Options
for Community Living, Inc.

APPLICATION
ACCESS TO CARE HOUSING PROGRAM

Please complete all items listed below and send with a signed Consent to Release Information form to:

Options Access To Care Program – Housing Department
202 East Main Street
Smithtown, NY 11787
Phone: (631) 361-9020 Ext. 200 Fax: (631) 361-9204

Type of Housing Assistance needed: (Please check)

☐ Financial Assistance (housing related)
Type: ☐ Broker Fees ☐ First Month's Rent ☐ Moving Expenses ☐ Utility Assistance
☐ Security Deposit (***note: refundable - must be paid back***)

☐ Permanent Supportive Housing
Location preference: ☐Suffolk County ☐Nassau County
Type of housing needed: ☐ Single** (**if single, amenable to share? ☐ yes ☐ no) ☐Family
Unit size needed: ☐ Studio ☐ 1 Bedroom ☐ 2 Bedroom ☐ 3 Bedroom ☐ 4+ Bedrooms

Section I (All applicants must complete.)

Name: _____ Date: _____

Telephone: _____ Emergency contact #: _____

HIV Status*: ☐ HIV positive ☐AIDS ☐ Other/unknown
Risk behavior:

☐ SEXUAL RISK FACTORS: SEX (VAGINAL OR ANAL) WITH ...☐ TRANSGENDER ☐ MALE ☐ FEMALE

☐ IN EXCHANGE: SEX FOR DRUGS / MONEY ☐ WHILE INTOXICATED AND / OR HIGH ON DRUGS
☐ WITH PERSON WHO IS AN IDU ☐ WITH PERSON WHO IS HIV POSITIVE
☐ WITH PERSON OF UNKNOWN HIV STATUS ☐ WITH PERSON WHO EXCHANGES SEX FOR DRUGS / MONEY
☐ WITH ANONYMOUS PARTNER ☐ WITH HEMOPHILIAC OR TRANSFUSION / TRANSPLANT RECIPIENT
☐ WITH PERSON WHO IS A KNOWN MSM (FEMALE CLIENT ONLY)

☐NON-SEXUAL RISK FACTORS

☐ INJECTION DRUG USE (IDU) ☐ SHARED DRUG INJECTION EQUIPMENT
☐ HEMOPHILIA / COAGULATION DISORDER ☐ BLOOD PRODUCT OR TRANSPLANT RECIPIENT
☐ MOTHER AT RISK / PERINATAL ☐ OTHER: _____

☐ **NO ADDITIONAL RISK INFORMATION SPECIFIED**
☐ **REFUSED TO REPORT ADDITIONAL RISK FACTORS**
☐ **NOT ASKED ADDITIONAL RISK FACTORS**

Date of most recent physical exam: _____
CD4 count: _____ **Viral load:** _____

Housing Status*: □ Homeless □ Inappropriately 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:_____

_____

_____

_____

Housing size: ☐ one ☐ two ☐ three ☐ four +

Monthly Household Income*: Amount_____ Source(s)_____

Insurance: ☐ Medicaid ☐ Medicare ☐ No insurance ☐ Private ☐ Other:_____

Please attach documented proof of HIV status, income and housing status.

Also required if applicable: *Consent to Release Information; Certification of Medical Necessity; HIPPA Acknowledgement, Statement of Need/Long Term Plan for Stable Housing form (including corresponding documentation) and Request for Taxpayer Identification Number (W9) needed to confirm taxpayer identification number.*

Section III (Required for applicants requesting Permanent Housing.)
Also please note that an interview and additional documentation will be required for permanent housing applicants.

Veteran Status: □ Yes □ No

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						

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 _____