

Mercy Care RBHA Scattered Site Housing Application

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

Case manager email: _____ Case manager phone: _____

1. Member information

Member name: _____ AHCCCS #: _____ DOB: _____

Type of subsidy housing requested: Member only
 Member and dependent family members

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: _____

Does the applicant have legal issues? Yes No If yes, 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):

- | | | |
|---|--|---|
| <input type="checkbox"/> SSI \$ _____ | <input type="checkbox"/> SSDI \$ _____ | <input type="checkbox"/> Social Security \$ _____ |
| <input type="checkbox"/> GA \$ _____ | <input type="checkbox"/> VA \$ _____ | <input type="checkbox"/> AFDC/TANF \$ _____ |
| <input type="checkbox"/> Unemployment benefits \$ _____ | <input type="checkbox"/> 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 member applied for Community Housing? Yes No
(If yes, member will be removed from Community Housing waitlist.)

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
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Clinical Coordinator (print name)	CC (signature)	Date
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Applicant (print name)	Applicant (signature)	Date
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Guardian (print name)	Guardian (signature)	Date
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Please complete this form, print/scan and email to housing@mercymaricopa.org