RurAL CAP
Rural Alaska Community Action Program, Inc.

Affordable Housing Supplemental Rental Application

Schedule M

Central Leasing Office
161 Klevin St., Suite 206A
Anchorage, AK 99508
Phone: (907) 868-4600
Fax: (907) 868-4609

PLEASE READ THIS BEFORE FILLING OUT APPLICATION

If you are applying for housing at Safe Harbor- Muldoon:

Please complete and/or sign the following forms*

- ☐ Intake Assessment (pages 1-2 for Head of Household, pages 3-4 for each family member
- ☐ Homeless Verification
- ☐ Notice of Privacy Practices and Acknowledgement Form
- ☐ Case Management Verification*
- ☐ Child in Transition*
- ☐ Self-Certification of Unborn Child/Adoption/Custody*
- ☐ Minor Turning 18 within 12 months Anticipated Income*

If a form does not apply to your situation, strike a line through the page and write "N/A," sign and date.

Completed Applications* may be submitted:

1. In person: 161 Klevin St., Suite 206A, Anchorage, AK 99508
2. Via Fax: 907-868-4609
3. Email: propertymanagement@ruralcap.com

**NOTE: incomplete applications will be not be accepted*

RurAL CAP Property:	☐325 E. 3rd Avenue ☐Davis ☐Karluk Manor ☐North Lane ☐Safe Harbor Muldoon ☐Peterkin ☐Sitka Place

Household Type:	☐ Couple with No Children ☐ Female Single Parent ☐ Male Single Parent ☐ Two Parent Family ☐ Grandparent(s) and Child ☐ Foster Parent(s) ☐ Non-Custodial Caregiver(s) ☐ Other: _____

For any answers below in which a client doesn't know or refuses to disclose information, please indicate **DK** (Doesn't Know) or **CR** (Client Refused).

Answer this section for each person in the household (complete additional data elements on the **Household Members** form and **Additional Adults** form). Please use additional forms for households with more than 6 people.

Client Name	SS#	Veteran?	Date of Birth	Race (see below)	Ethnicity (see below)	Gender (see below)	Relationship to Head of Household
		☐ Yes ☐ No	____/ ____/____				*Self (HoH)*
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				
		☐ Yes ☐ No	____/ ____/____				

Race: **Indicate Primary Race (1) & Secondary Race (2)*

- American Indian / Alaska Native (*AI / AN*)
- Asian (*A*)
- Black / African American (*B / AA*)
- Native Hawaiian / Other Pacific Islander (*NH/PI*)
- White (*W*)
- Client doesn't know (*DK*)
- Client refused (*CR*)

Ethnicity:

- Non-Hispanic / Non-Latino (*N*)
- Hispanic / Latino (*H/L*)
- Client doesn't know (*DK*)
- Client refused (*CR*)

Gender:

- Female (*F*)
- Male (*M*)
- Trans Female - Male to Female (*MTF*)
- Trans Male - Female to Male (*FTM*)
- Gender Non-Conforming (*GNC*)
- Client doesn't know (*DK*)
- Client refused (*CR*)

Residence Prior to Project Entry: (Select ***only one***, then complete the corresponding box below.)	☐Homeless Situation ☐Institutional Situation ☐Transitional or Permanent Housing Situation

Complete pages 1-2 once for whole household.

Complete pages 3-4 for each member of the household.

☐ Homeless Situation

☐ Place not meant for habitation ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher

"How long have you been in this current homeless situation?"	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than a month	☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer

<u>If Yes</u>, Approximate Date Homelessness started: _____/_____/_____

**The approximate date that the client's current episode of homelessness started.*

☐ Institutional Situation

☐ Foster care home or foster care group home ☐ Long-term care facility or nursing home
☐ Hospital or other residential medical facility ☐ Psychiatric hospital or other psychiatric facility
☐ Jail, prison, or juvenile detention facility ☐ Substance abuse treatment facility or detox center

"How long have you been in this institutional situation?"	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than a month	☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer

*"If the stay was less than 90 days, on the night before entering the 'institutional situation,' were you **on the streets** or **in emergency shelter**?"* ☐ **Yes** ☐ **No**

<u>If Yes</u>, Approximate Date Homelessness started: _____/_____/_____

**The approximate date that the client's current episode of homelessness started.*

☐ Transitional & Permanent Housing Situation

☐ Hotel paid for without voucher ☐ Rental by client, GPD TIP subsidy
☐ Owned by client, no ongoing subsidy ☐ Rental by client, other subsidy including RRH
☐ Owned by client, ongoing subsidy ☐ Residential project, no homeless criteria
☐ Permanent housing for homeless persons- no RRH ☐ Staying or living with family
☐ Rental by client, no subsidy ☐ Staying or living with friends
☐ Rental by client, VASH subsidy ☐ Transitional housing for homeless persons

"How long have you been in this transitional or permanent housing situation?"	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than a month	☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer

*"If the stay was less than 7 nights, on the night before entering the 'transitional or permanent housing situation,' were you **on the streets** or **in emergency shelter**?"* ☐ **Yes** ☐ **No**

<u>If Yes</u>, Approximate Date Homelessness started: _____/_____/_____

**The approximate date that the client's current episode of homelessness started.*

Living Situation *(Only complete if "Approximate Date Homelessness started" was answered above.)

"Regardless of where you stayed last night, <u>how many times</u> have you been **on the streets or **in emergency shelter** in the last 3 years?"*	☐ One time ☐ Two times ☐ Three times ☐ Four or more times
*"<u>How many months</u> have you been **on the streets** or in **emergency shelter** in the last 3 years?"*	☐ Fill in a number up to 12 months: _____ ☐ More than 12 months

"What is the primary reason that you are seeking assistance?"

☐ Illness/Injury
☐ Domestic Violence
☐ Hours of Work Cut
☐ House Repairs (Damaged/Destroyed)
☐ ATAP Delays/Sanction
☐ Death in Family
☐ Legal Issues
☐ Unemployed-Less than 60 Days
☐ Unemployed-More than 60 Days
☐ Nonpayment of Child Support
☐ Benefits Interrupted (i.e. SSI or VA)
☐ In Treatment
☐ Low Wages/Fixed Income
☐ Car Trouble/Accident
☐ Loss of Partner/Roommate
☐ Theft Victim
☐ Moved from w/in AK with Insufficient Funds
☐ Moved to AK with Insufficient Funds
☐ New Job/Paycheck Delay
☐ Mortgage Foreclosure
☐ Loss of Job
☐ Released from Medical Facility
☐ Released from Jail/Prison
☐ Living with Relative/Friend-Asked to Leave
☐ Substance Abuse
☐ Other (specify): _____

RurAL CAP Data Elements

CSBG Household Type:
- ☐ Single Person
- ☐ Two Adults NO Children
- ☐ Single Parent Female
- ☐ Single Parent Male
- ☐ Two Parent Household
- ☐ Non-Related Adults with Children
- ☐ Multigenerational Household
- ☐ Other
- ☐ Unknown / Not Reported

Education Level:
- ☐ Grades 0-8
- ☐ Grades 9-12 / Non-Graduate
- ☐ High School Graduate / Equivalency Diploma
- ☐ 12 Grade + Some Post-Secondary
- ☐ 2 or 4 Year College Graduate
- ☐ Graduate of Other Post-Secondary School
- ☐ Unknown / Not Reported

If Youth is 14-24, are they working or going to school? ☐ Yes ☐ No

Primary Language:

Secondary Language (if applicable):

Oral English Fluency: ☐ Excellent ☐ Good ☐ Moderate ☐ Poor

Written English Fluency: ☐ Excellent ☐ Good ☐ Moderate ☐ Poor

Do you require assistance with English?	If Yes, do materials need to be translated?	If assistance is required, who do you want to interpret for you?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Family member ☐ SHD Provided Interpreter ☐ Friend ☐ Other: _____

Health Insurance (Check all that apply.)

Is the client covered by health insurance?
- ☐ Yes ☐ No
- ☐ Client doesn't know
- ☐ Client refused

- ☐ Medicaid
- ☐ Medicare
- ☐ State Children's Health Insurance Program
- ☐ Veteran's Administration Medical Services
- ☐ Employer-Provided Health Insurance
- ☐ Health Insurance obtained through COBRA
- ☐ Private Pay Health Insurance
- ☐ State Health Insurance for Adults
- ☐ Indian Health Services Program
- ☐ Other: _____

Disabilities (Check all that apply.)

Does the client have a disabling condition?
- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

Disability Type	Long-Continued and Indefinite Duration?
☐ **Alcohol Abuse**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Both Alcohol & Drug Abuse**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Chronic Health Condition**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Developmental**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Drug Abuse**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **HIV/AIDS**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Mental Health Problem**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Physical**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Alaska Mental Health Trust (AMHT) Beneficiary (Select an answer for each disability type.)

Does the client have any of the following disabilities?

Alzheimer's Disease and Related Dementias	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Chronic Alcoholism or other Substance Use Disorder	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Intellectual or Developmental Disabilities	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Mental Illness	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Traumatic Brain Injuries	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Primary Alaska Native Regional Corporation

☐ Not Affiliated

- ☐ Ahtna Corp.
- ☐ Aleut Corp.
- ☐ Arctic Slope Regional Corp.
- ☐ Bering Straits Native Corp.
- ☐ Bristol Bay Native Corp.
- ☐ Calista Corp.
- ☐ Chugach Alaska Corp.
- ☐ Cook Inlet Regional Corp.
- ☐ Doyon Limited Corp.
- ☐ Koniag Incorp.
- ☐ NANA Regional Corp.
- ☐ Sealaska
- ☐ 13th Regional Corp.
- ☐ Client doesn't know
- ☐ Client refused

Secondary Alaska Native Regional Corporation (if applicable): _____

For Permanent Housing Projects—including Rapid Rehousing Projects—*only*

Please note that if you are completing this for a project that is not a permanent housing project and this data element is filled in on the Entry Assessment in HMIS for this client, remove it on the Entry Assessment.

Housing Move-In Date: _____/ _____/ _____

RurAL CAP Data Elements

Military Service?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Not Applicable
If Yes for Military Service:	☐ Active Duty, Combat ☐ Active Duty, Noncombat ☐ Afghan War, Combat ☐ Afghan War, Noncombat ☐ Gulf War, Combat ☐ Gulf War, Noncombat ☐ Iraq War, Combat ☐ Iraq War, Noncombat ☐ Reserves / Nat'l Guard, Combat ☐ Reserves / Nat'l Guard, Noncombat ☐ Retired, Combat ☐ Retired, Noncombat ☐ Vietnam, Combat ☐ Vietnam, Noncombat ☐ Veteran, Other Eras
Work Status:	☐ Employed Full-Time ☐ Employed Part-Time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (Short-Term, 6 Months or Less) ☐ Unemployed (Long-Term, More than 6 Months) ☐ Unemployed (Not in Labor Force) ☐ Retired ☐ Unkown / Not Reported
If Employed:	Length of Employment: Employed by: Employer's Address: Employer's Phone Number: Position Held:

Monthly Income (Select the specific sources and specify the monthly amount of each source.)

Does the client have a source of income?
☐ Yes ☐ No
☐ Client doesn't know
☐ Client refused

If yes, what is the total monthly income?

$_____

☐ Alimony/Other spousal support	$	☐ SSDI	$
☐ VA service connected disability compensation	$	☐ SSI	$
☐ VA non-service connected disability pension	$	☐ General assistance	$
☐ Worker's Compensation	$	☐ Unemployment insurance	$
☐ Retirement income from social security	$	☐ TANF	$
☐ Pension/Retirement income from another job	$	☐ Child support	$
☐ Private disability insurance	$	☐ Earned income	$

Level of Household Income:
☐ Up to 50% ☐ 51% to 75% ☐ 76% to 100% ☐ 101% to 125% ☐ 126% to 150% ☐ 151% to 175% ☐ 176% to 200% ☐ 201% to 250% ☐ 251% and Over ☐ Unknown / Not Reported

Non-Cash Benefits (Check all that apply.)

Does the client receive non-cash benefits?
☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

☐ TANF Child Care Services
☐ TANF Transportation Services
☐ Other TANF-Funded Services
☐ SNAP (Food Stamps)
☐ Special Supplemental Nutrition Program for WIC
☐ Other (specify): _____

Domestic Violence Victim / Survivor

"Are you a victim or survivor of domestic violence?"	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
If yes, when did the last experience occur?	☐ Within the last 3 months ☐ 6-12 months ago ☐ 1+ years ago ☐ Client doesn't know ☐ Client refused
If yes, is the client currently fleeing the DV situation?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Applicant Name: _____

Homeless applicants who meet the criteria described below must provide certification of homeless status from a public or private facility that provides shelter for such households, or from the local police department, or any social service agency that provides services for homeless people. In order to verify an applicant's homelessness please fill out the following form:

1. Applicant is "Homeless" (choose one of the following *or* select one from item 2):

   ☐ Moving from an emergency shelter

   ☐ Moving from Transitional Housing

   ☐ An individual who lacks a fixed, regular, and adequate nighttime residence

   Does the Applicant also meet the Chronic Homeless Definition?

   HUD has defined chronic homelessness as a individual or family with a disabling condition who has been continuously homeless for a year or more or has had a least four episodes of homeless in the past three years <u>where those episodes cumulatively total at least 12 months</u> and is living in an emergency shelter or a place not meant for human habitation.

   ☐ Yes

   ☐ No

2. Applicant is "At Risk of Homelessness" (if no item from #1 has been checked choose one of the following):

   ☐ Households with income at or below the greater of 20 percent of State Median Income (SMI) or Area Median Income (AMI) with no rental subsidy available to the household.

   ☐ Households with incomes above 20 percent but not exceeding 30 percent of the greater of SMI or AMI:

   AND (check all that apply)

   ☐ Face immediate eviction and have been unable to identify a subsequent residence.

   ☐ Face imminent release from an institution (i.e.; jail, hospital foster care system) where other housing placement resources are not available

   ☐ Reside in an overcrowded setting (more than two persons per living/sleeping area) in which the household does not hold a lease.

   ☐ Reside in substandard housing subject to a current official vacation notice.

   ☐ Pay more than 50 percent of income in housing costs.

3. Please provide documentation **or** certification of homelessness **(choose A or B).** Certifications can be made by a shelter provider, other social service provider or outreach worker.

A. I _____ from (agency)

_____ verify that

_____ (applicant) meets the criteria for homelessness

Checked above (items 1). Documentation is available at:

_____ (agency), located at:

_____, _____, _____

Street City State/Zip

B. The following documentation is need for people <u>at risk of homelessness.</u> (Please note: all elements of the definitions must be met. For example, a notice of eviction is not sufficient while a notice of eviction plus income verification documenting the potential tenant has income of less than 30% of AMI is sufficient.)

- ☐ Notice of eviction
- ☐ Notice pay rent or quit within 14 days
- ☐ Receipt of payment (SRO or Motel)
- ☐ Documentation of substandard housing
- ☐ Release papers (jail, hospital, or foster care system)
- ☐ Rent receipt with proof of income
- ☐ _____ (other).

4. Please sign and date.

Agent Signature: _____ Date: _____

Phone Number: _____

(Sponsor, Service Provider or Property Management Company Name)

Representative: _____ Date: _____

Phone Number: _____

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

HOMELESS DEFINITION AND RECORDKEEPING REQUIREMENTS

Criteria for Defining Homelessness	Literally Homeless	(1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution
	Imminent Risk of Homelessness	(2) Individual or family who will imminently lose their primary nighttime residence, provided that: (i) Residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing

Recordkeeping Requirements	Literally Homeless	• Written observation by the outreach worker; or • Written referral by another housing or service provider; or • Certification by the individual or head of household seeking assistance stating that (s)he was living on the streets or in shelter; • For individuals exiting an institution-one of the forms of evidence above and ○ Discharge paperwork or written/oral referral, or ○ Written record of intake worker's due diligence to obtain above evidence and certification by that individual that they exited the institution
	Imminent Risk of Homelessness	• A court order resulting from an eviction action notifying the individual or family that they must leave; or • For individual and families leaving a hotel or motel-evidence that they lack the financial resources to stay; or • A document and verified oral statement; and • Certification that no subsequent residence has been identified; and • Self-certification or other written documentation that the individual lack the financial resources and support necessary to obtain permanent housing

2018 AREA INCOME GUIDELINES AS DEFINED BY HUD

2018 Area Median Income Guide	1 Person	2 People	3 People	4 People	5 People	6 People	7 People	8 People
Median (100%)	$50,350	$57,500	$64,700	$71,900	$77,650	$83,400	$89,150	$94,900
30%	$20,850	$23,800	$26,800	$31,380	$36,780	$42,180	$47,580	$52,980

Acknowledgement: Receipt of Notice of Privacy Practices

I have received a copy of RurAL CAP – Supportive Housing Division's Notice of Privacy Practices effective January 1, 2016.

Name (please print): _____

Signature: _____

Date: _____

I am a parent or legal guardian of _____ (participant's name). I have received a copy of RurAL CAP – Supportive Housing Division's Notice of Privacy Practices effective January 1, 2016.

Name (please print): _____

Relationship to Participant: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

If the participant or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the participant, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective January 1, 2016 given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the participant or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

Supportive Housing Division
NOTICE OF PRIVACY PRACTICES

RurAL CAP
Rural Alaska Community Action Program, Inc.

Effective Date: January 1, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes our agency's practices and will be followed by the following:

- All employees and staff.
- All interns and students.
- All regional offices.
- Any member of a volunteer group associated with Supportive Housing Division.

All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or agency operations purposes described in this notice. "We," "us," and "our" in this notice refers to the parties listed above. This notice does not cover the care you may receive from independent providers or actions by any health plan.

Our Responsibilities

We are required by law to maintain the privacy of your health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We are required to follow the practices described in this notice and to give you a copy of this document. We will not use or share your information other than as described here unless we received a written authorization from you. You can change your mind at any time. Please let us know in writing if you have changed your mind.

For more information see:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for the individual identifiable health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the agency. The notice will contain the effective date on the first page.

If you have any questions about this notice or would like a copy of this notice, please contact the Privacy Officer by phone at (907)279-7535 and asking for the Privacy Officer. You may also stop by the Privacy Officer's office at 120 North Hoyt Street - Anchorage, Alaska 99508.

Our Uses and Disclosures

The following categories describe different ways that we use and disclose protected health information. We will explain the different categories of uses or disclosures and give some examples. Not every use or

disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Services (treatment): We may use health information about you to provide you with services. We may disclose health information about you to other agency personnel who are members of your support team and are involved in providing services to you. For example, a Case Manager is working with you at your job site and you begin to feel ill and can no longer continue to work. The Case Manager would immediately assess the situation and if it were not an emergency, would assist you in returning home. The Case Manager would then share information about your health status and symptoms with the Operation Technician so that they could continue to monitor and assist you as needed. In addition to your primary care providers, your current health status may be discussed with your primary physician for further treatment recommendations.

We may use and disclose your health information to tell you about or recommend possible service options or alternatives that may be of interest to you. We may use and disclose your health information to tell you about health-related benefits or services that may be of interest to you through flyers, newsletters, etc. (such as a flyer informing you about a workshop on autism which could be sent to the family of an individual who experiences autism). We may disclose information to a business associate and may allow our business associate to create, receive, maintain, or transmit protected health information on our behalf. We require that our business associates implement appropriate safeguards to protect your health information.

Run our organization (operations): We may use and disclose health information about you for agency operations. These uses and disclosures are necessary to run our organization and make sure that all of our service recipients receive quality care. For example, we may use protected health information to review our services and to evaluation the performance of our staff in caring for you. We may also combine medical information about many service recipients to decide what additional services the agency should offer, what services are not needed, and whether certain new services are effective. We may also combine protected health information we have with protected health information from other agencies involved in your care to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific recipients are.

Bill for services (payment): We may use and disclose health information about you so that the services you receive may be milled to and payment may be collected from you, an insurance company or a third party. For example, if you are residing in a Supportive Housing Division residential facility and receiving case management services funded through Medicaid then, a case manager will provide Medicaid and Xerox with any required documentation that substantiates your eligibility and your medical need for the services that are outlined in your Treatment Plan. Likewise, information will be shared with Medicaid if your health status changes significantly or if you are hospitalized while receiving services from Supportive Housing Division programs.

Comply with the law: We will disclose health information about you when required to do so by federal, state or local law.

Help with public health and safety issues: We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report reactions to medications or problems with products;

- to notify people of recalls of products they may be using
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe who choses our services has been the victim of abuse, neglect, or domestic violence. (We will only make this disclosure if you agree or when required or authorized by law);

We may use and disclose your health information when we reasonably believe it is necessary to prevent a serious threat to the health and safety of you, the public or another person. The disclosure would only be to someone who is likely to help prevent the threat.

Health oversight activities: We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights by laws.

Address judicial and administrative requests: We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if the requesting party states that it has made efforts to tell you about the request or to obtain an order protecting the information requested.

Address law enforcement requests: We may disclose your health information if asked to do so by a law enforcement official:

- as required by law;
- to identify or locate a suspect, fugitive, material witness, or missing person (but we will give out only limited information);
- about the victim of a crime in certain limited circumstances;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the agency; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

Work with a medical examiner or funeral director: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about services recipients to funeral directors as necessary to carry out their duties prior to and in reasonable anticipation of death or other duties as authorized by law.

Respond to organ and tissue donation requests: We may disclose health information or organizations that handle organ procurement or organ, eye or tissue transplants to an organ donation bank, as required and needed for organ or tissue donation and transplants.

Do research: Under certain circumstances we may use and disclose health information about you for research purposes. We may use or disclose your health information to prepare for a research project. Your authorization will be obtained before disclosing your information for research.

Address workers' compensation: We may disclose health information about you for workers' compensation or similar programs, as permitted by law.

Address other government requests:

- *Military Personnel* – If you are a member of the armed forces, we may release health information about you as required by your military command authorities.
- *National Security and Intelligence Activities* – We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- *Protective Services for the President and Others* – We may disclose health information about you to authorized federal officials so they may protect the President, other authorized persons, or foreign heads of state or may conduct special investigations.
- *Correctional institutions and other law enforcement custodial situations* – If you are an inmate of a correctional institution or a under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

De-identified Information: We may use and disclose health information that reasonably has been "de-identified" by removing certain identifiers (such as name and address) making it unlikely that you could be identified.

Limited Data Sets: We may disclose limited information, contained in a "limited data set,' to certain third parties for research, public health, and health care operations. Before disclosing limited data sets, we will enter into an agreement with the recipient that limits the recipient's use and discloser of this information and prohibits the recipients from attempting to re-identify the data or from contacting you.

Incidental Disclosures: Certain incidental disclosures of health information may occur as a by-product of permitted uses and disclosures. For example, a roommate may inadvertently overhear a discussion about your care if you share a room.

Minimum Necessary: We will limit the discloser of protected health information to that which is reasonably necessary to accomplish the purpose for which discloser is sought.

Your Rights

You have the following rights regarding health information we maintain about you. You have the right to:

Request to inspect and receive a copy of your paper or electronic record: You have the right to review and request an electronic or paper copy of most of the health information about you that we maintain. Usually, this includes medical and billing records. To review and/or receive an electronic or paper copy of your health information we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information you will receive a written denial. You may request that the denial be reviewed. Another licensed health care professional chosen by the agency will review your request. We will comply with the outcome of the review. In certain limited situations, we will have to deny you access but will not give you a review.

Request to amend your paper of electronic record: If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request as amendment for as long as the information is kept by or for the agency. Your request must be made in

writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request, at our discretion, if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the agency;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Request confidential communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

You must submit your request for confidential communication in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests.

Your request must specify how or where you wish to be contacted. The agreement for confidential communication may be conditioned upon obtaining information about how payment, if any, will be handled. We may terminate our agreement to your request if payment arrangements are not honored.

Request us to limit the information we share: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your car, like a family member or friend. We are not required to agree to your request unless the disclosure is to a health plan for purposes of carrying out payment or health care operations (not treatment purposes) and the information pertains solely to an item or service paid for fully out of pocket. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Request a list of those with whom we've shared your information: You have the right to request an accounting of disclosures of permanent health information. This "accounting" is a list of the disclosures we have made of your health information. This list does not include information disclosed for treatment, payment and operations. We are not required to give you an accounting of information we have shared with our business associates or for which you have given us a written authorization. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be more than six years prior to the date on which the accounting is requested. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Request a copy of this privacy notice: You have the right to a paper copy of this notice. You may ask us to give us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice contact the Privacy Officer.

Choose someone to act for you: Certain minors and incapacitated adults may have "personal representatives." These personal representatives may be able to act on the person's behalf, access the

person's health information, and exercise the person's privacy rights. We will verify that the person has this authority and can act for you before we take any actions.

Your Choices

In these cases, you have both the right and choice to authorize disclosure of your information:

Tell family and friends about your condition: We may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends health information needed for that person's involvement in your care or payment for your care or about your location or condition. Except in limited circumstances, such as an emergency, we will ask you for authorization prior to disclosure.

Provide disaster relief: We may disclose identifiable health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. Except in limited circumstances, such as an emergency, we will ask you or determine if you object.

Include you in our directory: Unless you object, we may include certain limited information about you in the agency directory while you are a service recipient or employee of the agency. This information may include your name and network in the agency. Directory information may be given to people who ask for you by name.

If you are not able to tell us your preferences in these cases, for example if you are unconscious, you may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious imminent threat to health or safety.

In the case of fundraising:

Fundraising: We may use certain information about you to raise money for the agency and its operations. This may include telling you about projects funded by the agency and sending you fundraising materials. We may disclose limited contact information, such as your name, address, phone number, and dates of service to a foundation related to the agency or to a business associate so that they may contact you in raising money for the agency. Fundraising material will contain clear and conspicuous information about how you may opt-out of receiving future fundraising materials. If we receive your request to not receive any further fundraising communications, we will make reasonable efforts so you will not be sent future fundraising materials. Treatment and payments will not be impacted with the respect to your decision about receipt of fundraising communications. Any fundraising usage not specifically described in this section will require your written authorization.

In these cases we never share your information unless you give us written permission:

Specially Protected Health Information: Unless otherwise required or permitted under law, we may need to obtain your specific authorization for discloser of the following health information:

- Positive AIDS/HIV test information
- Mental health and mental illness records
- Drug addiction, alcoholism, and other substance abuse treatment records.

Marketing purposes: Unless otherwise required or permitted under law, we will obtain your specific authorization prior to any disclosure of health information about you for marketing except if the communication is a face-to-face communication or if you receive a promotional gift or nominal value.

Unless otherwise required or permitted under law, we will obtain your specific authorization for prior to any disclosure of health information about you which will result in remuneration to the covered entity.

Sale of your information: Unless otherwise required or permitted under law, we will obtain your specific your specific authorization for prior to any disclosure of health information about you which will result in remuneration to the covered entity.

Other uses and disclosures of your health information may not be covered by this notice: Other uses and disclosures of your health information not covered by this notice or the laws that apply to us will be made only with your written authorization.

Revoke Authorization

You may revoke your authorization to use and disclose your health information in writing at any time (unless you are told otherwise at the time you sign the authorization). If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your written authorization, except to the extent that we have already taken action that relied on your authorization. You understand that we are required to retain our records of the care that we provided to you.

Questions/Exercising Rights

If you have any questions about this notice, would like a copy of this notice or would like to exercise any of your rights, please contact the Privacy Officer by (907)279-2511 and asking for the Privacy Officer. You may also stop by the Privacy Officer's office at 731 E 8th Avenue – Anchorage, Alaska 99501.

File a complaint

If you believe your privacy rights have been violated, you may file a complaint with the agency and with the Office of Civil Rights. You will not be retaliated against or penalized for filing a complaint.

You may file a complaint with the agency. To file a complaint with the agency, contact the Privacy Officer at (907)279-2511. All complaints must be submitted in writing. The written complaint can be submitted in person or by mail to the Privacy Officer at 731 E 8th Avenue – Anchorage, Alaska 99501 or by sending an e-mail to privacyofficer@ruralcap.com.

You may also file a complaint with the Secretary of the Department of Health and Human Services. You can use the OCR Complaint Portal or the OCR Health Information Privacy Complaint Form Package. If you need help filing a complaint or have a question about the complaint or consent forms, please e-mail OCR at OCRComplaint@hhs.gov. The Secretary of DHHS can also be reached at:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

ELIGIBILITY AND ETHNICITY STATEMENT

This program is funded by the Municipality of Anchorage with Federal Community Development Block Grant funds. This funding requires us to collect information on race, ethnicity, and income.

This form must be completed for every person participating in the program in the household.

1. What is your race (pick one that best describes you)?

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

2. Are you of Hispanic decent? ☐ Yes ☐ No
3. Female Head of Household? ☐ Check if applicable
4. Number of people living in your household _____.
5. Number of people in your household requesting services from this program_____.
6. Are you homeless or at risk of homelessness as defined by 24 CFR part 576.2? ☐ Yes ☐ No
7. What is your total yearly household income (before taxes) from all persons living in your household? $_____
8. Using the answer to 7 above and the table below, your income is (check the appropriate box):

☐ Extremely Low ☐ Very Low ☐ Low/Moderate ☐ Other

2018 INCOME GUIDELINES				
Household Size	Extremely Low Income 30%	Very Low Income 50%	HOME Low Income 60%	Low/Moderate Income 80%
1	$0 - $20,850	$20,851 - $34,750	$34,751 - $41,700	$41,701 - $50,350
2	$0 - $23,800	$23,801 - $39,700	$39,701 - $47,640	$47,641 - $57,550
3	$0 - $26,800	$26,801 - $44,650	$44,651 - $53,580	$53,581 - $64,750
4	$0 - $29,750	$29,751 - $49,600	$49,601 - $59,520	$59,521 - $71,900
5	$0 - $32,150	$32,151 - $53,600	$53,601 - $64,320	$64,321 - $77,700
6	$0 - $34,550	$34,551 - $57,550	$57,551 - $69,060	$69,061 - $83,450
7	$0 - $36,900	$36,901 - $61,550	$61,551 - $73,860	$73,861 - $89,200
8	$0 - $39,300	$39,301 - $65,500	$65,501 - $78,600	$78,601 - $94,950

I certify that this information indicated above is true and correct, to the best of my knowledge.

_____ _____

Applicant Name (Print) Applicant Signature Date

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency representing the U. S. as to any matter within its jurisdiction.

[Use of an alternate form will not be accepted unless the Grantee has requested and received approval in writing for its use from the Municipality.]

Revised 3/10/16

Property: ☐ Sitka Place ☐ Safe Harbor

Service Provision:

NOTE: Safe Harbor and Sitka Place require that referring agencies (outside of RurAL CAP) have an active Memorandum of Agreement.

Agency providing case management services:

Program within the Agency providing case management:

Service Provider Contact Information:

Name:
Telephone Number:
Address:
Director Supervisor?

_____ _____

Service Provider Signature Date

ANCHORAGE SCHOOL DISTRICT (ASD)
CHILD IN TRANSITION PROGRAM

To the Parent or Guardian:

Anchorage School District's Child in Transition Program provides services to children of families that are homeless or living in transitional living facilities. These services may include: early childhood and school age programs, school and related educational supplies, transportation (to/from school), referrals (Head Start, 21st Century and housing, etc.), and child advocacy.

Your consent will allow for exchange of information to benefit your child/children's education.

Consent for Mutual Exchange of Information

Child's Name	Birthdate	Child's Name	Birthdate

Parent or Guardian Name _____ Phone Number _____

Parent or Guardian Name _____ Phone Number _____

I hereby authorize CIT/H to release and exchange information necessary for my child/children's education for the purpose of providing educational services, to/from:

Safe Harbor Inn

This information will be treated in a confidential manner. No other party shall have access to this information without my written consent. I understand that CIT/H will keep this information in their records to be used to help the educational needs of my child/children.

This authorization is effective for one year beginning _____, unless I revoke such authorization in writing.

Parent/Guardian Signature _____ Date _____ Parent/Guardian Signature _____ Date _____

ASD Child In Transition Program: 907-742-3833

Applicant's Name:	Unit#:
Address:	

For purposes of determining the income limit and/or number of bedrooms applicable for my household size, I hereby certify that I am:

☐ Expecting a child (or children). The due date is: _____

☐ In the process of adopting a child (or children).

☐ In the process of obtaining custody of a child (or children).

☐ I do not have full custody of all the minor children in my household. (Attach applicable custody agreements)

Explanation:

Under penalties of perjury, I certify that the information presented in this Self-Certification is true and accurate to the best of my knowledge and belief. I further understand that providing false information herein constitutes an act of fraud. False, misleading or incomplete information may result in termination of the lease agreement.

_____ _____

Signature Date

_____ _____

Printed name Telephone Number

Penalties for misusing this content: *Title 18, Section 1001 of the U. S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD and any owner (or any employee of HUD or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willingly requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a misdemeanor and fined not more than $5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other relief, as may be appropriate, against the officer or employee of HUD or the owner responsible for the unauthorized disclosure or improper use. Penalty provisions for misusing the social security number are contained in the Social Security act at 208 (a) (6), (7) and (8). Violations of these provisions are cited as violations of 42 USC 408 (a), (6), (7) and (8).*

Applicant/Tenant:_____ Unit/Property: _____

Name of Minor Turning 18: _____

Check All That Apply Regarding The Above Minor:

☐ Is not receiving earned income at this time and do not expect to receive earned income in the next 12 months.

☐ Is not receiving earned income at this time and do not know if I will receive earned income in the next 12 months.

☐ Is not receiving earned income at this time but expect to begin receiving earned income on _____(date) as a _____(work type) at $_____(per hour) for _____ (# of hours per week).

☐ Is currently receiving earned income of $_____ (per hour) as a _____ (work type) for _____(# of hours per week) and expect this income to continue for the next 12 months.

☐ Is currently attending school at _____and plan on graduating on:_____.

☐ Other: _____.

Under penalty of perjury, I certify that the information presented in this Certification is true and accurate to the best of my knowledge. The undersigned further understand(s) that providing false representation herein constitutes an act of fraud and may lead to criminal penalties. False, misleading, or incomplete information may result in the termination of the lease agreement.

_____ _____ _____

Signature of Applicant/Tenant Printed Name of Applicant/Tenant Date

Return this form to:
RurAL CAP – Attn: Supportive Housing – 731 E 8th Avenue – Anchorage, AK 99501
Phone: (907)279-2511 Fax: (907)278-2309

ANNUAL STUDENT CERTIFICATION
(This form must be completed by each adult household member)

NAME: _____ UNIT # _____

UNIT DESIGNATION ☐ LIHTC ☐ HOME ☐ LIHTC & HOME

Complete the following if occupying a LIHTC unit

YES	NO	
☐	☐	Will all of the persons in your household be or have they been full-time students (Kindergarten and higher. Examples: Elementary, High School, College/University, trade school, etc.) during five (5) calendar months of the current and/or upcoming calendar year? (*Please note that the five calendar months do not have to be consecutive*)

If you answered NO to this question please proceed to the bottom of the questionnaire and sign and date.

If you answered YES to this question please specify which of the following exceptions your household meets.

☐	☐	Are you receiving assistance under Title IV of the Social Security Act (AFDC/TANF)?
☐	☐	Are you enrolled in a job training program receiving assistance through the Job Training Participation Act (JTPA) or other similar program?
☐	☐	Are you married and filing a joint tax return
☐	☐	Are you a single parent with a dependent child or children and neither you nor your child(ren) are dependent(s) of another individual other than a parent of such children
☐	☐	Are you a student who was previously under the care and placement responsibility of the state agency responsible for administering a plan under part B or part E of title IV of the Social Security Act

If none of the above five (5) exceptions have been identified, the household does not qualify to reside in a LIHTC unit.

Complete the following if occupying a HOME unit

YES	NO	
☐	☐	Are you a student at an institution of higher education (including but not limited to post-secondary colleges / universities and vocational institutes)?

If you answered NO to this question please proceed to the bottom of the questionnaire and sign and date.

If you answered YES to this question please specify which of the following exceptions your household meets.

☐	☐	Are you over the age of 24?
☐	☐	Are you a veteran of the United States military?
☐	☐	Are you married?
☐	☐	Do you have a dependent child?
☐	☐	Have you been independent of your parents for at least one year? *(emancipated minor or youth aging out of foster care)*

If none of the above five (5) exceptions has been identified, the household must income qualify including the income and assets of their parents.

UNDER PENALTIES OF PERJURY, I CERTIFY THAT THE INFORMATION PRESENTED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY/OUR KNOWLEDGE. THE UNDERSIGNED FURTHER UNDERSTANDS THAT PROVIDING FALSE REPRESENTATIONS HEREIN CONSTITUTES AN ACT OF FRAUD. FALSE, MISLEADING OR INCOMPLETE INFORMATION WILL RESULT IN THE DENIAL OF APPLICATION OR TERMINATION OF THE LEASE AGREEMENT.

_____ _____ _____

PRINTED NAME OF APPLICANT/TENANT SIGNATURE OF APPLICANT/TENANT DATE

_____ _____

WITNESSED BY (SIGNATURE OF OWNER/REPRESENTATIVE) DATE