



**APPLICATION**  
COMMUNITY FOLLOW-UP HOUSING AND SERVICES PROGRAM

Please complete all items listed below and send or fax or email to:

**Options Community Follow-up Program – Housing Department**

**Smithtown:** 202 East Main Street  
Smithtown, NY 11787  
 (631) 361-9020 Ext. 200  
Fax: (631) 361-9204

**Hempstead:** 1 Helen Keller Way  
Hempstead, NY 11550  
 (516) 481-6300 Ext. 134  
Fax: ( 516) 481-6728

**Type of Housing Assistance Needed: (Please check type(s) of assistance requested)**

- Housing Placement Assistance
- Housing related Financial Assistance
- Permanent Housing

**Section I (All applicants must complete.)**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Town: \_\_\_\_\_ Zip: \_\_\_\_\_ Emergency #: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Emergency contact: \_\_\_\_\_  
How may we contact you?  By Phone  By Mail  In Person  Other  
Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female  Transgender  
Veteran Status:  Yes  No  
Referred by: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Race:  White  Black  Asian  American Indian/Native Alaskan  Native Hawaiian/Pacific Islander

Ethnicity:  Hispanic  Non-Hispanic

*(The above race/ethnicity information is being requested to comply with equal opportunity and grant requirements and your answers will not affect your eligibility for housing assistance )*

**HIV/AIDS Status:**  HIV+  AIDS  HIV+ symptomatic

**Mode of Transmission:**

- Injecting Drug User (IDU)  IDU and MSM  Men Who Have Sex W/Men (MSM)
- Heterosexual Sex  Prenatal Exposure  Occupational Exposure  Blood Products

(OVER)



**Monthly Household Income:** Amount \_\_\_\_\_ Source(s) \_\_\_\_\_  
 Medical Insurance:  Private  Medicare  Medicaid  ADAP  No Insurance  Other \_\_\_\_\_

**Housing Status:**  Homeless  Inadequately Housed  At Risk of Homelessness

**Current Housing:**  Homeless on Street  Emergency Shelter  Motel  Transitional Housing  
 Rental Housing  Hospital/Nursing Home  Other:

Please describe your current living situation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Unit size needed:  Studio  1 Bedroom  2 Bedroom  3 Bedroom  4+ Bedrooms

Explain need for above unit size: \_\_\_\_\_

Geographic Areas of Preference: \_\_\_\_\_

**Section II (Required for applicants requesting Financial Assistance.)**

Type of Financial Assistance requested:  Broker Fees  First Month's Rent  Moving Expenses  
 Security Deposit (*loan must be paid back*)  Utility Assistance

**Section III (Required for applicants requesting Permanent Housing.)**

Also please note that an interview and additional documentation will be required for permanent housing applicants.

**Household Composition: List all persons who would live with you if you received assistance.**

Last Name	First Name	Relation-ship	Gen-der	Race/ Ethnicity	DOB	Age	SSN	Income Amount/Source
		Self						

**Additional documentation and forms will be necessary depending on assistance needed.**

I declare that the statements contained in this application are true and correct and that I have not willfully or knowingly made a false statement, given false information, or omitted information in connection with this application. I also understand that I will be required to submit to Options for Community Living, Inc. verification and/or proof to support any or all of the claims I have made above.

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
 Signature of Head of Household

\_\_\_\_\_  
 Date