Community Living Application

PNO: _____ Direct Care Clinic: _____ Case manager (print name): _____

Case manager email: _____ Case manager phone: _____

Type of housing requested: ☐ ACT HOUSING Location: _____

☐ COMMUNITY LIVING WITH STAFF SUPPORT

☐ INDEPENDENT COMMUNITY LIVING

Is the applicant requesting a specialized housing setting? ☐ Yes ☐ No

If yes, please select one. ☐ 24-hour ☐ Polydipsia ☐ SO ☐ Morten/Probation ☐ Deaf/Hard of Hearing

Is the applicant requesting (choose one): ☐ HOUSE ☐ APARTMENT ☐ NO PREFERENCE

Is the applicant willing to live with roommates? ☐ Yes ☐ No
**Please note that Community Living does not offer house settings without roommates.*

Is the applicant requesting a particular area of the valley? ☐ Yes ☐ No If yes, please identify: _____

Does the applicant have special needs related to housing? ☐ Yes ☐ No If yes, please identify: _____

1. Member Information

Member name: _____ AHCCCS #: _____ DOB: _____

Sex: ☐ Male ☐ Female Priority population: ☐ Yes ☐ No If yes, describe: _____

Is this member homeless? ☐ Yes ☐ No

ACT team: ☐ Yes ☐ No Title 19: ☐ Yes ☐ No COT: ☐ Yes ☐ No

Current housing situation/setting: _____

2. Housing history and current needs

Has the housing applicant lived independently in the past two years? ☐ Yes ☐ No

If yes, what was the most significant reason for leaving (*please check all that apply*):

☐ Eviction ☐ Hospitalization ☐ Inpatient Substance Abuse ☐ Jail/Prison ☐ Voluntary
☐ Other: _____

Is the applicant interested in moving from current environment? ☐ Yes ☐ No

If yes, preferred location: _____

Does the applicant have a service animal? ☐ Yes ☐ No

Does the applicant have a pet? ☐ Yes ☐ No

Does the applicant have a co-occurring/substance abuse? ☐ Yes ☐ No

If yes, provider agency: _____

Does the applicant have legal issues? ☐ Yes ☐ No If yes, please describe: _____

Sex offender: ☐ Yes ☐ No If yes, level: _____

Does the applicant have a parole/probation officer? ☐ Yes ☐ No

If yes, PO's Name: _____ Phone: _____

Does the applicant have a legal guardian? ☐ Yes ☐ No

If yes, guardian's name: _____ Agency: _____ Phone: _____

Current sources of income and amount *(please check all that apply):*

☐ SSI $_____ ☐ SSDI $_____ ☐ Social Security $_____
☐ GA $_____ ☐ VA $ _____ ☐ AFDC/TANF $_____
☐ Unemployment Benefits $_____ ☐ Employment $_____

Sources of financial assistance the applicant has applied or will apply for: _____

Does the applicant require a start-up box? ☐ Yes ☐ No

Has the recipient applied for other housing? ☐ Yes ☐ No If yes, housing type: _____

REQUIRED: Please complete and submit the VI-SPDAT along with this application.
**VI-SPDAT: Vulnerability Index-Service Prioritization Decision Assistance Tool*

3. Certification/Signatures

Case manager (print name)	CM (signature)	Date
Clinical Coordinator (print name)	CC (signature)	Date
Applicant (print name)	Applicant (signature)	Date
Guardian (print name)	Guardian (signature)	Date

Please complete this form, print/scan and email to: housing@MercyCareAZ.org