



Thank you for your interest in CIP Shared Housing!

The following pages contain our application. Please complete the entire application before returning it to CIP. Incomplete applications may take longer to process and/ or may be rejected. If you do not send in all parts of the application at once, you have 30 days to get uncompleted parts turned in. If the uncompleted parts of the application are not turned in within the 30 days, the application will be rejected. The applicant will not be placed on the waiting list until the entire application is received. **This includes the signed background check form and recent history for the applicant.**

Once a completed application is received, the applicant will be placed on the waiting list. When an applicant's name is up on the waiting list, the applicant and/ or the case manager will be notified and an interview will be scheduled. The applicant is responsible for notifying CIP if any contact information changes (i.e. address, phone number, etc). The applicant should also notify CIP if they have found alternative housing and are no longer interested in Shared Housing. If it is determined that the applicant meets the criteria for Shared Housing after the interview is conducted, a time will be scheduled for the applicant to tour the house. An applicant will only be accepted to Shared Housing after the interview and tour are complete and it is determined that the applicant meets the criteria for Shared Housing and would be a good fit for the house.

A background check will be conducted on every Shared Housing applicant. CIP reserves the right to reject an applicant based on the information received during a background check. Some reasons for rejection include, but are not limited to:

- Sexual Offenses
- Homicide Convictions
- Felony Assault Charges (within the past 5 years)
- Drug Charges (within the past 5 years)

CIP requires a minimum of 6 months sobriety and participant in an aftercare program if an applicant has a history of drug and/ or alcohol abuse. There is no smoking allowed in any CIP homes.

CIP does not discriminate against applicants because of race, color, creed, religion, national origin, or sexual orientation.

CIP SUPPORTIVE HOUSING REFERRAL APPLICATION

Thank you for your application for housing in the CIP Shared Housing and Home Share programs. Shared Housing is an affordable housing program in the suburban communities of St Louis Park, Minnetonka, Eden Prairie, Hopkins, Golden Valley, Crystal, Plymouth and Robbinsdale. In addition to housing CIP also offers in home support services and home health care. As a prospective tenant you are eligible to apply for these services. In order to best assess and plan for your support we need the most current information available covering your :

- Social History
- Psychiatric History
 - Examples would include: Recent psychiatric in-patient records, and/or Diagnostic Assessment or psychiatrist's notes.
- Current Psychiatric Evaluation and a Diagnostic with a doctor's signature
- Progress notes from current and recent other treatment providers
- Discharge Summaries from residential facilities and/or other recent hospitalizations
- Medical History and/or physical examination
- Employment History

A signed and dated Release of Information needs to accompany your submission of these materials

Material can be mailed with your housing application or sent under separate cover. Support Service referral information is confidential and is not officially part of your application for housing with CIP Shared Housing or Home Share.

Community Involvement Programs
Shared Housing
1600 NE Broadway St
Minneapolis, MN 55413-2961
FAX: 612-547-0556

Demographic Data

Applicant's Last Name _____ First Name _____

AKA First and Last Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____ - _____

Does Applicant have a Recent History of Homelessness? Yes No *(If Yes complete Homeless Eligibility Determination Form)*

Social Security # : _____ - _____ - _____	Education: <i>(Check the highest degree obtained)</i> OPTIONAL <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Less than H.S. Diploma/G.E.D.</td> <td><input type="checkbox"/> College Degree</td> </tr> <tr> <td><input type="checkbox"/> H.S. Diploma/G.E.D.</td> <td><input type="checkbox"/> Master's Degree</td> </tr> <tr> <td><input type="checkbox"/> Some College</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Vocational Training, Trade: _____</td> </tr> </table>	<input type="checkbox"/> Less than H.S. Diploma/G.E.D.	<input type="checkbox"/> College Degree	<input type="checkbox"/> H.S. Diploma/G.E.D.	<input type="checkbox"/> Master's Degree	<input type="checkbox"/> Some College	<input type="checkbox"/> Unknown	<input type="checkbox"/> Vocational Training, Trade: _____																																																
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Date of Birth: <i>(if unknown, Age)</i> ____/____/____ Age: ____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female																																																							
Marital Status: <i>(Check one)</i> OPTIONAL <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Other	Financial/Medical/Food Supports: <i>(Check one response for each support.)</i> <table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> <th style="text-align: center;">PENDING</th> <th style="text-align: center;">UNKNOWN</th> </tr> </thead> <tbody> <tr><td>Spenddown* _____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Social Security SSD/SSI</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Public Assistance</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Medicaid* _____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Medicare</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Food Stamps</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Veterans</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Pension</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Other* _____</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Annual income less than \$27,500</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table>		YES	NO	PENDING	UNKNOWN	Spenddown* _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social Security SSD/SSI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Public Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medicaid* _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food Stamps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Veterans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other* _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Annual income less than \$27,500	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Important Contacts: *(Provide Name, Relationship & Phone, include Emergency contact & Financial Team) See page 3 for professional contacts.*

CIP SUPPORTIVE HOUSING REFERRAL APPLICATION

Applicant Name:

S.S. #

Clinical Assessment

Axis I: Clinical Disorders and Other Conditions that May Be a Focus of Clinical Attention

None

Diagnosis _____ DSM-IV Code _____

Diagnosis _____ DSM-IV Code _____

Diagnosis _____ DSM-IV Code _____

Diagnosis _____ DSM-IV Code _____

Axis II: Personality Disorders and/or Mental Retardation

None

Diagnosis _____ DSM-IV Code _____

Diagnosis _____ DSM-IV Code _____

Axis III: General Medical Disorders, including Significant Communicable Diseases

None

If medical disorders are listed above, do any of them limit activities of daily living?
(If yes, please describe.)

Yes

No

Medical & Environmental Allergies
(If yes, please list.)

Yes

No

Current Medications

Psychotropic Medications: (List Names)

Non-Psychotropic Medications: (List Names)

Once Applicant is housed, what Level of Support, if any (new or in place), is required to maintain medication compliance?

None, Independent

Refuses/Noncompliant

Not Applicable/No Medications Prescribed

Medication setup (if checked a referral to Home Health will be made)

CIP SUPPORTIVE HOUSING REFERRAL APPLICATION

Applicant Name: _____

S.S. # _____

List Applicant's current treatment providers, including: medical, psychiatric and substance abuse programs, case manager, day treatment.

	Agency/Program Name	Name of Provider/Contact Person	Phone #
1. Psychiatrist:	_____	_____	_____
2. Case Manager:	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Hospitalizations

(Hospitalization history should be detailed in Psychiatric and Psychosocial Summaries.)

If ever in a psychiatric hospital, age of first psychiatric hospitalization: _____

Estimated number of psychiatric hospitalizations in past 3 Years: _____ Most recent discharge ____/____/____

Is Applicant Currently Hospitalized? No Yes

If yes, Date of Admission: ____/____/____; Service: Psychiatry Medicine Detox

Name of Hospital: _____

Current history of communicable disease Yes No *If yes, please explain*

Symptoms and Behaviors

(Check all that apply. For all items checked Current or History, provide explanation in the Psychiatric and Psychosocial Summaries.)

	CURRENT (Within past 3 months)	HISTORY (If checked, please include date next to box)	NEVER	UNKNOWN
Homicidal Ideation/Attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Ideation/Attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Violent Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disruptive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Criminal Activity/Arrests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arson/Fire setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self injurious behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Registered sex offender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CIP SUPPORTIVE HOUSING REFERRAL APPLICATION

Applicant Name:

S.S. #

Substance Abuse

(If Applicant is currently or has a history of substance abuse, provide elaboration in Psychiatric Summary.)

Is Applicant Currently Abusing Substances? No Yes If yes, specify substance(s): (Check all that apply.)

- | | | | | |
|---------------------------------------|----------------------------------|--|---|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Marijuana/Cannabis/THC | <input type="checkbox"/> Sedatives/Hypnotics |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Crack | <input type="checkbox"/> Opiates | <input type="checkbox"/> PCP | <input type="checkbox"/> Other, specify _____ |

Substance Abuse Pattern: (Check One)

- Less than weekly Once a week Several times a week Daily Unknown

Has Applicant abused substances in the past? No Yes If yes, specify substance(s): (Check all that apply.)

- | | | | | |
|---------------------------------------|----------------------------------|--|---|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Marijuana/Cannabis/THC | <input type="checkbox"/> Sedatives/Hypnotics |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Crack | <input type="checkbox"/> Opiates | <input type="checkbox"/> PCP | <input type="checkbox"/> Other, specify _____ |

Substance Abuse Pattern: (Check One)

- Less than weekly Once a week Several times a week Daily Unknown

Is Applicant now in a Substance Abuse Treatment Program? Yes No Unknown

Has Applicant had a history of substance abuse treatment? Yes No Unknown

If Applicant is Substance-Free, indicate period of sobriety:

Alcohol: Less than 3 months 3 to 6 months 6 months to 12 months 1 year or more

If known, indicate date since Applicant has been alcohol-free: _____
Month/Year

Drugs: Less than 3 months 3 to 6 months 6 months to 12 months 1 year or more

If known, indicate date since Applicant has been drug-free: _____
Month/Year

Recommendations of Referring Agency

Housing Options:

- Shared Housing Bass Lake Rd (family housing)

Services Applicant currently has in place

(Check all that apply, provide explanation of checked items in the Psychosocial Summary.)

- | | |
|---|--|
| <input type="checkbox"/> Ongoing Psychiatric Treatment | <input type="checkbox"/> Day Treatment/ Psychiatric Rehabilitation Program |
| <input type="checkbox"/> Substance Abuse Treatment Service | <input type="checkbox"/> Psychosocial/Clubhouse Program |
| <input type="checkbox"/> Self-Help Group (e.g. 12 step program) | <input type="checkbox"/> Ongoing Medical Treatment |
| <input type="checkbox"/> Medication Management | <input type="checkbox"/> Special Medical Equipment/Supplies |
| <input type="checkbox"/> Case Management Service | <input type="checkbox"/> Psychiatric/Home Health Services |
| <input type="checkbox"/> Rep Payee | <input type="checkbox"/> Therapeutic Diet |
| <input type="checkbox"/> Education, Training, Job Readiness, & Employment | <input type="checkbox"/> Wheelchair/Handicap Access |
| <input type="checkbox"/> ILS | <input type="checkbox"/> Assistance with Housekeeping/Homemaker |
| <input type="checkbox"/> ARMHS | <input type="checkbox"/> Meals Provided to Applicant |

Other, specify: _____

Services Recommended: ILS ARMHS Nursing

CIP SUPPORTIVE HOUSING REFERRAL APPLICATION

Applicant Name: _____

S.S. # _____

Referring Agency Information

Name of Referring Agency: _____

Address: _____ City _____ State _____ Zip _____ - _____

I verify that to the best of my knowledge the information provided in this application is accurate and complete. My signature verifies that the applicant requires housing as part of their mental health recovery plan.

Referring Worker's Name: *(Print)* _____ Title: *(Print)* _____

Signature: _____ Phone: (____) _____ E-mail: _____

Fax: (____) _____ Date: ____/____/____

CIP SUPPORTIVE HOUSING REFERRAL APPLICATION

Applicant Name:

S.S. #

Applicant's Housing Preferences

Applicant should sign and date this form in the area provided at the bottom

- 1. Do you have a particular suburb preference? Yes No
 If Yes, 1st suburb preference: _____ 2nd suburb preference: _____
- 2. Do you mind sharing common areas with roommates? Yes No No Preference
- 3. Do you mind sharing a bathroom with other people? Yes No No Preference
- 4. Are you able to prepare your own food? Yes No No Preference
- 5. Are you able to do your own house cleaning? Yes No No Preference
- 6. Would you be willing to live in housing which requires you to receive support services? Yes No No Preference
- 7. If recommended would you be willing to receive home health services for medication management? Yes No No Preference
- 8. Do you need assistance with: ADL's Transportation Keeping Room Clean Laundry
- 9. Do you have an objection to living in housing that has restrictions on visitors? Yes No No Preference
- 10. Are you currently interested in exploring educational/vocational opportunities? Yes No No Preference
- 11. Are you interested in participating in residence-sponsored social and recreational activities? Yes No No Preference
- 12. Overall, what level of support do you want from staff? High Medium Low None
- 13. Other Housing Requirements/Interests, specify: _____

I understand that along with the housing recommendations of the referring worker and the availability of different types of housing , my housing preferences will be considered in an effort to find an appropriate residence.

Applicant's Signature

Date

Verification Form A: Statement of Mental Illness

This form is to be completed by a physician, or licensed psychologist. All requested information must be provided. Please return this form with your application when completed.

Name of Applicant: _____ DOB: _____

A. Please indicate whether or not the following conditions apply to the applicant:

- | | | |
|------|------|--|
| Yes | No | |
| ____ | ____ | 1. A diagnosed mental illness which impacts the applicant's ability to live independently. |
| ____ | ____ | 2. A permanent physical functioning limitation which impacts the applicants ability to live independently. |
| ____ | ____ | 3. A sensory impairment which impacts the applicant's ability to live independently. |

B. How many days was the applicant hospitalized for psychiatric reasons the last calendar year? _____

C. Please describe the applicant's disability or illness: (include diagnosis)

D. List medications, therapies and/or other treatment this applicant is receiving:

E. Please describe the kind of supportive services you feel would enable this applicant to live independently in the community:

F. Date that you last examined this applicant: _____

I certify that I have the medical information to document the above statements and will provide such documentation to Community Involvement Programs at the request of the applicant.

Name of Professional

Signature of Professional

Profession

MN License #

Office Address

Date

Verification Form B - Public Funding Source/Employment

Part 1: Public Funding Sources: - if you receive State or Federal assistance (such as SSI, MSA, GA, RSDI) please have your financial worker fill out the Part 1 of this form.

Name of Applicant: _____ Social Security # _____ - _____ - _____

A. Check the type of public assistance received and write in amount of monthly assistance.

____ Social Security (RSDI) \$ _____

____ Social Security (SSI) \$ _____

____ MN Supplemental Aid (MSA) \$ _____

____ MN General Assistance (GA) \$ _____

____ Other _____ \$ _____

B. If you do not receive SSI, have you ever applied for it? _____

I certify that the above information is to the best of my knowledge correct and reflects current eligibility.

Signature of person completing form

Date

Part 2 - Employment Verification Request

To be completed by your employer

Name of Employee: _____

Position: _____

Currently Employed? ____
Yes No

Date Employment Began: _____ Pay Rate \$ _____ Hours per week: _____

Benefits (check that apply) _____ health _____ life _____ disability _____ vacation

Employer: _____

Authorized Signature: _____ Phone Number: _____

Address: _____

Housing Skills and Supports Checklist

This form should be completed by the applicant's current Case Manager or Support Staff to help identify their service needs. This form should be submitted with the completed application. The following skills are necessary, in varying degrees, for living successfully in the community.

Use checks to represent the level of assistance needed.

= **Almost never needs assistance**

= **Sometimes needs assistance**

= **Almost always needs assistance**

Money management skills and ability to pay rent (keep up with entitlement/benefits paperwork, cash checks, budget)

Ability to follow house rules (refrain from violence, keep noise down during hours of sleep, refrain from criminal activity, wear appropriate clothing in common spaces)

Housekeeping skills (able to clean space, wash sheets, remove garbage regularly, keep out mice and insects, remove excess clutter, maintain plumbing [remove hairs from drain, keep large items out of toilet])

Personal care skills (washing clothes, buying and using toiletries, dress appropriate to weather, bathing)

Travel skills (use public transportation, follow directions)

Shopping and cooking skills (able to obtain meals by buying or cooking food, store food properly)

Social skills (sensitivity to and respect for the needs and rights of others, conflict management skills, ability to maintain positive relationships)

Social supports (connections to family and significant others, needs for interaction or time alone)

Awareness of service needs and ability to seek and accept help

Communication skills (able to make needs known, ask for clarification when not clear about what others have said)

Ability to manage health, substance use, and psychiatric care (make and keep appointments, manage Medicaid or health insurance paperwork requirements, take medication as prescribed, advocate and communicate with doctors)

Awareness of substance use, relapse patterns, and consequences of use (disruptive behavior, deteriorated health, rent payment, inability to work, relapse triggers)

Ability to pursue goals (planning, prioritizing, and accessing needed resources; problem-solving and negotiation skills)



AUTHORIZATION SUPPORT SERVICES

Community Involvement Programs

_____ has applied for tenancy in CIP Shared Housing.

Please complete the following form, which authorizes CIP to provide support services to this individual. It is understood that the individual may be receiving and may continue to receive additional support from other mental health providers.

I authorize Community Involvement Programs to provide support services to:

Agency _____

FD/MI #: _____

Case Manager (print): _____

Phone Number: _____

Signature: _____ Date: _____

Supervisor Name _____

Supervisor Phone Number _____

Supervisor Signature (Front Door Only) _____ Date: _____

Please return form to: Community Involvement Programs
1600 Broadway Street SE
Minneapolis, MN 55413
Fax: (612) 362-4479

Questions/Comments: Emily Self
Shared Housing Coordinator
Office: (612) 362-4417
Cell: (612) 290-7522
Email: eself@cipmn.org



Criminal Background Check Consent Form

I hereby give my permission to Community Involvement Programs (CIP) to obtain information relating to my criminal history record. The criminal history record, as received from the reporting agencies, may include arrest and conviction data as well as plea bargains and deferred adjudications and delinquent conduct committed as a juvenile.

I understand that this information will be used as part of the screening process for CIP Supportive/Shared Housing.

I, the undersigned, do, for myself, my heirs, executors and administrators, hereby remise, release and forever discharge and agree to indemnify CIP, and each of their officers, directors, employees, and agents and hold them harmless from and against any and all causes and actions, suits, liabilities, costs, debts and sums of money, claims and demands whatsoever (including claims for negligence, gross negligence, and/or strict liability of CIP) and any and all related attorneys' fees, court costs and other expenses resulting from the investigation of my background in connection with my application for CIP Supportive/Shared Housing.

States of residence for the last five (5) years:

Signature of applicant

Printed name of applicant

Date



CIP – HOMELESSNESS ELIGIBILITY DETERMINATION

Tenant Name: _____
Social Security Number: _____ Date of Birth: _____

In order to be eligible to apply for a McKinney/SHP or Shelter plus care housing subsidy at Community Involvement Programs, HUD requires that the homelessness status of participants be documented. To facilitate program participation, please fill out all appropriate areas below. **In order to be utilized this form must be fully completed. This includes providing a check mark and a narrative response to both Part A and B and being copied onto agency letterhead.** Please return to:

CIP Shared Housing
1600 Broadway St NE
Minneapolis, MN 55413
Or faxed to 612-362-4479

A. According to HUD’s federal definition, a person is considered “homeless” only when he/she resides in one of the places described below. Please check all that apply for the accurate description of the applicant’s status and complete the narrative section attached to each check box:

1. _____ **Persons coming from the streets or places not meant for human habitation (cars, parks, sidewalks, abandoned buildings etc.).**
Please provide a statement regarding specific details, dates and time periods of this situation: _____

2. _____ **Persons coming from emergency shelter.**
Please verify all past specific dates, time periods and shelters that the applicant resided at: _____

3. _____ **Persons coming from transitional housing or supportive housing who also originally came from the streets or emergency shelters.**
Please verify the specific place and dates of transitional or supporting housing residence, along with specific verification that the applicant previously came from the streets or emergency shelters: _____

4. _____ **Persons in any of the above 3 places but is spending a short time (up to 30 consecutive days) in a hospital or other institution.**
Please verify specific place and dates of both past and current living status: _____



**COMMUNITY
INVOLVEMENT
PROGRAMS**

STANDING WITH AND SUPPORTING PEOPLE WITH DISABILITIES

5. _____ **Persons at risk of becoming homeless due to eviction.**

Please verify and provide evidence that the applicant is facing immediate eviction without adequate resource to find replacement housing: _____

6. _____ **Persons at risk of becoming homeless due to leaving institution (such as a mental health, substance abuse treatment facility or a jail/prison) in which the person has been a resident for more than 30 consecutive days with no identified subsequent residence and the person lacks the resources and support networks needed to obtain housing.**

Please verify specific information regarding the name of institution, days of the applicants stay and information why the person would be living on the streets or in an emergency shelter without SHP assistance: _____

I verify that the above information is true to the best of my knowledge,

Printed name of person completing Homelessness Eligibility determination:

Signature of person completing Homelessness Eligibility determination:

Agency: _____

Telephone: _____ Fax: _____ Date Signed _____

Tenant Signature and Date: _____
