**APPLICATION FOR HOUSING AND SERVICES
at**

**Warren House Mclaughlin House Douglas House Old Farm Rockport**

**Woburn, MA North Reading, MA Lexington, MA Rockport, MA**

 **Introduction**

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

Warren House is equipped to house 16 individuals and consists of 11 apartments, 5 with 2 bedrooms and 6 1-bedroom units. There is a kitchen and living room in each apartment. Each person living at Warren House has his/her 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, parlor, dining room, kitchen, laundry room and an outside patio.

Douglas House will accommodate 15 individuals each with their own private bedroom, bathroom, and an option for a mini kitchen. Common areas include a parlor, dining room, kitchen, laundry room, TV room, sitting area, and an outside patio and deck.

Old Farm Rockport consists of two buildings and can accommodate 6 individuals. The main building, Norwood House, has four 1st floor bedrooms. The second building, Murphy House, has two studio style bedroom units on the 1st floor.

Supportive Living, Inc., has entered into an agreement with Advocates, Inc. of Framingham, MA to provide supportive services.

Accordingly, each individual with a disability who desires to become a resident must complete two application forms and one authorization forms to release medical record information, as follows:

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**

1. Please type or print all sections in black ink. Do not leave any sections blank, even those which do not apply to you. For instance, if a section asks for a driver’s license and you do not have a driver’s license, enter “none” or “N/A” (not applicable). If you need to make a correction, draw one line through the incorrect information. Then print the correct information above to note the change.
2. It is important that all information on both of these forms be complete and correct. False, incomplete or misleading information will cause your application to be rejected.
3. Please send your application to:

Supportive Living, Inc.

400 West Cummings Park #6100

Woburn, MA 01801

1. As long as your application is on file with us, it is your responsibility to contact and inform us regarding any changes in your address, telephone number, income situation or other changes in your housing status that might affect your application.
2. After we review your application, 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 establishes that you are not qualified for Housing and Services, your application will be rejected and you will be so notified. We will process your application according to our standard procedures, which are summarized in the Tenant Selection Plan posted in the Management Office.

**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.

**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

**Program Administrator:** Stephanie DeSilva

**Phone:** 781-937-3199

**Email:** sdesilva@supportivelivinginc.org

**Application for Housing**

**PLEASE TYPE OR PRINT IN INK**

FULL LEGAL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. SOCIAL SECURITY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. THE ABOVE RESIDENCE IS:

 OWN HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NURSING HOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENTS HOME: \_\_\_\_\_\_\_\_\_\_\_\_ REHAB CENTER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APARTMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OTHER (SPECIFY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*How did you hear about this housing opportunity (if a publication, please specify which one)?*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. IF I CAN NOT BE REACHED AT THE ABOVE NUMBER, PLEASE CONTACT:

PERSON TO CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TEL #: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. HAVE YOU EVER USED A DIFFERENT NAME FROM THE NAME SHOWN ABOVE?

 NO \_\_\_\_\_ YES \_\_\_\_\_ PLEASE LIST NAMES USED AND THE DATES WHEN

 SUCH NAME WERE IN USE:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Is there someone currently living in your home that will not be moving in with you?*  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Do you anticipate any additions to the household in the next 12 months? NO \_\_\_\_\_\_YES \_\_\_\_\_\_*

*If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**EQUAL OPPORTUNITY HOUSING**

1. HAVE YOU EVER BEEN EVICTED OR OTHERWISE REMOVED FROM RENTAL HOUSING:

NO \_\_\_\_\_ YES \_\_\_\_\_ PLEASE PROVIDE LANDLORD NAME, ADDRESS AND

DATES AND REASON FOR EVICTION OR REMOVAL.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. HAS ANY PLACE WHERE YOU WERE LIVING BEEN DESTROYED/DAMAGED

BY FIRE?

 NO \_\_\_\_\_ YES \_\_\_\_\_ PLEASE PROVIDE DETAILS AND DATES:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. LIST ALL FULL-TIME, PART-TIME AND SEASONAL EMPLOYMENT (SUPPORTIVE

 OR COMPETITIVE) INCLUDING SELF EMPLOYMENT WITHIN THE PAST 5 YEARS:

PLACE OF EMPLOYMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY/TOWN/STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATES: FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY/TOWN/STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATES: FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY/TOWN/STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATES: FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. LIST NON-EMPLOYMENT INCOME AS FOLLOWS:

 ESTIMATED ESTIMATED

 TOTAL $ FOR TOTAL $ FOR

TYPE INCOME NEXT 12 MONTHS TYPE INCOME NEXT 12 MONTHS

 INTEREST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ UNEMPLOYMENT

 COMPENSATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DIVIDENDS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ALIMONY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 FROM RENTAL

 PROPERTY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CHILD SUPPORT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SOCIAL SECURITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORKERS

 COMPENSATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PENSIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DISABILITY

 PUBLIC ASSISTANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COMPENSATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SSI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ALL OTHER

 INCOME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SSDI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. LIST ASSETS AS FOLLOWS:

ESTIMATED

ESTIMATED ANNUAL INCOME

TYPE OF ASSET CURRENT VALUE FROM ASSETS

CHECKING ACCOUNT (S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SAVINGS ACCOUNT (S) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TRUST ACCOUNT (S) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CERTIFICATES (CD’S) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STOCKS(S) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIFE INSURANCE POLICY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BOND (S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CREDIT UNION SHARES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAND: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REAL ESTATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER ASSETS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Are you applying for a Market Rate Unit? NO \_\_\_\_\_\_YES \_\_\_\_\_\_*

*Will the person/s in the household be or have been full-time students during five calendar months of this year or plan to be in the next calendar year at an educational institution. NO \_\_\_\_\_\_YES \_\_\_\_\_\_*

*IF YES, please answer the following questions:*

 Yes No

|  |  |  |
| --- | --- | --- |
| Are any full-time student(s) married and filing a joint tax return? |  |  |
| Are any student(s) enrolled in a job-training program receiving assistance under the Job Training Partnership Act (JTPA)? |  |  |
| Are any full-time student(s) a TANF or Title IV recipient? |  |  |
| Are any full-time student(s) a single parent living with his/her minor child who is not a Dependent on another person/tax return? |  |  |

*OPTIONAL: Do you or any member of your household classify yourself as any of the following? (This may include more than one group). Responses will help us track the diversity of the applicant pool. Your entry will have no bearing on your eligibility for housing.*

□ White/Caucasian □ Latino/a □ Asian/Native Hawaiian/Pacific Islander/Alaskan

□ Native American

□ Black/African-/Caribbean-American □ Another race (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING YES OR NO AND USE THE SPACE PROVIDED TO EXPLAIN ANY YES QUESTION.

A. DO YOU RECEIVE REGULAR CASH CONTRIBUTIONS FROM

AGENCIES OR FROM INDIVIDUALS NOT LIVING WITH YOU?

NO \_\_\_\_ YES \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B. DO YOU RECEIVE INCOME FORM ASSETS, INCLUDING INTEREST,

DIVIDENDS, STOCKS, OR BONDS?

NO \_\_\_\_ YES \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

C. DO YOU RECEIVE MONEY FROM SCHOOL-AID, SCHOLARSHIP OR

EDUCATIONAL GRANT?

NO \_\_\_\_ YES \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D. HAVE YOU SOLD OR GIVEN AWAY ANY MONEY, REAL ESTATE PROPERTY

OR OTHER ASSETS IN THE PAST TWO YEARS?

NO \_\_\_\_ YES \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E. DO YOU CURRENTLY USE ANY ILLEGAL DRUG OR OTHER ILLEGAL

 CONTROLLED SUBSTANCE?

NO \_\_\_\_ YES \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

F. HAVE YOU EVER ENGAGED IN OR BEEN CONVICTED OF DRUG-RELATED

CRIMINAL ACTIVITY, SUCH AS USE, POSSESSION, DISTRIBUTION,

TRAFFICKING, OR MANUFACTURE OF AN ILLEGAL DRUG?

NO \_\_\_\_ YES \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

G. HAVE YOU BEEN INVOLVED IN OR BEEN CONVICTED OF CRIMINAL

ACTIVITY THAT POSE A THREAT TO THE HEALTH, SAFETY OR WELFARE OF OTHERS?

NO \_\_\_\_ YES \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **\_\_\_\_\_\_\_\_\_\_INITIALS**

**CERTIFICATION:**

I CERTIFY THAT ALL INFORMATION GIVEN IN THIS APPLICATION AND ANY ADDENDUM

THERETO IS TRUE, COMPLETE AND ACCURATE.

I UNDERSTAND THAT IF ANY OF THIS INFORMATION IS FALSE, MISLEADING OR INCOMPLETE, MANAGEMENT MAY DECLINE MY APPLICATION OR, IF MOVE-IN HAS OCCURRED, TERMINATE MY RENTAL AGREEMENT.

I AUTHORIZE THE PROPERTY MANAGER TO MAKE ANY AND ALL INQUIRIES TO VERIFY

THIS INFORMATION EITHER DIRECTLY OR THROUGH INFORMATION EXCHANGED

NOW OR LATER WITH RENTAL AND CREDIT SCREENING SERVICES, AND TO CONTACT

PREVIOUS AND CURRENT LANDLORDS OR OTHER SOURCES FOR CREDIT AND

VERIFICATION CONFIRMATION WHICH MAY BE RELEASED TO APPROPRIATE FEDERAL,

STATE OR LOCAL AGENCIES.

I AGREE TO NOTIFY MANAGEMENT IN WRITING REGARDING ANY CHANGES IN

HOUSEHOLD ADDRESS, TELEPHONE NUMBERS, INCOME, AND HOUSEHOLD

COMPOSITION.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS APPLICATION, IN

PARTICULAR, THE INFORMATION CONTAINED IN THE INSTRUCTIONS AND AGREE TO

COMPLY WITH SUCH INFORMATION.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE SIGNATURE OF APPLICANT

APPLICATION CHECKLIST

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

Some of the Income documentation required for each household member include:

* Copies of Birth Certificate and social security card.
* If applicable, SIX weeks’ 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.).
* A no-income-statement, signed and notarized, for any household member over 18 who has no source of income.

**Special Unit Requirements Questionnaire**

THIS QUESTIONNAIRE IS USED TO DETERMINE WHETHER AN APPLICANT NEEDS

SPECIAL FEATURES IN THEIR HOUSING UNIT. THE NEED FOR SPECIAL ADAPTIONS

MUST BE VERIFIED IN ORDER TO ASSURE THAT THE PROPER UNITS WITH SPECIAL

FEATURES GO TO APPLICANTS THAT ACTUALLY NEED THE FEATURES.

APPLICANTS NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FILE #: \_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I CHOOSE NOT TO COMPLETE THIS FORM: \_\_\_\_\_\_\_

APPLICANTS SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. DO YOU HAVE A CONDITION THAT REQUIRES’:

FIRST FLOOR UNIT: \_\_\_\_\_\_ BARRIER FREE UNIT: \_\_\_\_\_\_\_

UNIT FOR VISION IMPAIRED: \_\_\_\_\_\_ UNIT FOR HEARING IMPAIRED: \_\_\_\_\_\_\_

OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. CAN YOU GO UP AND DOWN STAIRS UNASSISTED?

 YES \_\_\_\_ NO \_\_\_\_

3. CAN YOU OPERATE AN ELEVATOR UNASSISTED?

 YES \_\_\_\_ NO \_\_\_\_

 WILL YOU REQUIRE AN AID TO ASSIST YOU?

YES \_\_\_\_ NO \_\_\_\_

 IF YOU CHECKED YES FOR ANY OF THE ABOVE LISTED CATEGORIES, PLEASE

EXPLAIN EXACTLY WHAT YOU NEED TO ACCOMMODATE YOUR SITUATION.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Who should be contacted to verify your need for the feature’s you have identified above?*

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TEL # ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY/TOWN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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:

1. **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **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… (please 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*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **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**

**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:

1. Are your parents receiving or eligible to receive Section 8 assistance? \_\_\_\_\_\_ \_\_\_\_\_\_
2. Are you claimed as a dependent on your parent’s tax return? \_\_\_\_\_\_ \_\_\_\_\_\_
3. 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  |   | Welfare Agencies  | Veterans Administrations  |
| Support and Alimony Providers  |   | Educational Institutions  | Retirement Systems  |
| State Unemployment Agencies  |   | Social Security Administration  | Medical and Child Care  |
| Banks and other Financial  |   | Previous Landlords (including  | Providers  |
| Institutions  |   | Public Housing Agencies)  |  |

**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