

# IDAHO HOUSING AND FINANCE ASSOCIATION

## HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS APPLICATION INSTRUCTIONS

**APPLICATION INSTRUCTIONS—Please read the instructions on this page very carefully before completing the application.**

This is the Idaho Housing and Finance Association (IHFA) official application for services offered under the Housing Opportunities for Persons With AIDS (HOPWA) program. This application consists of five different forms that need to be completed according to the instructions and signed in the appropriate places by both the Applicant and the Service Provider. When completed, the case manager must send the original application to:

**Rental Assistance, HOPWA Program  
Idaho Housing and Finance Association  
P.O. Box 7899  
Boise, ID 83707-1899**

Please read the following instructions very carefully and complete each form as appropriate. Failure to complete these forms correctly may delay services. The Household with HIV/AIDS (Applicant) must complete the application. If the Applicant is a minor, the legal guardian must sign and date the application in lieu of the minor.

**AHS 1001—Information Notice**

This form is a notification to the Applicant regarding reporting requirements for the grant and confidentiality of applicant information. The Service Provider should present this notice to the Applicant to read. The Service Provider may answer any questions that the Applicant may have regarding this notice. The Applicant may request a signed copy from the Service Provider.

Place the Applicant signature and Social Security Number in the appropriate spaces on the Information Notice. If the Applicant is a minor, both the Legal Guardian's name and Social Security Number and the Applicant's name and Social Security Number are required. The applicant may use a Tax Identification Number or an Alien Registration Number in lieu of a Social Security Number (SSN) if a SSN has not been issued to the Applicant or Legal Guardian. The applicant signature acknowledges receipt of this notice.

The Service Provider should also sign and date the form to acknowledge completion of this step. A confidential identification number for future reference may be inserted in the space provided.

**AHS 02—Applicant Information**

This form is required. The Applicant (or Legal Guardian if applicable) must provide all of the information requested in the **General Information** section.

The Applicant must then choose the type of service(s) by checking the appropriate box in the **Services Requested** section. The Service Provider should be able to identify and explain the different services offered under the HOPWA program.

The Applicant must then complete the **Household Composition** section by placing his/her name in the first row (indicated by "SELF"). Any other Household family members who are requesting services under this application must place their names on the following rows. If this application is requesting Housing Assistance, the Applicant must include all members of the family who will live in the residence.

Finally, complete the question regarding your **Most Recent Living Arrangement**. This information is requested by the U.S. Department of Housing and Urban Development (HUD) and is part of their Annual Performance Report on demographic information. This information will not be used to determine eligibility.

**AHS 03—Income Verification**

This form is required unless the Applicant has absolutely no income, in which case AHS-04 will be submitted instead. All forms of income must be reported. ***Place the Applicant name and Social Security Number at the top of the page. If the Applicant is a minor,*** both the Legal Guardian's name and Social Security Number and the Applicant's name and Social Security Number are required.

Indicate in the appropriate spaces all sources of income for both the Applicant and each applicable Household family member. The information on this page must include the salary of every Household family member 18 years of age or older listed in the **Household Composition** section on form **AHS-02**.

The Applicant (or Legal Guardian if applicable) must sign and date the form in the appropriate place certifying that the information provided is truthful and accurate.

**\*\* See Service Provider Requirements below**

**AHS 04—Statement of no Income**

***This form is only required if the Applicant and the Applicant Household has no income.***

The Applicant (or Legal Guardian if applicable) must sign and date the form in the appropriate place certifying that the information provided is truthful and accurate.

**AHS 05—Service Provider Information and Certification**

This form is required. This form should be completed by the Service Provider and must include all of the requested information about the Service Provider.

The Service Provider must complete the HIV/AIDS certification for the Applicant and sign and date the form in the appropriate places.

**\*\* See Service Provider Requirements below**

**SERVICE PROVIDER REQUIREMENTS:**

On page **AHS-1001** THE SERVICE PROVIDER MUST CERTIFY the applicant's awareness of HUD's reporting requirements. The certification shows IHFA that the signing provider has presented the information notice to the applicant and has verified that this applicant understands the reporting requirements for HOPWA grant assistance.

Income and HIV/AIDS certifications are paramount to your client's eligibility for HOPWA services. On page **AHS-03** THE SERVICE PROVIDER MUST CERTIFY THE **APPLICANT'S INCOME**. The certification shows IHFA that the service provider has verified a qualifying income by county of residence and number in household using HUD's income limits chart (attached) to determine each applicant's eligibility for the program.

On page **AHS-05**, THE SERVICE PROVIDER MUST CERTIFY **HIV/AIDS** status. The certification shows IHFA that the signing provider is qualified to verify HIV/AIDS status and has determined this status as positive in determining each applicant's eligibility for the program.

Supporting documentation for these certifications **MUST BE ON FILE** at the certifying agency.

**INCOMPLETE FORMS WILL DELAY CLIENT SERVICES**

**IHFA HOPWA APPLICATION  
USE OF APPLICANT INFORMATION  
NOTICE**

The U.S. Department of Housing and Urban Development (HUD) and its grantee, Idaho Housing and Finance Association (IHFA) that distributes the HOPWA funds in Idaho, are responsible under federal law (AIDS Housing Opportunity Act, 42 U.S.C. § 12901 et seq. and 24 C.F.R. § 574 et seq.) to determine proper accounting and disbursement of HOPWA funds.

An Applicant for HOPWA assistance under the Housing Opportunities for Persons with AIDS (HOPWA) grant must provide verification of HIV status and qualifying income by completion of this application. This information is sufficient to qualify an applicant for housing assistance.

If the Service Provider offers other types of assistance eligible under the HOPWA grant HUD/IHFA must review documentation verifying payments made on behalf of an Applicant before reimbursements can be made.

Further verification demonstrating provision of these services may also be required for review by HUD/IHFA. HUD and IHFA do not make copies of this documentation as a part of the verification. Neither is information reviewed during the verification included in any database by HUD or IHFA as a result of such verification. Demographic information that does not identify the Applicant may be used to satisfy HOPWA reporting requirements.

HUD and IHFA are compelled by federal law to maintain the privacy of all confidential information reviewed in the verification process.

**YOUR SIGNATURE BELOW IS ONLY TO ACKNOWLEDGE RECEIPT OF THIS NOTICE. YOU MAY REQUEST A COPY FROM YOUR SERVICE PROVIDER.**

Applicant Signature: \_\_\_\_\_ Social Security # \_\_\_\_\_

Legal Guardian Signature: \_\_\_\_\_ Social Security # \_\_\_\_\_  
(if applicant is a minor)

**Service Providers/Case Managers Certification**

**By signing below, the case manager hereby certifies that this Information Notice has been presented and that the applicant understands the reporting requirements by HUD for this grant assistance.**

\_\_\_\_\_  
Service Provider/Case Manager

\_\_\_\_\_  
Date

**Please assign this Applicant a Confidential I.D. Number to be used for all billing purposes: # \_\_\_\_\_**

# IHFA HOPWA APPLICATION

## APPLICANT INFORMATION

### General Information

First Name \_\_\_\_\_ Middle Init. \_\_\_\_\_ Last Name \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Street Address \_\_\_\_\_ City, State, and Zip \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Emergency Contact # \_\_\_\_\_  
 Name of Guardian (if applicable) \_\_\_\_\_

### Services Requested

Please indicate the Housing or Supportive Service requested with this application

<input type="checkbox"/> Supportive Services (includes case management, housing placement & limited health services)
<input type="checkbox"/> Housing Information <span style="margin-left: 150px;"><input type="checkbox"/> Resource Identification</span> <span style="margin-left: 150px;"><input type="checkbox"/> Homeless Prevention</span>
<input type="checkbox"/> Housing Assistance ( <b>tenant-based rental assistance/housing voucher</b> )

### Household Composition

The HOPWA program requires that the Applicant have HIV/AIDS in order to be eligible for Housing or Supportive Services. Please place the Applicant's name in the first row and place any Household family member living in the Household where services are provided under this application on the following rows.

Name	SSN	Relationship to Applicant	Date of Birth	Gender		Ethnicity		Race (see codes below)
				M	F	Hispanic	Non-Hisp.	
		SELF						

RACE CLASSIFICATIONS: A = Asian/Pacific Islander B= Black C= Native American or Alaskan Native D= White

Is the Head of Household (please check if applicable):  Veteran  Chronically Homeless  Domestic Violence Survivor

### Most Recent/Current Living Arrangement

For applicants requesting long-term rental assistance, please check the box which best describes your most recent or current living arrangement:		
<input type="checkbox"/> Homeless from the Streets	<input type="checkbox"/> Emergency Shelter	<input type="checkbox"/> Transitional Housing
<input type="checkbox"/> Psychiatric Facility*	<input type="checkbox"/> Substance Abuse Facility*	<input type="checkbox"/> Hospital*
<input type="checkbox"/> Jail or Prison	<input type="checkbox"/> Domestic Violence Shelter**	<input type="checkbox"/> Friend or Relative
<input type="checkbox"/> Rental Housing	<input type="checkbox"/> Applicant-Owned Housing	<input type="checkbox"/> Other (specify):

\* These categories can only be checked if the applicant was in an in-patient facility for 30 days or longer. If the applicant was an in-patient for less than 30 days, please identify the living arrangement prior to hospitalization.

\*\* Applicant need not spend any time in a Domestic Violence Shelter to qualify for housing. The applicant(s) must prove they are fleeing a domestic violence situation that is typically verified through DV shelters.

## IHFA HOPWA APPLICATION INCOME VERIFICATION

Applicant Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Legal Guardian Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
(if Applicant is a minor)

**Household Income**

**NOTE: Income verification must be completed for all family members over 18 years of age living in the household.**

Sources of Income or Assistance	Gross Monthly Income (all necessary persons)	
	Applicant	Family Member(s)
Disability Insurance, SSI, SSDI, VA Benefits	\$	\$
Public Assistance /TAFI/ AABD/ Refugee	\$	\$
Child Support	\$	\$
Wages/Tips/Earnings	\$	\$
Retirement/ Social Security/ Savings/ Investments	\$	\$
Unemployment Insurance	\$	\$
Regular/frequent gifts of money from family/friends	\$	\$
Other (please specify):	\$	\$
Other (please specify):	\$	\$
<b>TOTAL (each column)</b>	<b>\$</b>	<b>\$</b>
<b>Grand TOTAL (both columns combined)</b>	<b>\$</b>	
No Financial Resources	<b>Must complete "Statement of No Income" form (AHS-04) quarterly.</b>	

Falsifying or deliberately omitting information regarding your income (or household income) may result in immediate termination from the program and/or criminal charges or civil suit(s) to repay the amount of assistance received. By signing below, the applicant hereby certifies that the information above is correct and true to the best of his/her knowledge.

\_\_\_\_\_  
Applicant Signature Date

\_\_\_\_\_  
Legal Guardian Signature (if Applicant is a minor) Date

**NOTE: The Service Provider must complete the INCOME CERTIFICATION and document it in client files.**

**Service Provider/Case Manager Certification**

Applicant and Applicant Household income must be 80% or less of area median income to qualify for HOPWA services. The case manager must complete income verification. **Source documentation** (copy of SSI check, child support order, pay stubs, etc.) must be made available in the client's file. This must be completed prior to the client receiving services. Income verification must be completed for every person 18 years of age or older living in the household.

Area median income in \_\_\_\_\_ County or MSA is \$\_\_\_\_\_ monthly for a family of \_\_\_\_\_

**By signing below, the provider/case manager hereby certifies that appropriate third-party documentation verifying the statements made above has been collected on all required persons in the Household, is correct to the best of his/her knowledge, and is available in the client's file.**

\_\_\_\_\_  
Service Provider/Case Manager Date

## IHFA HOPWA APPLICATION STATEMENT OF NO INCOME

[DO NOT COMPLETE IF INCOME WAS REPORTED ON PREVIOUS FORM AHS-03]

Applicant Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Legal Guardian Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
(if Applicant is a minor)

I, \_\_\_\_\_ (applicant's name), do hereby state that I am not presently receiving any type of income.

Income is defined as follows:

1. gross amount of wages, salaries, overtime pay, commissions, fees, tips and bonuses;
2. net income from operation of business profession or from rental or real property;
3. interest, dividends and other net income of any kind for real and personal property;
4. full amount of periodic payments received from social security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of periodic receipts; including a lump sum payment for the delayed start of periodic payments;
5. payment in lieu of earnings, such as unemployment and disability compensation, workman's compensation and severance pay;
6. public assistance;
7. alimony and child support payments;
8. regular pay, special pay and allowance of a member of the Armed Forces (whether or not living in the dwelling) head of family or spouse;
9. education scholarships and veteran's educational benefits which exceed the cost of tuition, fees, books and expenses;

**Falsifying or deliberately omitting information regarding your income (or household income) may result in immediate termination from the program and/or criminal charges and/or civil suit(s) to repay the amount of assistance received. By signing below, the applicant hereby certifies that the information above is correct and true to the best of their knowledge.**

\_\_\_\_\_  
Applicant Signature Date

\_\_\_\_\_  
Legal Guardian Signature (if Applicant is a minor) Date

**By signing below, the provider/case manager hereby certifies that third-party documentation verifying this statement has been collected on all persons in the Household, that the information is correct to the best of his/her knowledge, and is available in the client's file.**

\_\_\_\_\_  
Service Provider/Case Manager Signature Date

## IHFA HOPWA APPLICATION SERVICE PROVIDER INFORMATION AND CERTIFICATION

### Service Provider Information

Service Provider's Name:
Agency or Organization:
Agency's Executive Director
Physical address where services are provided:
Phone number(s):
Address or PO Box of Executive Director:
Official use only

### Applicant HIV/AIDS Certification

**NOTE: The Service Provider must complete the HIV/AIDS certification for the Applicant.**

#### Certification of HIV/AIDS Status

By signing below I certify that \_\_\_\_\_ has AIDS or is HIV-positive.  
Name of Applicant

\_\_\_\_\_  
 Certifying Person (typed or printed name) Title/Occupation

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Credential (MD, RN, MSW, etc): \_\_\_\_\_

\_\_\_\_\_  
 Signature of Certifying person Date