

TBRA Application:

General Information:

For assistance with completing this application, contact Pat Brown at the DCA Office of Programs and Public Affairs at Patrick.Brown@dca.ga.gov or at (404) 679-0630. For application processing and wait list information, call (404) 982-3581. TTD operator at (404) 679-4915. DCA has a variety of services available to assist persons with disabilities, elderly, or persons with limited English proficiency complete this application and to access this program and other programs at DCA.

Fax completed applications and the four Attachments to DCA TRA Office at (770) 359-3799. Completed applications can be scanned and emailed to DCA but they need to be password protected to protect the application's confidential health care information. Applications can also be mailed to DCA at 60 Executive Park South NE, Atlanta, GA 30329-2231 or hand delivered to the same address.

DETAILED PROGRAM INFORMATION

For an overview of DCA's HOME Tenant-Based Rental Assistance programs and to download the applications and all the forms used in processing the rental assistance, visit: <http://dca.ga.gov>.

An incomplete application slows review time and delays assistance for your client. For the fastest possible determination of eligibility:

Be sure you have the most current version of the application before you begin. Also, don't forget to download the Four required Attachments to the application.

Read the instructions found throughout the application to be sure you are filling it out correctly. If you have a question or need help, it's better to contact DCA first than to submit an application you're not sure is complete and correct.

Fill out the Service Plan **Attachment A** in detail if you are not submitting a copy of your agency's Service Plan or Treatment Plan. Include the names of all practitioners the applicant sees, how often he or she sees the applicant, and all details relevant to the categories listed—even if they describe future plans of action rather than issues currently being worked on. Do not leave any sections blank unless they do not apply to the Applicant.

Include documentation of the Applicant's disability **Attachment B. This is required.** No Applicant can be found eligible for assistance without this documentation. DCA does not need the details about the applicant's disability only that they meet one or more of the base disability requirements for the program. The MFP Referral Form can also be substituted for Attachment B.

Attachment C is the HIPAA Authorization that allows the DCA TBRA housing staff to discuss housing information with the case manager, service provider and other specified persons related to assisting the applicant in securing and maintaining affordable housing.

DCA requires that all applicants are on a wait list for Section 8 or some other form of rental assistance. The applicant may use this form for this purpose or they can bring in written documentation from the housing authority or property manager verifying that they are on a wait list for rental assistance. This is **Attachment D.**

Sign the form in all areas where required. Both the Case Manager and the applicant must sign in multiple locations.

Make sure the application is legible and will remain so after you fax it to us. **Use only dark-colored ink.**

Save time and paper—don't fill out and fax us pages we don't need. Don't fax us these instructions or the Application Checklist. If you are a single individual applying, don't fill out or fax us the 'Other Adults' and 'Minors' pages in Sections 5 and 6.

Fair Housing: The HOME TBRA program is a Fair Housing and Equal Opportunity Program. The Georgia Department of Community Affairs does not discriminate on the basis of race, color, national origin, sex, religion, age, or disability in employment or services.

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful, false statements of misrepresentation to any department or agency of the United States or to any matter within its jurisdiction.

TBRA Application:

CHECKLIST

The purpose of this checklist is to help you complete an Application for DCA HOME TBRA.

Please do not send this page with the application.

- Check to make certain that Sections 1-14 of the application are filled out completely. Skip Section 5 if there are no other adults in the household; skip Section 6 if there are no minor children in the household.
- Check to make certain that the applicant has signed the Applicant Certifications in Section 13 and their Case Manager has also signed in Section 14.
- Attachment A:** Tenant Service Plan - is completely filled out. You may also choose to submit a copy of your agency's current Treatment or Service Plan instead of completing the one in this application packet.
- Attachment B:** Disability Verification - is completely filled out with at least ONE disability option checked. Make certain that the form is signed by a person with the proper credentials. The MFP referral form can be substituted for the Disability Verification in this packet.
- Attachment C:** HIPAA Consent for Disclosure of Applicant's Protected Health Information - is completely filled out and signed by the Applicant and a witness.
- Attachment D:** Status on Section 8 or HCV Wait List Verification - is completely filled out and signed by a housing authority or other rent subsidy provider or property manager. If the applicant has a housing plan that does not include the use of government funded rental assistance, we will need a written housing plan indicating the housing arrangement that the applicant plans to move to when the TBRA rental assistance expires.
- A copy of the Applicant's documentation of legal non-citizen status is attached, if applicable. This only applies to an applicant that does not have a US birth certificate or other verification that they are a US citizen.

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TBRA Application:

➤ SECTION 1. Applicant Information

Applicant Name:

First: _____ Middle _____ Last: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

➤ SECTION 2. Case Manager Contact

All applicants must be referred by a State approved Money Follows the Person (MFP) participating agency.

Case Manager: _____

Agency: _____

Office Phone: (_____) _____ Fax (_____) _____

Cell Phone: (_____) _____ Email: _____

➤ SECTION 3. Emergency Contact

Name: _____ Relationship: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Cell: (_____) _____

Referral Program	DCA Housing Use Only	
MFP Contact Information	Agency: _____	Contact Person: _____
Waiver Y <input type="checkbox"/> N <input type="checkbox"/>	Address: _____	Phone: _____

Forms	Applicant <input type="checkbox"/>	Other Adults <input type="checkbox"/>	Minors <input type="checkbox"/>	Disability <input type="checkbox"/>	Service Plan <input type="checkbox"/>
Eligibility	Income 60% <input type="checkbox"/>	Nursing Home <input type="checkbox"/>	PRTF <input type="checkbox"/>	Hab Center <input type="checkbox"/>	Group Home <input type="checkbox"/>
Disability	Youth SMI <input type="checkbox"/>	Elderly <input type="checkbox"/>	TBI <input type="checkbox"/>	PD <input type="checkbox"/>	I/DD <input type="checkbox"/>
IDIS Number:			MITAS Number:		
Wait List Approved	Date: _____		DCA Staff		

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TBRA Application:

➤ SECTION 4. APPLICANT'S INFORMATION

Applicant Name: _____

U.S citizen Eligible non-citizen
Applicant's primary language: _____

If the primary language is not English, can the Applicant speak limited English? Yes No
Country of origin if not U.S.: _____

Race:
 American Indian/Alaska Native
 American Indian/Alaska Native & Black or African American
 American Indian/Alaska Native & White
 Asian
 Asian & White
 Black/African-American
 Black/African-American & White
 Native Hawaiian/Other Pacific Islander
 White
 Other Multi-Racial

Ethnicity:
 Hispanic Non-Hispanic

Gender:
 Male Transgender, male to female
 Female Transgender, female to male

Marital Status:
 single separated
 married divorced
 widowed same-sex couple

Are you pregnant? Yes No No.of months: _____
 Delivery date: _____ / _____ / _____

Temporary Address/Location:
 Where do you currently live? Provide at least a city and zip code.
 Street address _____ Apt. _____
 City _____ State _____
 Zip Code _____ Phone _____

Last Permanent Address/Location:
 Where did you last live for at least 90 days where you paid rent or had a mortgage? Provide at least a city and zip code.
 Street address _____ Apt. _____
 City _____ State _____ Zip Code _____

If you are currently homeless please answer questions 1 to 4, if you are not homeless go to question 5.

- Where did you spend the night before filling out this application?**
 - Emergency shelter (includes a motel or hotel room paid for by an emergency shelter voucher; and a respite bed)
 - Transitional housing program
 - A place not meant for human habitation (car, park, etc.)
 - Jail, prison or juvenile detention center
 - Substance abuse treatment facility/detox center
 - Safe Haven
 - Hospital (non-psychiatric)
 - Psychiatric hospital or similar facility
 - Other
- How long did you stay in the above situation?**
 - One week or less 1-2 years
 - More than one week 2-4 years
 - 1-3 months Four or more years
 - 4-6 months Don't know
 - 7-12 months
- Do you have health insurance? Check all that apply.**
 - Medicare private insurance
 - Medicaid medication assistance
 - VA Medical no insurance
- What is the primary reason for your homelessness? Check one.**
 - stranded/transient relocating
 - physical abuse loss of income
 - insufficient income fire
 - kicked out of house housing condemned
 - substandard housing no power
 - no water eviction
 - building sold spousal desertion
 - mental health issues Section 8 violation
 - drug/alcohol issues never lived independently
 - high-risk neighborhood Katrina, etc.
 - marriage/separation victim of crime
 - displaced institution discharge
 - shelter termination employment situation
 - domestic violence disaster
 - mental/emotional abuse release from incarceration
- Have you ever been a victim of domestic violence?**
 - Yes No Don't Know Refuse to Answer
- If yes, how long in the past did this occur?**
 - Within past three months
 - 3-6 months ago
 - 6-12 months ago
 - More than one year ago
 - Don't Know Refused to Answer
- Are you currently in school and/or working on any degree or certificate?** Yes _____ No _____
- Have you received vocational training or been in a trade apprenticeship** Yes _____ No _____

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TBRA Application:

APPLICANT'S NAME: _____

✓ **SECTION 4 - Continued**

What is the highest grade you've completed?

- no school completed
- nursery school to 4th grade
- 5th grade to 6th grade
- 7th grade to 8th grade
- 9th grade
- 10th grade
- 11th grade
- 12th grade, no diploma
- high school diploma
- GED
- Associates degree
- some college, no degree
- Bachelor's degree
- Master's degree
- doctorate
- other graduate or post-secondary education
- Certificate of advanced training or skilled artisan
- Don't Know

Are you employed? Yes No

If yes, what type of employment is it?

- Permanent Temporary Seasonal

How many hours did you work last week? _____

If not employed, are you looking for work?

- Yes No

What is your general physical health status?

- Excellent Very good Good Fair
 Poor

Do you have a mental illness?

- Yes No Don't Know

If yes, is the mental illness a disabling condition?*

- Yes No

[If Attachment A, "Disability Verification," indicates a mental illness or a dual diagnosis, you must answer "yes" to the above.]

Are you receiving services or treatment for the mental illness? Yes No

Do you have a substance abuse disorder?

- Yes, alcohol abuse yes, drug abuse
 Yes, both alcohol and drug abuse
 No Don't Know

If yes, is the substance abuse disorder a disabling condition? Yes No

[If Attachment A, "Disability Verification," indicates a substance abuse disorder, you must answer "yes" to the above.]

Are you receiving services or treatment for the substance abuse disorder?

- Yes No

Do you have HIV or AIDS?

- Yes No Don't Know

If yes, is this a disabling condition?

- Yes No

[If Attachment A, "Disability Verification," indicates a diagnosis of HIV or AIDS, you must answer "yes" to the above.]

If yes, are you receiving services or treatment for HIV or AIDS?

- Yes No

Do you have a developmental disability?*

- Yes No Don't Know

If yes, is the developmental disability a disabling condition?

- Yes No

[If Attachment A, "Disability Verification," indicates a developmental disability diagnosis, you must answer "yes" to the above.]

If yes, are you receiving services or treatment for the developmental disability?

- Yes No

Do you have a chronic health condition*?**

- Yes No Don't Know

If yes, please specify what the condition is:

If yes, is the chronic health condition a disabling condition?

- Yes No

If yes, are you receiving services or treatment for the chronic health condition?

- Yes No

Do you have a physical disability?

- Yes No Don't Know

If yes, please specify what the disability is:

If yes, is the physical disability a disabling condition?

- Yes No

Are you receiving services or treatment for the physical disability?

- Yes No

* "Disabling condition" means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

** "Developmental disability" includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and some learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

*** **Chronic health conditions** include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

TBRA Application:

APPLICANT'S NAME: _____

✓ SECTION 5.

INFORMATION ABOUT OTHER ADULTS IN HOUSEHOLD (ANYONE 18+ YEARS OLD)

Use additional copies of Section 5 if the Applicant's household has more than one adult aside from the Applicant. Omit this section if there are no other adults in the household.

Other Adult's Name: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____ / _____ / _____

Race:

- American Indian/Alaska Native
- American Indian/Alaska Native & Black or African American
- American Indian/Alaska Native & White
- Asian
- Asian & White
- Black/African-American
- Black/African-American & White
- Native Hawaiian/Other Pacific Islander
- White
- Other Multi-Racial

Ethnicity:

- Hispanic
- Non-Hispanic

Gender:

- Male
- Female
- Transgender, male to female
- Transgender, female to male

What is this adult's relationship to the Applicant?

- spouse
- parent
- aunt
- brother
- son
- niece
- significant other/partner
- step-parent
- uncle
- sister
- daughter
- nephew
- grandparent
- roommate
- step-child
- other

Is this adult pregnant? Yes No No. of months: _____

Temporary Address/Location:

Check here if this adult currently lives at the same location as the Applicant; if the location is different, fill it in below. Please provide at least a city and zip code.

Street address _____ Apt. _____
City _____ State: _____ Zip: _____
Telephone _____

Last Permanent Address/Location:

Check here if this adult's last permanent address was the same as the Applicant's; if it was different, fill it in below. Please provide at least a city and zip code.

Street address _____ Apt. _____
City _____ State _____ Zip _____

If you are currently homeless please answer questions 1-2, if you are not homeless go to question 3.

1. Where did this adult spend the night before this application was filled out?

- Emergency shelter (includes a motel or hotel room paid for by an emergency shelter voucher; and a respite bed)
- Transitional housing program
- A place not meant for human habitation (car, park, etc.)
- Jail, prison or juvenile detention center
- Substance abuse treatment facility/detox center
- Safe Haven
- Hospital (non-psychiatric)
- Psychiatric hospital or similar facility
- Other

2. How long did this adult stay in the above situation?

- One week or less
- More than one week but less than one month
- 1-3 months
- 4-6 months
- 7-12 months
- 1-2 years
- 2-4 years
- Four or more years
- Don't know

3. Has this adult ever been a victim of domestic violence?

- Yes No Don't Know Refuse to Answer

4. If yes, how long in the past did this occur?

- Within past three months
- 3-6 months ago
- 6-12 months ago
- More than one year ago
- Don't Know
- Refused to Answer

5. Is this adult currently in school and/or working on any degree or certificate?

- Yes No

6. Has this adult received vocational training or been in a trade apprenticeship?

- Yes No

7. What is the highest grade completed by this adult?

- no school completed
- nursery school to 4th grade
- 5th grade to 6th grade
- 7th grade to 8th grade
- 9th grade
- 10th grade
- 11th grade
- 12th grade, no diploma
- high school diploma
- GED
- Associates degree
- some college, no degree
- Bachelors degree
- Masters degree
- doctorate
- other graduate or post-secondary education
- Certificate of advanced training or skilled artisan
- Don't Know

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TBRA Application:

APPLICANT'S NAME: _____

➤SECTION 5—Continued

Other Adult's Name: _____

Is this adult employed? Yes No

If yes, what type of employment is it?

Permanent Temporary Seasonal

How many hours did this adult work last week? _____

If not employed, is this adult you looking for work?

Yes No

What is this adult's general physical health status?

Excellent Very good Good Fair Poor

Does this adult have a mental illness?

Yes No Don't Know

If yes, is the mental illness a disabling condition?*

Yes No

If yes, is this adult receiving services or treatment for the mental illness? Yes No

Does this adult have a substance abuse disorder?

Yes, alcohol abuse yes, drug abuse

Yes, both alcohol and drug abuse

No Don't Know

If yes, is the substance abuse disorder a disabling condition? Yes No

If yes, is this adult receiving services or treatment for the substance abuse disorder?

Yes No

Does this adult have HIV or AIDS?

Yes No Don't Know

If yes, is this a disabling condition?

Yes No

If yes, is this adult receiving services or treatment for HIV or AIDS? Yes No

Does this adult have a developmental disability?*

Yes No Don't Know

If yes, is the developmental disability a disabling condition?*

Yes No

If yes, is this adult receiving services or treatment for the developmental disability?

Yes No

Does this adult have a chronic health condition*?**

Yes No Don't Know

If yes, please specify what the condition is:

If yes, is the chronic health condition a disabling condition?

Yes No

If yes, is this adult receiving services or treatment for the chronic health condition?

Yes No

Does this adult have a physical disability?

Yes No Don't Know

If yes, please specify what the disability is:

If yes, is the physical disability a disabling condition?

Yes No

If yes, is this adult receiving services or treatment for the physical disability?

Yes No

* **"Disabling condition"** means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

** **"Developmental disability"** includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

*** **Chronic health conditions** include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

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APPLICANT'S NAME:

SECTION 6.

INFORMATION ABOUT MINORS IN HOUSEHOLD (ANYONE 17 YEARS OLD OR YOUNGER)

Fill out one Section 6 per minor that will live in the Applicant's household. Omit this section if there are no minors in the household.

Minor's Name: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____ / _____ / _____

Does the Applicant have legal custody of this minor?

Yes No

Race:

- American Indian/Alaska Native
- American Indian/Alaska Native & Black or African American
- American Indian/Alaska Native & White
- Asian
- Asian & White
- Black/African-American
- Black/African-American & White
- Native Hawaiian/Other Pacific Islander
- White
- Other Multi-Racial

Ethnicity:

- Hispanic
- Non-Hispanic

Gender:

- Male
- Female
- Transgender, male to female
- Transgender, female to male

What is this minor's relationship to the Applicant?

- brother sister
- son daughter step-child
- niece nephew grandchild
- other

Is this minor pregnant? Yes No No. of months: _____

Temporary Address/Location:

Check here if this minor currently lives at the same location as the Applicant; if the location is different, fill it in below. Provide at least a city and zip code.

Street address _____ Apt. _____

City _____ State _____

Zip Code _____

Telephone _____

Last Permanent Address/Location:

Check here if this minor's last permanent address was the same as the Applicant's; if it was different, fill it in below. Provide at least a city and zip code.

Street address _____ Apt. _____

City _____ State _____ Zip Code _____

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If the minor child is currently homeless please answer questions 1 to 2, if they are not homeless go to question 3.

1. Where did this minor spend the night before this application was filled out?

- Emergency shelter (includes a motel or hotel room paid for by an emergency shelter voucher; and a respite bed)
- Transitional housing program
- A place not meant for human habitation (car, park, etc.)
- Jail, prison or juvenile detention center
- Substance abuse treatment facility/detox center
- Safe Haven
- Hospital (non-psychiatric)
- Psychiatric hospital or similar facility
- Other

2. How long did this minor stay in the above situation?

- One week or less 1-2 years
- More than one week 2-4 years
- 1-3 months Four or more years
- 4-6 months Don't know
- 7-12 months

3. Is this minor currently enrolled in school?

Yes No the minor is not old enough

If yes, please give the name of the school:

4. If enrolled, is this minor connected with the school district's official homelessness coordinator?

Yes No Don't Know

5. If enrolled, what type of school does the minor attend?

- public (includes charter schools)
- parochial or private
- don't know

If not enrolled, give the most recent date of enrollment:

_____ / _____ / _____

6. If the minor is old enough to attend school but is not enrolled, please identify any problems or obstacles to enrollment:

- none
- residency requirements
- availability of school records
- birth certificate
- legal guardianship requirements
- transportation
- lack of available preschool programs
- immunization requirements
- physical examination records
- other don't know

7. Has this minor ever been a victim of domestic violence?

Yes No Don't Know Refuse to Answer

8. If yes, how long in the past did this occur?

- Within past three months
- 3-6 months ago 6-12 months ago
- More than one year ago
- Don't Know Refused to Answer



APPLICANT'S NAME:

✓ **SECTION 6.—Continued**

Minor's name: _____

What is the minor's general physical health status?

Excellent Very good Good Fair Poor

Does the minor have a mental illness?

Yes No Don't Know

If yes, is the mental illness a disabling condition?

Yes No

If yes, is the minor receiving services or treatment for the mental illness? Yes No

Does the minor have a substance abuse disorder?

Yes, alcohol abuse yes, drug abuse
 Yes, both alcohol and drug abuse
 No Don't know

If yes, is the substance abuse disorder a disabling condition?

Yes No

If yes, is the minor receiving services or treatment for the substance abuse disorder?

Yes No

Does the minor have HIV or AIDS?

Yes No Don't know

If yes, is this a disabling condition?

Yes No

If yes, is the minor receiving services or treatment for HIV or AIDS?

Yes No

Does the minor have a developmental disability?*

Yes No Don't know

If yes, is the developmental disability a disabling condition?

Yes No

If yes, is the minor receiving services or treatment for the developmental disability?

Yes No

Does the minor have a chronic health condition*?**

Yes No Don't know

If yes, please specify what the condition is:

If yes, is the chronic health condition a disabling condition?

Yes No

If yes, is the minor receiving services or treatment for the chronic health condition?

Yes No

Does the minor have a physical disability?

Yes No Don't know

If yes, please specify what the disability is:

If yes, is the physical disability a disabling condition?

Yes No

If yes, is the minor receiving services or treatment for the physical disability?

Yes No

* **"Disabling condition"** means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

** **"Developmental disability"** includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

*** **Chronic health conditions** include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

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APPLICANT'S NAME:

✓ **SECTION 7. INCOME**

Have you or anyone who will live with you received cash income from any source in the past 30 days? Yes No

If yes, please check the boxes next to all sources of **CASH** income in the list below received by all household members (do not include food stamps) and state the amount received per month.

- Type Amount/Month** _____
- Employment income \$ _____
 - Child support \$ _____
 - Social Security Disability (SSDI) \$ _____
 - Supplemental Security Income (SSI) \$ _____
 - Social Security retirement \$ _____
 - TANF \$ _____
 - Veteran's pension \$ _____
 - Veteran's disability payment \$ _____
 - Unemployment Insurance \$ _____
 - Alimony/other spousal support \$ _____
 - Pension from a former job \$ _____
 - Worker's Compensation \$ _____
 - Private disability insurance \$ _____
 - Other sources of income \$ _____

Specify any other sources of cash income and amount below:

If any of the income sources checked above are received by a household member other than the Applicant, please describe here:

Have you or anyone who will live with you received non-cash benefits or services in the past 30 days? Yes No

Please check all sources of **NON-CASH** benefits and services.

Type Name of household member receiving assistance

- Food stamps/EBT _____
- Specify food stamp amount/month: _____
- Medicaid/MO HealthNet _____
 - Medicare _____
 - WIC _____
 - TANF childcare services _____
 - TANF transportation services _____
 - Other TANF-funded services _____
 - Children's Health Insurance Program _____
 - VA Medical Services _____
 - Other assistance source _____

➤ **SECTION 8. ZERO INCOME DECLARATION**

Complete this section only if the Applicant has NO cash income.

➤ **APPLICANT:** If you have no cash income, please read the statement below, then print your name, sign your name, and fill in the date. *Please be aware that falsification of this statement is grounds for denial or termination of housing assistance.*

To the best of my knowledge and belief, I have no income at the time of making this application.

➤ _____
(Print Applicant Name)

➤ _____
(Sign Applicant Name)

_____ / _____ / _____
(Date)

➤ **CASE MANAGER:** If the Applicant has no cash income, please read the statement below, then print your name, sign your name, and fill in the date.

To the best of my knowledge and belief, _____ (print applicant name) has no income at the time of making this application.

➤ _____
(Print Case Manager Name)

➤ _____
(Sign Case Manager Name)

➤ _____ / _____ / _____
(Date)

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APPLICANT'S NAME: _____

✓ **SECTION 9. ASSET INFORMATION**

Assets: Please list all checking, savings, and investment accounts below for all persons that will be living in your household.

Household Member's Name	Bank/Institution Name	Account Number	Types of Account (checking, savings, investment)	Current Balance

List the value of all stocks, bonds, trust, pension contributions or other assets: _____

Have you sold or given away real property or assets in the past two years? Yes No

If yes, what is the current market value of the asset: _____

✓ **SECTION 10. EXPENSES**

Expenses: Please provide the information requested below. These answers may help reduce the amount of rent for which you will be responsible in DCA's HOME TBRA program.

Do you pay for childcare that enables you or another household member to work or go to school.?

If yes, give the name and address of the childcare provider, weekly cost and the name of the household member working or in school:

Provide Name & Address:

Name of household member who works or goes to school: _____

Weekly Cost: _____

Do you pay for a care attendant or for any equipment for a disabled member of the household necessary to permit that person or someone else in the household to work? Yes No

If yes, give the name of the household member who works because of this expense:

Do you incur unreimbursed medical expenses on a regular basis? Yes No

If yes, amount per month: \$ _____

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Do you owe money on back rent? Yes No

If yes, amount: \$ _____

Do you owe money on past due utility bills?

Yes No

If yes, amount: \$ _____

Do you or any member of your household owe money to any Housing Authority or any housing assistance program?

Yes No

If yes, amount: \$ _____

➤ SECTION 11. Criminal Background

Have you or any member of your household been evicted from public housing or a Housing Choice Voucher program because of drug or drug-related criminal activity? Yes No

Are you or any member of your household illegally using a controlled substance or abuse alcohol? Yes No

Do you and all members of your household have U.S Citizenship or have eligible immigration status? Yes No

Are you or any member of your household subject to a lifetime registration under a State Sex Offender Registration Program?
 Yes No

Have you or any member of your household been convicted of a violent criminal act or a felony drug-related act within the past 3 years? Yes No

Have you or any member of your household been terminated from another assisted housing program for fraud within the last two years? Yes No

Have you or any member of your household been convicted of the manufacture and/or sales of methamphetamine?
 Yes No

✓ SECTION 12. VETERANS STATUS

Is anyone in this household a veteran? Yes No

If yes, name: _____

If no, skip the rest of this section.

What date did the veteran begin military service?

_____/_____/_____

What branch was served in?

Army Air Force Navy Marines
 Other Don't know

When was the service? Choose one; if the service dates overlap two choices, choose the one containing most of the service time.

- Post-September 11th (September 11, 2001-present)
- Persian Gulf (August 1991-September 10, 2001)
- Post-Vietnam (May 1975-July 1991)
- Vietnam (August 1964-April 1975)
- Between Korea and Vietnam (Feb. 1955-July 1964)
- Korea (June 1950-January 1955)
- Between WW2 and Korea (August 1947-May 1950)
- WW2 (September 1940-July 1947) Don't know

Duration of Active Duty: _____ Enter months served

Was the service in a war zone? Yes No Don't Know

If yes, which one?

- Europe North Africa Vietnam
- Laos and Cambodia South China Sea
- China, Burma, India Korea South Pacific
- Persian Gulf Afghanistan Don't know

Number of months in war zone: _____

Did the veteran receive fire, either hostile or friendly?

Yes No Don't Know

Discharge Status: Honorable General

Medical Bad Conduct Dishonorable
 Other Don't Know Refused to Answer

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➤ **SECTION 13. APPLICANT CERTIFICATIONS** □

Applicant: please read the paragraphs below and then sign to show that you have read the information, understand it and agree to it.

- ✓ I understand that if I am approved to receive assistance from the Department of Community Affairs TBRA program, I agree to follow all of the rules of the TBRA program.
- ✓ I understand that I must report all increases and decreases in my income to my local processing center agency within 30 days of the change in income;
- ✓ I understand that I must adhere to the Service Plan that I established with the agency that is referring this application to the Department of Community Affairs;
- ✓ I understand that if my referring agency can no longer provide case management or supportive services, I will secure a new agency of my choice to provide those services.
- ✓ I understand that if I change supportive service agencies I must notify my local processing center agency of the change within 30 days.
- ✓ I understand that having support services is not a mandatory requirement of the TBRA program and that I'm under no obligations to maintain support services as a condition of this program.
- ✓ I understand that as a TBRA participant I am required to obey the rules and restrictions of my lease, including paying my share of rent on time, not disturbing fellow tenants, and keeping my unit clean and free of damages.
- ✓ I certify that all information given on this application by me or other parties is accurate and complete to the best of my knowledge and belief. I also understand that making false statements or providing false information is grounds for denial or termination of rental assistance.

➤ _____
(Print Name of Applicant, or of Parent, Guardian or Legal Representative of Applicant)

➤ _____
(Signature of Applicant, or of Parent, Guardian or Legal Representative of Applicant)

➤ _____ / _____ / _____
(Date)

➤ **SECTION 14. CASE MANAGER CERTIFICATIONS**

CASE MANAGER: please read the following and indicate your understanding and agreement by signing below.

- ✓ I understand that by referring this Applicant to the TBRA program, my agency is committing to providing case management and/or other supportive services for the Applicant for as long as the Applicant continues to qualify for such services. In the event that my agency is unable to continue services to the applicant, I will assist the applicant in connecting with another support service provider that will assist them with fulfilling their obligations and commitments to the TBRA program.
- ✓ I will ensure that all children in this household are properly enrolled in school and are connected to the appropriate services within the community, including early childhood education programs.
- ✓ I will attend the initial TBRA orientation with the Applicant at the local housing processing center agency, once the applicant has been approved to receive TBRA assistance.
- ✓ I will assist the Applicant in his or her housing search once the Applicant is approved for TBRA assistance.
- ✓ I will ensure that this Applicant for TBRA receives case management services consistent with the Service Plan included in this application, and that those services will be adequate to help him or her maintain stable independent housing. DCA strongly recommends at least one visit per quarter to the Participant's home.
- ✓ I understand that if I leave my position or if this Applicant is assigned to a different Case Manager, I am responsible for ensuring that DCA is notified of the change in case management and for facilitating the transfer of services to another person or agency.

✓ I understand that making false statements or providing false information is grounds for denial or termination of the Applicant's rental assistance.

✓ I certify that all information provided on this application is accurate and complete to the best of my knowledge and belief.

➤ _____
(Print Name of Case Manager)

➤ _____
(Signature of Case Manager)

➤ _____
(Name of Agency Employing Case Manager)

➤ _____ / _____ / _____
(Date)

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Tenant Service Plan Attachment A

INSTRUCTIONS: Use this form to identify the service plan that will help the Applicant achieve stable housing and increase his or her self-sufficiency and job skills. For all types of services, list both the name of the provider and the frequency with which the Applicant receives or attends the service. Please provide as much detail as possible, even if the service is not in place yet or the goal not yet achieved.

APPLICANT NAME: _____

* Denotes REQUIRED field

Mental Health Services

Doctor, Psychologist or Psychiatrist visits: _____

Therapist visits: _____

Group therapy: _____

Case management: _____

Substance Abuse Treatment and Aftercare

Treatment services: _____

Aftercare: _____

Case management: _____

AA/NA meetings: _____

Relapse plan and sponsor: _____

Intellectual/Developmental Disability Services

Doctor visits: _____

Therapist visits: _____

Case management: _____

Senior Services and Employment/Training

Vocational rehabilitation: _____

Supported employment: _____

Case management follow-ups: _____

Employment and training goals: _____

Income and Benefits

Applied for benefits: _____

Appeals for benefits: _____

Benefits goals: _____

Case management follow-ups: _____

Housing

*Other forms of housing assistance applied for:

Section 8 Housing Choice Voucher _____ Subsidized Project-Based Rental Unit _____

DBHDD Rental Assistance _____ Other rental assistance or voucher program _____

Housing search & moving assistance: _____

Furniture & household items: _____

*Schedule of case management home visits: _____

(Signature of Applicant) (Date)

(Case Manager Signature) (Date)

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Disability Verification Attachment B

INSTRUCTIONS: This form identifies the Applicant's primary disability that is of long and continuing duration and impedes his or her ability to work and live independently. If the Applicant has multiple disabilities, please choose only the one that most substantially impedes his or her ability to work and live independently.

This form may be filled out only by a person who is licensed by the State of Georgia to make one of the diagnoses listed below. The agency must maintain appropriate documentation related to the diagnosis. Please indicate your professional licensure by checking a box below, and provide your license number.

- | | |
|---|---|
| <input type="checkbox"/> Advanced Practice Registered Nurse | <input type="checkbox"/> Medical Doctor |
| <input type="checkbox"/> Licensed Clinical Social Worker | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Licensed Professional Counselor | <input type="checkbox"/> Psychologist |

APPLICANT'S NAME: _____ DOB: _____ SS# _____

- The Applicant has been diagnosed with a **serious and persistent mental illness (SPMI)**.
- The Applicant has been diagnosed with **both a serious and persistent mental illness (SPMI) and a chronic alcohol or drug abuse disorder (SPMI/CSA)**.
- The Applicant has a **chronic alcohol abuse disorder and/or a chronic drug abuse disorder (CSA)**.
- The Applicant has an **intellectual/developmental disability (I/DD)** that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Manifested before the individual attained the age of 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity (*please check three or more of the following*):

- Self-care
- Receptive and expressive language
- Learning
- Mobility
- Self-direction
- Capacity for independent living
- Economic self-sufficiency; and

5. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

- The Applicant has **traumatic brain injury (TBI)**.

I have personally made the diagnosis specified above. The above individual has a disability that is expected to be of long-continued and indefinite duration; is expected to substantially impede this person's ability to live independently; and is of such a nature that it could be improved by more suitable housing conditions.

➤ _____ ➤ _____
(Print Name of Person Verifying Disability) *(Signature of Person Verifying Disability)*

➤ License number (required): _____ Date: _____

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HIPAA
Consent for Disclosure of Applicant's Protected Health Information
Attachment C

I, (full name): _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

Hereby authorize the Georgia Department of Community Affairs DCA and the programs, agencies and persons listed below to communicate and disclose to one another written and verbal information regarding my protected health information:

- DCA Tenant Based Rental Assistance Program TBRA rent subsidy processing office
Georgia Money Follows the Person Program MFP
MFP Direct Provider Agency
U.S. Department of Housing and Urban Development (HUD)
Local Public Housing Authority
Rental Property Owner or Manager
Current Housing Provider

The purpose of the disclosure is to obtain information used to secure and/or maintain rental assistance and housing through DCA's rent subsidy programs or through a local housing authority.

DCA does not have my permission to disclose the following items: _____

I understand that my medical/health information records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and cannot be disclosed without written consent unless otherwise provided for in the regulations. I understand that by signing this authorization, I am allowing the release of my protected health information. The protected health information in my record may include mental/behavioral health information, information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol/drug abuse, and/or a developmental disability.

I understand that I may revoke this consent at any time, except to the extent that disclosure has already been made in reliance on this or any other consent. Revocation may be accomplished by written request and may be for specific items or the entire release. To revoke this consent, mail a signed written request to revoke consent to: Georgia Department of Community Affairs, Office of Special Housing Initiatives, TBRA Program Manager, 60 Executive Park South, N.E., Atlanta, Georgia, 30329-2231.

I understand that this consent remains effective until I am no longer a participant in the DCA TBRA program, unless I specify expiration on the following date, or based on the following event or special condition: _____

I understand that while signing this consent form is not a precondition to being declared eligible for housing assistance, DCA cannot complete the process of delivering such assistance to me unless I sign this consent form. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Would you like a copy of this consent form? Please initial: () YES () NO

Signature of Consumer: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent/Guardian/Representative: _____ Date: _____

Guardian/Representative: please include a description of authority to act on Consumer's behalf:

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**Verification of Status on Wait List
Attachment D**

TO: Property Owner or Housing Authority
FROM: Georgia Department of Community Affairs Office of Special Housing Initiatives (DCA)
Re: HOME TBRA Program

The Georgia Department of Community Affairs operates a HOME Tenant-Based Rental Assistance program (TBRA) for individuals with disabilities and families with a disabled adult family member. To meet the basic eligibility criteria all applicants must verify that they are on a Wait List for a Section 8 Housing Choice Voucher (HCV) or some other form of subsidized rental assistance (i.e. HUD Section 811 or 202).

The TBRA program provides 24 month rental assistance as transitional assistance until the household can obtain a more permanent rent subsidy program or until they no longer need rental assistance.

This form is used to verify that the person below is on a Wait List managed by your organization and that their name is active on your Wait List. This form does not obligate your agency in any way to provide housing or to grant any preference for the client.

The HOME statute requires that TBRA recipients who have also applied for HCV assistance (either project or tenant based) retain, for the purpose of the HCV waiting list, any tenant selection preference and status on the Wait List for which they qualified for at the time TBRA was provided. This policy enables families and individuals to receive TBRA without jeopardizing their opportunity to receive HCV assistance in the future.

The person listed below authorizes your agency to release this information to DCA.

TBRA Applicant: _____ Signature: _____

DOB: _____ SS#: _____

Date Person was added to the Wait List: _____

Wait List(s) that person is on: _____

Property Owner/ Manager or Representative of Public Housing Authority: _____
Agency: _____

Contact Person Signature Print Name: Phone: _____

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