Exhibit C

HOPWA STRMU/PH Assistance Request Form

CLIENT INFORMATION

Client URN: _____
(Case Sensitive eURN)

Client DOB: _____

☐ Client is Homeless
*(*See HUD definition below)*
☐ Client is Chronically Homeless
*(**See HUD definition below)*
☐ Client is Pregnant
☐ Client is Female Head of Household

Gender
☐ Male
☐ Female

HIV Diagnosis
☐ HIV+ Asymptomatic
☐ HIV+ Symptomatic
☐ AIDS, yr of diagnosis _____ (if known)
☐ HIV+, but AIDS
☐ status unknown

County of Residence
☐ Adams
☐ Arapahoe
☐ Broomfield
☐ Clear Creek
☐ Denver
☐ Douglas
☐ Elbert
☐ Gilpin
☐ Jefferson
☐ Park
☐ Other

Client Ethnicity
(check all that apply)
☐ African American or Black
☐ American Indian or Alaska Native
☐ Asian
☐ Latino/Latina
☐ Pacific Islander or Native Hawaiian
☐ White or Caucasian
☐ American Indian/Alaska Native & White
☐ Asian & White
☐ Black/African American & White
☐ American Indian/Alaska Native & Black/African American
☐ Other multiracial:
☐ Undisclosed

*** Zip Code:** _____ (Zip code is required for each FAR submitted)

Client Transmission
(check all that apply)
☐ Opposite sex contact
☐ Same sex contact
☐ Transfusion
☐ Sharing needles/IDU
☐ Born HIV infected
☐ Don't know
☐ Undisclosed
☐ Other: _____ (please specify)

Primary HIV Medical Care
☐ Denver Health ID or EIS Clinic
☐ University Hospital ID Clinic
☐ Children's ID Clinic
☐ Clinica Tepeyac ☐ MCPN
☐ VA ID Clinic
☐ Kaiser
☐ Private Infectious Disease Doctor
☐ None
☐ Other _____ (please specify)

Insurance

☐ Medicaid
☐ Medicare A
☐ Medicare B
☐ Medicare D
☐ Private or Employer Plan
☐ CICP
☐ CHS
☐ ADAP
☐ VA
☐ DFAP
☐ None
☐ Other _____ (please specify)

HOUSEHOLD INFORMATION

Household Members: List all people living in the household (including dependents)

Name	Gender	Ethnicity	Date of Birth	Spouse, Partner or Dependent?	HIV Status	If Dependent, Custody?	Monthly Gross Income	Source of Income	Verification Date
Client				**Client**					
	M F		/ /			Y N N/A			
	M F		/ /			Y N N/A			
	M F		/ /			Y N N/A			
	M F		/ /			Y N N/A			
	M F		/ /			Y N N/A			
	M F		/ /			Y N N/A			
	M F		/ /			Y N N/A			
	M F		/ /			Y N N/A			

Household Size: _____ # of Dependents: _____ Total Household Income: $ _____ -

Living Situation Prior to Assistance
☐ Don't Know or Refused
☐ Emergency Shelter/Motel (Paid for w/Voucher)
☐ Foster care home or foster care group home
☐ Hospital
☐ Hotel/Motel paid for by Client
☐ House you own
☐ Jail, prison or juvenile detention facility
☐ Transitional Housing for homeless persons
☐ Permanent Housing for formerly homeless
☐ Place not meant for human habitation
☐ Psychiatric hospital/facility
☐ Rented room, apartment or house
☐ Staying or living in someone else's place
☐ Substance abuse treatment facility or detox
☐ Other _____

Destination After Assistance
☐ Emergency Shelter
☐ Temporary Housing
☐ Private Housing
☐ Other HOPWA
☐ Other Subsidy
☐ Institution
☐ Jail/Prison
☐ Disconnected/Inactive
☐ Death

Sources of Income for listing above:
AND
SSDI
SSI
TANF
Employment
Untaxed/Unreported
Emp. Disability
Pension
VA
No Income
Aid to the Blind
Child Support
Other: _____ (please specify)

_____
(please specify)

STRMU & PERMANENT HOUSING INFORMATION **(Eviction/Foreclosure Prevention & Deposit)**

Monthly Rent: $ _____ **Assistance Amount Requested: $** _____

Period of Assistance: Start Date _____ to End Date _____
(start and end dates should be a minimum of a full month)

Unit Size, number of Bedrooms: _____

☐ Short-Term Rent *(Eviction Prevention)* Assistance
☐ Short-Term Mortgage *(Foreclosure)* Assistance
☐ Permanent Housing *(Deposit)* Assistance

Pay To Information:

Pay to: _____

Address: _____

City, State & Zip: _____

If unit is owned by an individual, did the Case Management Agency confirm with the assessor's office that the property is owned by the individual to whom these payments will be made ? ☐ **Yes** ☐ **No**

Has the client completed a US Residency Affidavit and provided supportive documentation to your agency? ☐ **Yes** ☐ **No**

Did client complete and sign the HOPWA Demographic and Income Form? ☐ **Yes** ☐ **No**

Client/Provider Survey Questions:

☐ Created/discussed long-term stable housing plan?
☐ Contacted a Case Manager (CM) at least once in the past 3 months?
☐ Has medical insurance coverage or other medical assistance?
☐ Obtained an income producing job that resulted from a HOPWA funded job training, employment, education, or case management service. ☐ This job provided benefits
☐ Contacted a Primary Care Provider at least once in the last 3 months?

I hereby attest that all of the above information is true and correct as verified by me based on documentation received (either directly from the client or a reliable third party) and is on file in our office. This documentation is held in a file specifically for the client. I am aware that Burden of Proof is the sole responsibility of myself and the ASO I represent.

Referring Agency: _____

Referring Case Manager: _____ Fax Number: _____

Authorized Signature: _____ _____ Date: _____

Supporting Documention Attached: _____

It is the responsibility of each AIDS Service Organization to assure that this client is eligible for assistance based on the current HOPWA Standards of Care. All sections must be completed. Any incomplete information will cause a delay in processing until the information is received.

** HUD defines "homeless" as "a person sleeping in a place not meant for human habitation (e.g. living on the streets for example) OR living in a homeless emergency shelter*

*** HUD defines a Chronically Homeless person as: an unaccompanied homeless person (a single homeless person who is alone and is not part of a homeless family and not accompanied by children) who has been continuously homeless for one year or more, or has had four (4) periods of homelessness in the last three (3) years.*