ATC HOUSING APPLICATION CHECKLIST

Instructions: To begin the screening process, please complete the attached forms and provide backup documentation where indicated. Fax to ATC Housing Program @ 631-361-9204 or mail to 25 Howard Place, Ronkonkoma, NY 11779. Questions! Call 631-361-9020 ext. 1200.

Checklist for required documentation

_____ **ATC Housing Applications** (*2 pages*)

_____ **Proof of disability** (*labs, hospital reports, etc.*)

_____ **Copy of Insurance Card**

_____ **Proof of Income** (*i.e. copy of current/annual/SSI/SSD/PA/pay stubs*)

_____ **Consent(s) for Release of Information** (*for any external providers that Options may need to contact, i.e. case manager, care coordinator, medical providers, etc.*)

_____ **PSYCKES Consent**

_____ **HIPAA Form**

_____ **Homeless Certification Form**

_____ **Income Questionnaire**

_____ **Criminal/Sex Offender Form**

_____ **References** (*current landlord, previous landlord, medical provider, case manager, etc.*)

Options
for Community Living, Inc.

APPLICATION

ACCESS TO CARE HOUSING PROGRAM

Please complete all items listed below and send with a signed Consent to Release Information form to:

Options Access To Care Program – Housing Dept.
25 Howard Place
Ronkonkoma, NY 11779
Phone: 631-361-9020 ext. 1200 Fax: 631-361-9204

Type of Financial Assistance Needed: (Please check)

☐ Broker Fees ☐First Month's Rent ☐ Moving Expenses ☐ Utility Assistance
☐ Security Deposit (***note: refundable – must be paid back)***

Section I (All applicants must complete.)

Name: _____ Date: _____

Address: _____

Telephone: _____ Emergency Contact: _____

Referral source: _____ Phone: _____

Housing Status*: □ **Homeless** (Street or shelter) □ **Inappropriately Housed** (doubled up, transitional housing)
□ **At Risk of Homelessness** (pending eviction)

Please describe your current living situation:

_____
_____
_____

Monthly Household Income*: Amount _____ Source(s) _____

Please attach documented proof of income and housing status.

***Also required if applicable**: Consent to Release Information; Certification of Medical Necessity; HIPPA Acknowledgement; Statement of Need/Long Term Plan for Stable Housing form (including corresponding documentation) and Request for Taxpayer identification Number (W9) needed to confirm taxpayer identification number.*

Household Composition: List all persons who would live with you if you received assistance.

Last Name	First Name	Relation-ship	Gen-der	Race/ Ethnicity	DOB	Age	SSN	Income Amount/Source
		Self						

25 Howard Place, Ronkonkoma, NY 11779
631.361.9020 ▪ Fax: 631.361.9204 ▪ optionscl.org

Last Name	First Name	Relation-ship	Gen-der	Race/ Ethnicity	DOB	Age	SSN	Income Amount/Source

Section II (Required for all applicants):

Veteran Status: □ Yes □ No Victim of Domestic Violence: □ Yes □ No

Elderly: □ Yes □ No HIV/AIDS: □ Yes □ No

Mental Health: □ Yes □ No Other disabilities: □ Yes □ No

Section III (Required for all applicants):

Insurance: □ Yes □ No

Type of Insurance: Medicaid: □ Yes □ No If Yes, ID number: _____
Medicare: □ Yes □ No If Yes, ID number: _____
Other: _____ ID number: _____

I declare that the statements contained in this application are true and correct and that I have not willfully or knowingly made a false statement, given false information, or omitted information in connection with this application. I also understand that I will be required to submit to Options for Community Living, Inc. verification and/or proof to support any or all of the claims I have made above.

_____ _____ _____
Print Name Signature of Head of Household Date

New York State Department of Health
AIDS Institute

Authorization for Release of Health Information and Confidential HIV-Related Information*

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- ☐ My HIV-related information
- ☐ My non-HIV health information
- ☒ Both (non-HIV health and HIV-related information)

Name and address of facility/person disclosing HIV-related information:
Options for Community Living, Inc.
25 Howard Place, Ronkonkoma, NY 11779

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above): _____

Relationship to person whose information will be released: _____

Describe information to be released: Application and documentation for assistance/housing

Reason for release of information: To make referral/ To prevent duplication of services

Time Period During Which Release of Information is Authorized: From: _____ To: _____

Exceptions to the right to revoke consent, if any: _____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):
May result in denial of services

Please sign below only if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.

Signature _____ Date _____

* This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.

Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general health and/or HIV-related information:

CARE COORDINATION PROVIDER:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

MEDICAL PROVIDER:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release health and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

If legal representative, indicate relationship to subject:

Print Name _____

Client/Patient Number _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

Complete information for each facility/person to be given general information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general health and/or HIV-related information:

EMERGENCY CONTACT INFORMATION:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

LONG ISLAND COALITION FOR THE HOMELESS
600 Albany Avenue Suite 2 Amityville, NY 11701 631-464-4314

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

If any/all of this page is completed, please sign below:

Signature _____ Date _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

Client/Patient Number _____

* This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.

Details about patient information in PSYCKES and the consent process:

1. **How Your Information Can be Used.** Your electronic health information can only be used by your treatment provider to:
   - Provide you with medical treatment, care coordination, and related services
   - Evaluate and improve the quality of medical care provided to all patients
   - Notify your treatment providers if you have an emergency (e.g., go to an emergency room)

2. **What Types of Information About You Are Included?** If you give consent, Options for Community Living Inc. can access ALL of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. The information in PSYCKES may include information from your health records, such as a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays, blood tests, or screenings), assessment results, and lists of medicines you have taken. Care plans, safety plans, and psychiatric advanced directives you and your treatment provider may have developed may also be included. This information may relate to sensitive health conditions, including but not limited to:
   - Mental health conditions
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Sexually transmitted diseases

3. **Where Health Information About You in PSYCKES Comes From.** If you received health related services that were paid for by Medicaid, information about those services will be in PSYCKES. If you received services from a State operated psychiatric center, health related information taken from your clinical records will also be in PSYCKES. However, although the information contained in PSYCKES may come from your clinical record, your PSYCKES record is not the same thing as your complete clinical record. PSYCKES information can also be entered by you or your treatment provider. Health information from other databases maintained by NYS is also included in PSYCKES. New health databases may be added to PSYCKES as available. For an updated list and more information about the data available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: Options for Community Living Inc.'s doctors and other treatment providers who are involved in your care; health care providers who are covering or on call for Options for community Living Inc. and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Susan Steinhardt at (631) 361-9020 Ext.1207 or call the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by Options for Community Living Inc.; to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.

7. **Effective Period.** This Consent Form will remain in effect until 3 years after the last date you received any services from Options for Community Living Inc. or until the day you withdraw your consent, whichever comes first.

8. **Withdrawing Your Consent.** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to your care coordinator or counselor. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling Susan Steinhardt at (631) 631-9020 Ext. 1207 Note: Organizations that access your health information through Options for Community Living Inc. while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Copy of Form.** You are entitled to receive a copy of this Consent Form after you sign it.

PSYCKES CONSENT FORM

Options for Community Living Inc.

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is a web-based application maintained by the New York State (NYS) Office of Mental Health (OMH). It contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

PSYCKES data includes identifying information (such as your name and date of birth), information about health services that have been paid for by Medicaid, information about your health care history (such as treatment for illnesses or injuries, test results, lists of medication you have taken), and information entered by you or your treatment provider into the PSYCKES application (such as a Safety Plan).

The health information in PSYCKES can help your provider deliver better care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the **"I DENY CONSENT"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," THIS DOES NOT MEAN YOUR PROVIDER IS COMPLETELY BARRED FROM ACCESSING YOUR MEDICAL INFORMATION IN ANY WAY. FOR EXAMPLE, IF THE MEDICAID PROGRAM HAS A QUALITY CONCERN ABOUT YOUR HEALTHCARE, THEN UNDER FEDERAL AND STATE REGULATIONS YOUR PROVIDER MAY BE GIVEN ACCESS TO YOUR DATA TO ADDRESS THE QUALITY CONCERN. QUALITY CONCERNS HELP HEALTHCARE PROFESSIONALS DETERMINE WHETHER THE RIGHT SERVICES ARE BEING DELIEVERED AT THE RIGHT TIME TO THE RIGHT PEOPLE. THERE ARE ALSO EXCEPTIONS TO THE CONFIDENTIALITY LAWS THAT MAY PERMIT YOUR PROVIDER TO OBTAIN NECESSARY INFORMATION DIRECTLY FROM ANOTHER PROVIDER FOR TREATMENT PURPOSES UNDER STATE AND FEDERAL LAWS AND REGULATIONS.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

- ☐ **I GIVE CONSENT for this provider to access ALL** of my electronic health information that is in PSYCKES in connection with providing me any health care services.
- ☐ **I DENY CONSENT for this provider to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number
Signature of Patient or Patient's Legal Representative	Date	
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)	
Signature of Witness	Print Name of Witness	

Options for Community Living, Inc.

SUMMARY OF PRIVACY PRACTICES

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

Options for Community Living, Inc. (Options) is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our staff.

By signing this consent, you are authorizing Options to use and disclose your protected health information to carry out:

- treatment, including direct or indirect treatment by other healthcare providers involved in your treatment;
- obtaining payment from third party payers; and
- day to day healthcare operations of Options.

You have the right to request restrictions on how your protected health information is used and disclosed to carry out treatment, payment and health care operations. However, Options is not required to agree to these requested restrictions. If Options does agree, then we will be bound to comply with these restrictions.

You also have the right to review and secure a complete copy of Options' Notice(s) of Privacy Practices, which contains a more complete description of the uses and disclosures of your protected health information, and your rights under HIPAA. A copy of Options' current privacy notice(s) is always posted in our administrative offices and supervised community residence sites. You or your personal representative may also obtain a copy of any of the current privacy notices by requesting it from staff. Options reserves the right to change the terms of the privacy notices(s) from time to time and you may contact Options at any time to obtain the most current copy of these notice(s).

You have the right to be notified of any breach of your unsecured protected health information.

If you have any questions about this summary notice or would like further information, please contact the Privacy Officer Susan Steinhardt at 631-361-9020 extension 1207 or at ssteinhardt@optionscl.org. You may contact the Privacy Officer or any other staff member if you would like a summary of all Options' Privacy Policies.

25 Howard Place, Ronkonkoma, NY 11779
631.361.9020 ▪ Fax: 631.361.9204 ▪ optionscl.org

Options for Community Living, Inc.

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of the Summary of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the Options and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also have been given information about how I might view or obtain a complete copy of Options Notice of Privacy Practices. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information.

Signature of Program Participant or Personal Representative	Date
Print Name of Program Participant or Personal Representative	Description of Personal Representative's Authority

By signing below, I consent to the use and disclosure of my health information to seek and receive payment for services given to me, and for the business operations of Options, its staff, and the facilities listed at the beginning of this notice.

Signature of Program Participant or Personal Representative	Date
Print Name of Program Participant or Personal Representative	Description of Personal Representative's Authority

25 Howard Place, Ronkonkoma, NY 11779
631.361.9020 ▪ Fax: 631.361.9204 ▪ optionscl.org

Options
for Community Living, Inc.

HOMELESS STATUS CERTIFICATION

I, _____, certify and acknowledge that I meet one of the
(Name)
following criteria for being considered Homeless. *Please check one.*

_____I reside in a place not meant for human habitation, such as cars, parks, sidewalks, and abandoned buildings;
_____I reside in an emergency shelter;
_____I reside in a transitional or supportive housing for homeless persons and I originally came from the streets or emergency shelters.
_____Currently in hotel/motel
_____Currently in transitional facility and must leave within 30 days
_____ Current residence condemned/dangerous (explain) _____
_____Family violence
_____Documented history of frequent evictions
_____Temporarily doubled up in other person's residence
_____Family has been separated legally/physically; may now be unified
_____Unable to live independently without support services
_____At risk of becoming homeless because _____
_____Can't afford market rent
_____Current apartment is substandard (explain) _____
_____Overcrowded
_____Other: _____

Documentation of homeless status must be attached to Homeless Status Certification

_____	_____	_____
Applicant's signature	Applicant's SSN/other ID	Date
_____	_____	_____
Witness' signature	Title	Date

Case Manager/Provider Recommendation:

To the best of my knowledge all information is accurate.

Name:_____ Title:_____
Agency:_____ Date:_____
Contract Number:_____

4/2019

25 Howard Place, Ronkonkoma, NY 11779
631.361.9020 ▪ Fax: 631.361.9204 ▪ optionscl.org

EQUAL HOUSING OPPORTUNITY

ASPIRE to Excellence carf ACCREDITED
Accreditation of Selected Programs

INCOME QUESTIONNAIRE

Name and address of head of household:_____

We need to know about the "income" that every member of your household earns. The following is a list of items the government counts as *income* in determining eligibility for housing assistance. **Check "yes" for a particular type of income if any household member gets it. We'll get the details from you later. Check "no" only if no member of your household gets the particular type of income.**

Warning: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful or false statements, or misrepresentations, of any material fact involving the use or obtaining of federal funds.

1. Adult's employment income
   (*This doesn't include employment income of children younger than 18 or live-in aides.)*
   - Wages ☐Yes ☐No
   - Salaries ☐Yes ☐No
   - Overtime pay ☐Yes ☐No
   - Commissions ☐Yes ☐No
   - Fees ☐Yes ☐No
   - Tips ☐Yes ☐No
   - Bonuses ☐Yes ☐No
   - Any other amounts adult household members earn for working for other people or from their own business ☐Yes ☐No

2. Benefit payments
   (*This includes lump-sum payments received because of delays in processing benefits, but not lump-sum payments received under settlements with insurance companies or lump-sum payments of Social Security or Supplemental Security income*)
   - Social Security ☐Yes ☐No
   - Supplemental Security Income (SSI) ☐Yes ☐No
   - Workers' compensation ☐Yes ☐No
   - Disability pay or benefits ☐Yes ☐No
   - Unemployment benefits ☐Yes ☐No
   - Severance pay ☐Yes ☐No
   - Annuities ☐Yes ☐No
   - Insurance policy payments ☐Yes ☐No
   - Pensions ☐Yes ☐No
   - Retirement fund benefits ☐Yes ☐No
   - Death benefits ☐Yes ☐No
   - Any other benefit payments ☐Yes ☐No

3. Welfare assistance
   (*This includes lump-sum payments received because of delays in processing benefits, but not grants or other amounts received specifically for medical expenses or care and equipment for a disabled person.)* ☐Yes ☐No

4. Alimony and/or child support ☐Yes ☐No

5. Interest, dividends, and other income from household assets
   - Interest from bank accounts or bonds ☐Yes ☐No
   - Dividends from stocks or mutual funds ☐Yes ☐No
   - Income distributed from trust funds ☐Yes ☐No
   - Money from renting household assets ☐Yes ☐No
   - Any other interest, dividends, or rent ☐Yes ☐No

6. Lottery winnings paid in periodic payments ☐Yes ☐No

7. Money regularly given by persons not living in the unit
   (*This includes rent or utility payments regularly by someone on behalf of the household, but doesn't include annual rent credits or rebates paid to senior citizens or payments received for the care of foster children.*) ☐Yes ☐No

8. Any other source of income? ☐Yes ☐No

If yes, please specify:_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby certify that all of the above information is true and correct to the best of my knowledge.

Signature of head of household_____ Date_____

Signature of other adults in household_____ Date_____

6/2005

Options for Community Living, Inc.

CRIMINAL & SEX OFFENDER BACKGROUND INFORMATION

Options for Community Living, Inc.'s policies and government regulations require us to obtain criminal background and sex offender information about all adult household members applying for assisted housing. To enable us to do this, all household members age 18 or older must answer the questions below and sign below to consent to a background check. The questions ask about drug-related and other criminal activity that could adversely affect the health, safety, or welfare of others.

1. Have you been evicted from a federally assisted site for drug-related criminal activity within the past three years? _____yes _____no

2. Do you currently use illegal drugs or abuse alcohol? ____yes ____no

3. Are you currently subject to a lifetime registration requirement under a state sex offender registration program? _____yes ____no

4. Have you been convicted of any crime within the past five years? ____yes ____no

5. Are you currently charged with any criminal activities? ____yes ____no

6. Please list all states in which you have lived or have held licenses to drive (include driver's license #'s)

_____

_____

7. Have you ever used or been known by any other name? ____yes ____no
   If yes, please list names used

_____

I understand that the above information is required to determine my eligibility for residency. I certify that my answers to the above questions are true and complete to the best of my knowledge. I understand that making false statements on this form may be grounds for denial of my application or grounds for termination of my residency agreement. I authorize Options for Community Living, Inc. To verify the above information, and I consent to the release of the necessary information to determine my eligibility.

I hereby authorize law enforcement agencies to release criminal records and/or sex offender registration information to Options for Community Living, Inc.

Applicant's Signature_____Date_____

Applicant's Name (Please Print)_____

25 Howard Place, Ronkonkoma, NY 11779
631.361.9020 ▪ Fax: 631.361.9204 ▪ optionscl.org