than 62 years of age at the time of the family's initial occupancy of a project.

Signature of Applicant _____ Date _____

PLEASE NOTE:

Barkan Management Co., Inc. does not discriminate against applicants in the provision of services, or in any other manner on the grounds of race, color, creed, religion, sex, handicap, familial status, national origin or receipt of public assistance.

Barkan Management Co., Inc., will make every effort to provide assistance should applicants require an alternative way of presenting this application to meet the needs of persons with disabilities and will provide assistance in filling out this application should such assistance be requested.

Reasonable Accommodation Requests

You Have a Right to Request a Reasonable Accommodation

If you have a disability, and as a result of your disability you need something changed to give you an opportunity to use and enjoy a Barkan Management Property equal to someone without that disability, then you may ask for this kind of change. This is called a Reasonable Accommodation, and could include requests such as:

- a change in the rules or policies or how we do things
- a change or repair in your apartment or a special type of apartment
- a change or repair to some other part of the housing site
- a change in the way we communicate with you or give you information

The Reasonable Accommodation Request Form can be requested in the office. If you need help filling out any forms, or if you want to give us your request in some other way, we will help you. If you're not sure what change would be helpful with your disability, we may be able to provide examples of changes that have worked for other people in a similar situation.

In addition to completing a Reasonable Accommodation request form, the Resident/Applicant may be required to provide verification that he or she has a disability and that the accommodation is necessary to give the Resident equal opportunity to use and enjoy the community. This can be demonstrated by obtaining a signed letter from a qualified professional which identifies:

1. the professional's expertise and experience
2. the factual basis for his or her statements
3. an explanation of how the Resident and/or any member of the Resident household meet the definition of "individual with disability", including how the particular disability limits major life functions
4. a description of the accommodation requested
5. an explanation of the connection between any alleged disability and the accommodation requested
6. an indication if there has been a determination that the items requested are the only methods of achieving for the Resident equal opportunity to use and enjoy the community.

We may ask for an independent expert to confirm your disability and that the requested accommodation will likely provide an opportunity to enjoy the housing that is equal to someone without that disability.

We will give you an answer on your request within 30 days unless there is a problem getting the information we need or unless you agree to a longer time. We will let you know if we need more information from you, or if we would like to talk to you about other ways to meet your needs. Requests may be denied if they impose an undue financial and administrative burden on the housing provider or fundamentally alter the nature of the provider's operations.

7 Wells Avenue Newton, MA 02459 617.482.5500 barkanco.com

If your disability is verified and your request meets the criteria as reasonable, we will try to make the changes you request in a reasonable timeframe. If we turn down your request, we will explain the reasons and you can give us more information if you think that will help.

NOTE: All information you provide will be kept confidential among the people necessary to evaluate and complete your request. It will be used only to help you have an equal opportunity to enjoy your housing and the common areas. If you need help completing a form or if you want to give us your request in some other way, we will help you.

Please print clearly

Name of Applicant/Resident: _____

Please provide me with the following Reasonable Accommodation:

_____

_____

_____

_____

I need this accommodation because:

_____

_____

_____

_____

Signature_____ Date_____

Return to:
Barkan Management Company, Inc.
Attn: Reasonable Accommodation Coordinator
7 Wells Avenue, Newton, MA 02549
Telephone: 617-482-5500 Fax: 617-482-5500

Barkan Management Company Inc. does not discriminate on the basis of disability status in the admission or access to, or treatment or employment in, its federally assisted programs and activities. The person named below has been designated to coordinate compliance with the nondiscrimination requirements contained in the Department of Housing and Urban Development's regulations implementing Section 504 (24 CFR, part 8 dated June 2, 1988):

I, the undersigned, understand that this is a preliminary rental application and in no way ensures my occupancy. Additional information may be required at a later date to complete processing of this application.

My signature below certifies that the information contained in this application is true and authorizes the management to verify that information. I understand that any false statements will result in the cancellation of this application.

Signature of Applicant _____ Date _____

Signature of Co-Applicant _____ Date _____

Supportive Living, Inc.

CORI REQUEST FORM

Supportive Living Inc. (SLI) has been certified by the Criminal History Systems Board for access to Criminal Offender Record Information (CORI) pursuant to M.G.L c. 6, Paragraph 172(b) and/or 172(c). SLI has been granted access for the purpose of tenant selection only, and shall not be otherwise used or disseminated. **By signing below, I provide my consent to a CORI check and acknowledge that the information provided is true an accurate.**

Applicant/Employee Signature: _____ Date: _____

APPLICANT/EMPLOYEE SIGNATURE INFORMATION (PLEASE PRINT)

_____ _____ _____
Last Name First Name Middle Name

_____ _____
Maiden Name or Alias (if applicable) Place of Birth

_____ _____-_____
Date of Birth Last six digits of social security number

ID THEFT INDEX PIN (if applicable): _____

_____ _____
Mother's Full Maiden Name Father's Full Name

Current and Former Addresses:

_____

_____

_____

_____

Sex: _____ Height: ____ ft. ____in. Eye Color: _____ Race: _____

Driver's License Number or ID Number: _____ State of Issue: _____

*** THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM(S) OF GOVERNMENT ISSUED IDENTIFICATION:

_____
_____
_____

VERIFIED BY: _____
SIGNATURE OF CORI AUTHORIZED EMPLOYEE

* The CHSB Identify Theft Index Pin Number is to be completed by those applicants that have been issued an Identify Theft Index Pin Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process.

STUDENT CERTIFICATION

Applicant: _____ Unit:_____

To be completed by each adult Applicant/Resident

Are you a student at an institution of higher education? _____Yes _____No

**Institutes of higher education include post-secondary vocational institutions; "proprietary institutions of higher education" which prepare students for "gainful employment in a recognized occupation," and accredited post-secondary colleges and universities. If you are not sure, please mark "yes" and we will verify it.*

If you have answered "no", please skip the following questions and sign below.

If you answered "yes", please complete the following questions:	**Yes**	**No**
1. Are you a full-time student?	_____	_____
2. Are you a graduate or professional student?	_____	_____
3. Are you at least 24 years of age?	_____	_____
4. Are you a veteran of the United States military?	_____	_____
5. Are you married?	_____	_____
6. Do you have a dependent child?	_____	_____
7. Do you have dependents other than a child or spouse?	_____	_____
8. Were you an orphan or a ward of the court through the age of 18?	_____	_____
9. Do you live with your parents?	_____	_____
If no:		
a. Are your parents receiving or eligible to receive Section 8 assistance?	_____	_____
b. Are you claimed as a dependent on your parent's tax return?	_____	_____
10. Are you receiving any financial assistance to pay for your education?	_____	_____

If you or another member of your household is determined to be an ineligible student now or in the future, you may not be eligible for assistance. If we determine at any time after move-in that you are ineligible for assistance, we will notify you by providing a 30-day notice that your assistance will be terminated. Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned understand(s) that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of a lease agreement.

_____ _____ _____

Signature of Applicant/Resident Printed Name of Applicant/Resident Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Re: Applicant/Tenant_____

Property Name: _____

Address: _____

I/We, the undersigned below hereby authorize all persons or companies in the categories listed below to release information regarding employment, income and/or assets for purposes of verifying information on my/our apartment rental application. I/We authorize release of information without liability to the owner/manager of the apartment community listed on the attached verification form and/or the State and Local Agencies/Department's service provider.

INFORMATION COVERED

I/We understand that previous or current information regarding me/us may be needed. Verifications and inquires that may be requested include, but are not limited to: personal identity, student status, employment, income assets, medical or child care allowances. I/We understand that this authorization cannot be used to obtain information about me/us that is not pertinent to my eligibility for and continued participation as a Qualified Tenant.

GROUPS OR INDIVIDUALS THAT MAY BE ASKED

The groups or individuals that may be asked to release the above information include, but are not limited to:

Past and Present Employers
Support and Alimony Providers
State Unemployment Agencies
Banks and other Financial Institutions
Welfare Agencies
Educational Institutions
Social Security Administration
Previous Landlords (including Public Housing Agencies)
Veterans Administrations
Retirement Systems
Medical and Child Care Providers

CONDITIONS

I/We agree that a photocopy of this authorization may be used for the purposes stated above. The original of this authorization is on file and **will be valid for 15 months from my signature date**. **Everyone 18 years or age and older must sign this form.**

SIGNATURES

_____	_____	_____
Signature of Applicant/Resident	Printed Applicant/Resident Name	Date
_____	_____	_____
Signature of CO/Applicant Resident	Printed Co/Applicant/Resident Name	Date
_____	_____	_____
Signature of Adult Member	Printed Adult Member Name	Date
_____	_____	_____
Signature of Adult Member	Printed Adult Member Name	Date

NOTE: THIS GENERAL CONSENT MAY NOT BE USED TO REQUEST A COPY OF A TAX RETURN. IF A COPY OF A TAX RETURN IS NEEDED, IRS FORM 4506, "REQUEST FOR COPY OF A TAX FORM" MUST BE PREPARED AND SIGNED SEPARATELY

PLEASE NOTE:

Barkan Management Co., Inc. does not discriminate against applicants in the provision of services, or in any other manner on the grounds of race, color, creed, religion, national or ethnic origin, citizenship, ancestry, class, sex, familial status, disability, military/veteran status, source of income, age, actual or perceived sexual orientation, gender identity, or marital status, or other basis prohibited by local, state or federal law.

Barkan Management Company does not discriminate on the basis of disability status in the admission or access to or treatment or employment in its federally assisted programs and activities. You have the right to request a reasonable accommodation which is a change in rules, policies, practices, or services so that a person with a disability will have an equal opportunity to use and enjoy a dwelling unit or common space.

Barkan Management Co., Inc., will make every effort to provide support should applicants require an alternative way of presenting this application to meet the needs of persons with disabilities or with Limited English Proficiency, and will provide assistance in filling out this application should such assistance be requested.

Also be advised that Barkan Management Co., Inc. conducts applicant screening to determine eligibility and suitability of applicants based on ability and willingness to pay the rent, abide by the lease, care for the unit, and cooperate with management.
ability and willingness to pay the rent, abide by the lease, care for the unit, and cooperate with management.

Privacy Act Notice

The Department of Housing and Urban Development (HUD) is authorized to collect this information by the U.S. Housing Act of 1937 (42 U.S.C. 1437 et. seq.), by Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d), and by the Fair Housing Act (42 U.S.C. 3601-19). The Housing and Community Development Act of 1987 (42 U.S.C. 3543) requires applicants and participants to submit the social security number of each household member who is 6 years old or older.

Purpose: Your income and other information are being collected by HUD to determine your eligibility, the appropriate bedroom size, and the amount your family will pay toward rent and utilities.

Other Uses: HUD uses your family income and other information to assist in managing and monitoring HUD-assisted housing programs, to protect the Government's financial interest, and to verify the accuracy of the information you provide. This information may be released to appropriate federal, state, and local agencies, when relevant, and to civil, criminal, or regulatory investigators and prosecutors. However, the information will not be otherwise disclosed or released outside of HUD, except as permitted or required by law.

Penalty: You must provide all of the information requested by the owner, including all social security numbers you, and all other household members age 6 years and older, have and use. Giving the social security numbers of all household members 6 years of age and older is mandatory, and not providing the social security numbers will affect your eligibility. Failure to provide any of the requested information may result in a delay or rejection of your eligibility approval.

WARREN HOUSE	MCLAUGHLIN HOUSE	DOUGLAS HOUSE	OLD FARM ROCKPORT
17 Warren Avenue	333 Park Street	7 Oakland Street	291 Granite Street
Woburn, MA	North Reading, MA	Lexington, MA	Rockport, MA

Advocates, Inc. Application for Services

1. IDENTIFYING INFORMATION

Participant Name: _____ Tel #: ( )_____

Present
Address _____ City: _____ State: ____ Zip: _____

Diagnosis: _____

Functional Limitations:_____

_____

_____

_____

_____

_____

_____

Current Living Arrangements: Alone ( ) With Others ( ) Other:_____

_____

_____

_____

If living with others, please describe living situation and care needed: _____

_____

_____

Marital Status: (Circle one) S M W D Sep. Sex: M F Birthdate:_____/_____/_____

Total Monthly Income: _____ Medicaid Card #:_____

Social Security #: _____ Medicare #: _____

Other Insurance Specify with policy #'s: _____

Subscriber:_____

_____

2. CONTACT INFORMATION

A. Emergency Contact: _____ Tel #: (____) _____

Address: _____ Relationship: _____

B. Emergency Contact: _____ Tel #: (____) _____

Address: _____ Relationship: _____

C. Case Manager: _____ Agency: _____

Address: _____ Tel #: (____) _____

D. Guardian: _____ Tel #: (____) _____

Address: _____

Referred by: _____ Title: _____ Tel #: (____) _____

Address: _____

E. Mass Rehabilitation Counselor: _____ Tel #: (____) _____

Address: _____

Comments: _____

3. MEDICAL INFORMATION

Primary Care Physician: _____ Tel #: (____) _____

Address: _____

Date of Last Physical: _____

Present Hospital Affiliation: _____

INPATIENT HOSPITALIZATION HISTORY (USE ADDITONAL PAPER IF NECESSARY)

Facility	Reason for Admission	Admission Date	Discharge Date

OUTPATIENT SERVICES HISTORY (USE ADDITIONAL PAPER IF NECESSARY)

Facility	Reason for Admission	Therapies Used: Physical, Occupational, Speech, Neuropsychological, Psychological, Other… (pleas specify)	Discharge Date

NURSING HOME, LONG TERM CARE, MENTAL HEALTH FACILITY HISTORY

Admission Date	Facility	Reason for Admission	Discharge Date

MEDICATION SCHEDULE

Medication	Dosage	Purpose	Prescribing Physician	Date Started

Names of other physicians involved with their telephone number:

Neurologist:_____Tel #:_( )_____

Neurosurgeon:_____Tel #: ( )_____

Psychiatrist:_____Tel #:_( )_____

Other physicians involved in your care: _____

_____

_____

_____

_____

Allergies: _____

_____

Any other significant illness or injuries: _____

_____

4. ASSISTANCE IN HOME

Certified Home Health Agency currently using: _____

Address: _____ Tel #: ( )_____

Nurse ( ) Frequency: _____

Home Health Aid ( ) Frequency: _____

Homemaker ( ) Frequency: _____

Personal Care Assistant ( ): _____

Other services needed: _____

Special Equipment being used: _____

Other (describe): _____

_____

Signature of person filling out this application: _____

Printed name of person filling out this application: _____

Signature of applicant: _____

Printed name of applicant: _____

Date: _____

Advocates, Inc.

1 Clarks Hill, Suite 305
Framingham, MA 01702

WARREN HOUSE	MCLAUGHLIN HOUSE	DOUGLAS HOUSE	OLD FARM ROCKPORT
17 Warren Avenue	333 Park Street	7 Oakland Street	291 Granite Street
Woburn, MA	North Reading, MA	Lexington, MA	Rockport, MA

AUTHORIZATION FORM
FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Client Name:_____ **DOB**:_____

By signing this Authorization, I authorize the use or disclosure of my Protected Health Information designated below between:

Staff at Warren House, McLaughlin House, Douglas House or Old Farm Rockport Clinician/Staff or Advocates staff at Advocates, Inc. 1 Clarks Hill, Suite 305, Framingham, MA 01702

And the following person / Organization:

Supportive Living, Inc. (SLI)
Print Name

400 West Cummings Park, Suite 6100, Woburn, MA 01801
Print Address

Health information includes information collected from me or created by the above Providers, or information received by the above Providers from another health care provider, a health plan, my employer or a health care clearinghouse. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

I further understand that Advocates and its employees are prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part2).

I further understand that under state law Advocates and its employees are prohibited from disclosing information about my HIV status without my specific written authorization. Advocates and its employees are also prohibited under state law from disclosing the results of a genetic test (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed consent," except when the test results disclosed will be used only as confidential research information for use in epidemiological or clinical research conducted for the purpose of generating scientific knowledge about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatments of disease.

Check appropriate boxes:

Health Information that may be used or disclosed through this Authorization is as follows:

_X_ All health information about me, including my clinical records, created or received by Advocates or any of its employees and the above listed Provider/Organization. This information may include, if applicable:

____ Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse; Specifically for the following purpose(s)_____

____ Information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (i) this test is ordered, performed, or reported and (ii) the test results are positive or negative.
Specifically for the following purpose(s)_____

____ Information regarding the results of a genetic test.

- Specific information including only: _____
_____
_____
_____

This Authorization expires: upon discharge from the program
(Insert applicable event or date – mm/dd/yy)

(Note: If an expiration event is used, the event must relate to the Client or the purpose of the use or disclosure).

1. I understand that Advocates and its employees cannot guarantee that PHI disclosed to the above indicated Person/Organization will not be re-disclosed to a third party. The Person/Organization may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in an alcohol or drug abuse program, the Person/Organization is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the Client or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from Advocates, Inc, except when (i) my refusal may limit Advocates ability to provide safe and effective care (ii) I am receiving research-related treatment or (iii) receiving health care solely for the purpose of creating information for disclosure to a third party. If any of these exceptions apply, my refusal to sign an authorization may result in my not obtaining treatment (or payment, if applicable) from the Provider.

3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by Advocates or its employees in reliance on this Authorization before written notice of revocation is received by Advocates or its employees. I further understand that that I must provide any notice of revocation in writing to the Privacy Office at Advocates, Inc. 27 Hollis St., Framingham, MA 01702

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's signature:_____ Date of signature:_____

Print Client's full name:_____

Client's Home Address:_____

Client's Home Telephone:_____ Date of Birth:_____

When client is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

Signature of legal representative:_____ Date of signature:_____

Print name:_____

Relationship of representative to client:_____

AGENCY CODE: XSLIVI
FEE EXEMPTION CODE: FE411