Application for Assistance with First Month's Rent and/or Deposit (Housing Placement)

Phone number: May we leave a message?

Email: May we email you about this application?

We do not share or sell email/phone number information. We will not use your email or phone number for any purpose other than to communicate about services you have requested.

At least one household member MUST be HIV+ to qualify for assistance. If you have already leased a unit, we cannot assist with your first month's rent or deposit.

Please provide the following information for everyone who will live with you.

First name	Last name	Relationship to applicant	Age	Income source(s)
		Self		

You must provide income verification documents for everyone in the household who has income. If income verification documents are not provided, your application will not be considered.

If the income is from employment, provide the most recent 4 weeks paystubs.
If the income is from Social Security, provide this year's award letter from Social Security.
If you have other sources of income, please provide the verification you have available.

These questions help Caracole decide which applications have the greatest need. Please include details about your situation to help us understand your need.

What is the current NET monthly income for your household (the amount you receive after taxes and other deductions)?	
If you or a household member recently lost income, when did this loss of income occur?	
What was your monthly NET income prior to losing income?	

Where do you sleep most nights currently? Who else lives there?

How did you become homeless or at risk of losing your housing?

Are you currently dealing with any additional health conditions, financial problems, or other special circumstances? Please describe.

How will you pay your full rent after moving into a new unit? If you have new employment lined up, please list hourly wage and number hours per week you will be paid.

Do you have a Caracole case manager? If yes, who?

We will respond to your application within 1 week via the contact information you provided. Please do not contact our offices to follow up on your application unless it has been more than 7 days since you applied.

This release of information will be used to contact your HIV doctor to verify that you are living with HIV. If your doctor is not listed or you (the person completing this form) are not the person in your household living with HIV, leave this form blank and we will contact you for other verification.

Authorization for Release of Confidential Information

By signing below, I, _____(print name) authorize_____(HIV medical provider) to disclose information to Caracole Inc.; and/or _____(print name) authorize Caracole Inc. to disclose information to_____(HIV medical provider) for the purpose of receiving and coordinating services.

- My health information
- My finances
- My legal history
- Services I have requested and/or received
- Mental Health
- Substance Use Disorders and Treatment
- Communicable Disease (including HIV, AIDS or AIDS Related Conditions)

The information cannot be shared except for these purposes.

I know that:

- I do not have to sign this form. I can still receive services if I do not sign this form.
- I have the right to have all of my questions about this form answered before signing.
- Information released may include information concerning testing, diagnosis or treatment of HIV, AIDS, AIDS Related Conditions, mental health and/or drug/alcohol treatment.
- Information about drug and alcohol treatment is protected by federal law and cannot be re-disclosed without your consent. Other information could be disclosed again if the receiving organization is not required by state or federal privacy law to protect it.
- I can end the release of information at any time over the phone, in person or in writing to stop the sharing of information. If I end this release of information the "authorization revoked*" portion of this form will be completed. ***Information already shared cannot be taken back.***

This release of information will end in thirteen (13) months, and I will need to sign a new form at that time.

SIGNATURE: _____ DATE: _____

Prohibition on re-disclosure: *Information that has been disclosed to you from records whose confidentiality is protected by federal law (42 CFR Part 2) is prohibited from being further disclosed without specific consent from the person to whom it pertains.*

*AUTHORIZATION REVOKED ☐ In writing ☐ Verbally

COMPLETED BY: _____ DATE: _____