

Five County Mental Health Authority  
**SHELTER PLUS CARE CONTACT INFORMATION SHEET**

APPLICANT: \_\_\_\_\_ APPLICATION DATE: \_\_\_\_\_

Referral Source: \_\_\_\_\_  
*(Please Provide: Agency Name/Contact Person/Telephone Number)*

**FAMILY COMPOSITION**

List head of household, applicant, and all others who will be living with the applicant, and their relationship to head of household. **List only those people living in the household.**

<u>FULL NAME</u>	<u>RELATIONSHIP</u>	<u>BIRTHDATE</u>	<u>AGE</u>	<u>GENDER</u>	<u>SOC SEC #</u>

ARE YOU A VETERAN?    Yes [ ]    No [ ]

**RACE OF HEAD OF HOUSEHOLD**

- White     Black/African American     American Indian/Alaskan Native     Asian
- Native Hawaiian/Other Pacific Islander     American Indian/Alaskan Native & White
- Asian & White     Black/African American & White     American Indian/Alaskan Native
- Other Multi-Racial

ETHNICITY:     Hispanic     Non-Hispanic

**FAMILY INCOME**

List the source and amount of the annual income of members listed above:

<u>NAME</u>	<u>SOURCE/TYPE OF INCOME</u>	<u>ANNUAL INCOME</u>

**Attach verification forms for all income listed.**

**FAMILY ASSETS**

List the checking and savings accounts of each member listed above:

<u>NAME</u>	<u>SOURCE/TYPE OF INCOME</u>	<u>ANNUAL INCOME</u>

**Attach verification forms for all accounts listed.**

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*Page 2*

\_\_\_ No family member owns stocks, bonds, trusts, pensions or other assets, **OR**  
\_\_\_ a list of such assets is attached.

\_\_\_ No family member has disposed of any assets for less than their fair market value during the last two years, **OR** \_\_\_ a list of those assets is attached.

Are you homeless? Yes [ ] No [ ]

Are you disabled? Yes [ ] No [ ]

What is your current housing situation that qualifies you for this Shelter Plus Care Program?

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ADDITIONAL CERTIFICATIONS (complete each item)

The applicant and Program Representative certify that the applicant:

\_\_\_ is disabled/handicapped as defined (verification attached).

\_\_\_ does not have a legal guardian **OR** \_\_\_ verification of legal guardian is attached.

\_\_\_ does not have regular expenses for childcare for a child under 12 **OR** \_\_\_ verification of such childcare expenses are attached.

\_\_\_ does not pay the cost of attendant care of equipment to enable household member to work **OR** verification of these expenses are attached.

\_\_\_ chooses not to report and consent to verification of medical expenses **OR** verifications are attached for medical expenses

HUD defines a **chronically homeless person** as "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for one year or more **OR** has had a least four (4) episodes of homelessness in the past three (3) years." To be considered chronically homeless a person must have been on the streets or in an emergency shelter (i.e., not transitional housing) during these stays. **Based on HUD's definition of chronically homeless people, are you chronically homeless? Yes [ ] No [ ]**

As the applicant for Shelter Plus Care housing, I certify that all of the above information is true, and I authorize the undersigned Program Representative to verify all information in this application. I understand that providing false information on this application may result in denial or termination of assistance.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Program Representative: \_\_\_\_\_ Date: \_\_\_\_\_