

RENTAL ASSISTANCE: PERMANENT SUPPORTIVE HOUSING
CASE PRESENTATION

Date: _____

Applicant Name: _____ SSN: _____ DOB: _____

Gender: _____ Race: _____

Ethnicity: _____ Chronically Disabled: Yes No

Is the client a Veteran? Yes No Military Branch: _____

Discharge Status: _____ Service Era: _____

Household Members:

Name:	SSN:	DOB:	Relationship:

Please describe the client's current living situation. Include information on prior living situation. Individual **MUST** meet homeless criteria to be eligible for the program.

Chronically Homeless₁

Non-Chronically Homeless₂

Location/Prior Residence:

County of Residency: SLC MC IRC Other: _____

Residence Prior to Entry: _____

Length of Stay: _____

Time on streets or Emergency Shelter (ES):

Clients entering from the streets? Yes No Approximate Start Date: _____

Number of times spent on the streets or ES: _____

Total months homeless on the street or ES in past 3 months: _____

1 **Chronically Homeless:** An individual with a disabling condition who has been (1) continuously homeless for a year or more **OR** (2) has had four episodes of homelessness in the past three years totaling 12 months.

2 **Non-Chronically Homeless:** A person sleeping in a place not meant for human habitation or in an emergency shelter, or a person in transitional housing for homeless persons.

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S+C Disability Eligibility: A disabling condition is defined as “a diagnosable substance abuse disorder, serious mental illness or disability, including the co-occurrence of two or more of these conditions.” A disabling condition limits an individual’s ability to work or perform one or more activities of daily living.” A physician or licensed mental health professional **MUST** verify condition in writing.

Diagnosis/Disability: _____

Code/Description: _____

SMI: Seriously Mentally Ill **PWOD:** Person with Other Disabilities **PWA:** Person with Aids

Applicant Barriers:

Barrier:	Barrier Present:		Receiving Services/ Treatment:		Indefinite Condition:		Documentation provided:	
Alcohol Abuse	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chronic Health Condition	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Developmental Disability	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Drug Abuse	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HIV/AIDS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Mental Illness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Physical Disability	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Household Gross Monthly Income:

Employment	\$	<input type="checkbox"/> Receiving	<input type="checkbox"/> Applied	<input type="checkbox"/> Denied	<input type="checkbox"/> N/A
SSI	\$	<input type="checkbox"/> Receiving	<input type="checkbox"/> Applied	<input type="checkbox"/> Denied	<input type="checkbox"/> N/A
SSDI	\$	<input type="checkbox"/> Receiving	<input type="checkbox"/> Applied	<input type="checkbox"/> Denied	<input type="checkbox"/> N/A
Social Security Administration	\$	<input type="checkbox"/> Receiving	<input type="checkbox"/> Applied	<input type="checkbox"/> Denied	<input type="checkbox"/> N/A
VA Benefits	\$	<input type="checkbox"/> Receiving	<input type="checkbox"/> Applied	<input type="checkbox"/> Denied	<input type="checkbox"/> N/A
Child Support	\$	<input type="checkbox"/> Receiving	<input type="checkbox"/> Applied	<input type="checkbox"/> Denied	<input type="checkbox"/> N/A
Other:	\$	<input type="checkbox"/> Receiving	<input type="checkbox"/> Applied	<input type="checkbox"/> Denied	<input type="checkbox"/> N/A
TOTAL:		\$			

Please provide emergency contact/NOK information:

Name: _____ Number: _____ Relation: _____

Name: _____ Number: _____ Relation: _____

I verify that the information provided above is correct. I give permission for the referring agency to share this information and any other documents needed to determine my eligibility. I also give the referring agency permission to communicate on my behalf with other Social Services organizations to better serve my needs. I understand that signing this does not guarantee placement in the program.

Applicant Signature: _____ **Date:** _____

Case Manager Signature: _____ **Date:** _____