MAINE STATE HOUSING AUTHORITY
Stability Through Engagement Program (STEP) Preliminary Application
(SHELTER NAVAGATOR USE ONLY)

MaineHousing
26 Edison Drive
Augusta, ME 04330-4633
1-800-452-4668 Voice
7-1-1 (Maine Relay)

If you would like assistance in completing this application, need this document in an alternative format, need translation assistance or need this document in audiotape form, please call.

The Fair Housing Act of 1988, Section 504 of the 1973 Rehabilitation Act, and the Americans with Disabilities Act require that we reasonably accommodate persons with disabilities. Do you, or a family member who will be living with you, require a specific accommodation in order to fully participate in the STEP Program? ☐ Yes ☐ No
If Yes, MaineHousing may request disability-related information that (1) is necessary to verify that the person meets the definition of "disability," (2) describes the needed accommodation, and (3) shows the relationship between the disability and the requested accommodation. You can also contact the Fair Housing and Equal Opportunity National toll free hot-line number **1-800-424-8590.**

Name (Head of Household)

Current Address Apt. No.

City State Zip Code

Mailing Address (if different from above*) Apt. No.

City State Zip Code

Primary and Alternate Phone Number(s)

Zip Code of last permanent address_____

Referring Agency

Navigator/Agency Address

Navigator's Name

Navigator's Phone /Fax Number(s)

Navigator's e-mail address

*All STEP related correspondence will be sent to the Mailing Address listed here unless or until MaineHousing receives a written request from you to update your Mailing Address information. Failure to provide a current Mailing Address may result in the loss or delay of your receipt of important information regarding your participation in the STEP Program.

Have you ever received services or benefits under another name? ☐ Yes ☐ No
If "Yes", what name(s)? _____

In what city or town do you intend to live? _____.
If you know the county where that city or town is located, please check below. Please check only one county.

☐ Cumberland	☐ Androscoggin	☐ Franklin	☐ Kennebec	☐ Aroostook	☐ Hancock
☐ York	☐ Knox	☐ Lincoln	☐ Oxford	☐ Piscataquis	☐ Penobscot
	☐ Sagadahoc	☐ Somerset	☐ Waldo	☐ Washington	

HOUSEHOLD COMPOSITION AND CHARACTERISTICS

1. List the Head of Household and **all other household members who will be living with you**. Give the relationship of each member to the Head of Household. If more room is needed for additional members, attach another sheet.

Family Member's Full Name	Relationship To Applicant	Birth Date	Sex	Social Security Number	OPTIONAL	
					Race	Ethnicity
	Head of Household					

☐ Check here if Head of Household is an emancipated minor and can provide documentation.

2. Are you, or any member of your household, a United States Military Veteran? ☐ Yes ☐ No

3. Are any members of your household, who are over the age of 18, a full time student? ☐ Yes ☐ No
   If yes, who: _____

4. Do you expect any changes in your household composition in the next 6 months? ☐ Yes ☐ No
   If yes, explain: _____

5. Have you or any other members of your household ever received, or are you or they now receiving, rental assistance?
   ☐ Yes ☐ No
   If yes, where and when? _____

6. Are you on the waiting list anywhere for rental assistance?
   ☐ Yes ☐ No
   If yes, where and when did you apply ? _____

ASSET DECLARATION

I declare I have the following assets:

Asset Type	Value
Cash	$
Checking Accounts	$
Savings Accounts	$
Money Market Accounts	$
Trusts*	$
Investments (stocks, bonds, CDs, etc.)*	$
Retirement Accounts (IRA, 401(k), Keogh, etc.)*	$
Other (specify):	$
Total Assets	**$**

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INCOME INFORMATION **Verification of all income must be provided**

Income Category	Amount Received (monthly)
Earned Income	$
Unemployment	$
Disability Income	$
Worker's Compensation	$
TANF	$
Social Security	$
Supplemental Security Income (SSI)	$
Social Security Disability Income (SSDI)	$
Alimony/Child Support/Foster Care Income	$
Armed Forces Income	$
Retirement/Pension	$
Interest/Dividends	$
Other (specify):	$
Total Monthly Income	$

For purposes of Program Income Deductions:

a. Is head of household disabled? ☐ Yes ☐ No
b. Is spouse of head of household disabled? ☐ Yes ☐ No
c. Are any other household members disabled? ☐ Yes ☐ No

EXPENSE INFORMATION **If yes on any question, the appropriate verification form must be accompanied with this application**

Out-of-pocket child care expenses for children under 13 years old, and children with a documented disability under 18 years old can be deducted from and reduce overall gross income. This can potentially reduce the tenant portion of the rent.

☐ Yes ☐ No Does your household pay child care expenses for children under age 13 that enable another family member to work or go to school?

☐ Yes ☐ No Does your household pay for the care of a family member with disabilities that enables another family member to work?

Out-of-pocket medical expenses in excess of 3% of annual income can be deducted from and reduce overall annual gross income. This can potentially reduce the tenant portion of the rent. Anticipated, out

☐ Yes ☐ No Does your household have unreimbursed medical expenses in excess of 3 percent of annual income?

Out of pocket, unreimbursed prescription drug costs can be deducted from and reduce overall annual gross income. This can potentially reduce the tenant portion of the rent.

☐ Yes ☐ No Does your household have any anticipated out-of-pocket prescription drug expense on a regular basis?

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HOUSEHOLD SCREENING

MaineHousing screens **all adult household members** for drug-related criminal activities, violent criminal activities, sex offenses and sex offender registrations, debts owed to housing agencies, alcohol related crimes and use of illegal drugs including "medical marijuana". **MaineHousing's medical marijuana policy denies usage, possession or cultivation in federally subsidized housing units.**

☐ Yes ☐ No **Do any household members currently use, cultivate or possess illegal drugs including "medical marijuana"?**

If your answer is "Yes": Household Member Name: _____

☐ Yes ☐ No **Have any household members ever been arrested for drug-related or violent criminal activity?**

If your answer is "Yes": Household Member Name: _____

Where and when: State: _____ Year: _____

☐ Yes ☐ No **Do any household members owe money to any Housing Authority?**

If your answer is "Yes": Household Member Name: _____

Year: _____ Amount Owed: $ _____ to_____

Warning:

Title 18, Section 101 of the United States Code states that a Person is guilty of felony for knowingly and willingly making false or fraudulent statements to any Department or Agency of the United States, and shall be fined not more than $10,000, or imprisoned for not more than 5 years, or both.

I certify that the information given to MaineHousing regarding my household family members, income, assets, allowances and deductions is accurate and complete to the best of my knowledge and belief. I understand that false statements or information are punishable under Federal Law. I also understand that false statements or information are grounds for denial of housing assistance.

Signature of Head of Household: _____ Date: _____

Signature of other Adults in Household _____ _____

EQUAL HOUSING OPPORTUNITY

MaineHousing Authority does not discriminate on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, national origin, ancestry, physical or mental disability, age, familial status or receipt of public assistance in the admission or access to or treatment in its programs and activities. In employment, MaineHousing does not discriminate on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, national origin, ancestry, age, physical or mental disability or genetic information. MaineHousing will provide appropriate communication auxiliary aids and services upon sufficient notice. MaineHousing will also provide this document in alternative formats upon sufficient notice. MaineHousing has designated the following person responsible for coordinating compliance with applicable federal and state nondiscrimination requirements and addressing grievances: Kelly Stonebraker, Maine State Housing Authority, 26 Edison Drive, Augusta, Maine 04330-4633, Telephone Number 1-800-452-4668 (voice in state only), (207) 626-4600 (voice) or Maine Relay 711.

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STEP Application Addendum – DATA REQUIREMENTS for Head of Household and Adults

Please complete one sheet for each adult served, whether they are an individual or a family member

First Name: _____ **MI**: _____ **Last Name**: _____ **Suffix**: _____

U.S. Military Veteran? (clients 18 and older): ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑Data Not Collected

Primary Race:
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black/African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Client Doesn't know
- ❑ Client Refused
- ❑ Data Not Collected

Secondary Race:
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black/African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Client Doesn't know
- ❑ Client Refused
- ❑ Data Not Collected

Ethnicity:
- ❑ Hispanic/Latino
- ❑ Non-Hispanic /Latino)
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

Residence prior to project entry:

HOMELESS SITUATION
- ❑ Place Not Meant for Habitation
- ❑ Emergency Shelter, including hotel or motel paid for with emergency shelter voucher
- ❑ Safe Haven
- ❑ Interim Housing

INSTITUTIONAL SITUATION
- ❑ Foster Care Home or Foster Care Group Home
- ❑ Hospital or other Residential Non-Psychiatric Medical Facility
- ❑ Jail, Prison or Juvenile Detention Facility
- ❑ Long-Term Care Facility or Nursing Home
- ❑ Psychiatric Hospital or Other Psychiatric Facility
- ❑ Substance Abuse Treatment Facility or Detox Center

TRANSITIONAL AND PERMANENT HOUSING SITUATION
- ❑ Hotel or Motel Paid for without an Emergency Shelter Voucher
- ❑ Owned by Client, No Ongoing Housing Subsidy
- ❑ Owned by Client, with Ongoing Housing Subsidy
- ❑ Permanent Housing for Formerly Homeless Persons
- ❑ Rental by Client, No Ongoing Housing Subsidy
- ❑ Rental by Client with VASH Subsidy
- ❑ Rental by Client with GPD TIP Subsidy
- ❑ Rental by Client with Other Ongoing Housing Subsidy (Non-VASH)
- ❑ Residential Project or Halfway House with no Homeless Criteria
- ❑ Staying or Living in a **Family** Member's Room, Apartment or House
- ❑ Staying or Living in a **Friend's** Room, Apartment or House
- ❑ Transitional Housing for Homeless Persons (includes homeless youth)
- ❑ Client Doesn't Know
- ❑ Client Refused

❑ Data Not Collected

Length of stay in prior living situation:

❑ 1 night or less
❑ 2 to 6 nights
❑ 1 week or more but less than 1 month
❑ 1 month or more but less than 90 days
❑ 90 days or more but less than 1 year
❑ 1 year or longer
❑ Client Doesn't Know
❑ Client Refused
❑ Data Not Collected

If Literally Homeless, then:

Length of stay in prior living situation:

❑ 1 night or less
❑ 2 to 6 nights
❑ 1 week or more but less than 1 month
❑ 1 month or more but less than 90 days
❑ 90 days or more but less than 1 year
❑ 1 year or longer
❑ Client Doesn't Know
❑ Client Refused
❑ Data Not Collected

Approximate Date Homelessness Started: _____/_____/_____

Regardless of where they stayed last night, number of times the client has been on the streets, in ES, or SH in the past three years including today:

❑ One Time
❑ Two Times
❑ Three Times
❑ Four or More Times
❑ Client Doesn't Know
❑ Client Refused
❑ Data Not Collected

Total Number of Months Homeless on the street, in ES or SH in the Past Three Years:

❑ One Month (this time is the first month)
❑ 2 Months
❑ 3 Months
❑ 4 Months
❑ 5 Months
❑ 6 Months
❑ 7 Months
❑ 8 Months
❑ 9 Months
❑ 10 Months
❑ 11 Months
❑ 12 Months
❑ More than 12 Months
❑ Client Doesn't Know
❑ Client Refused
❑ Data Not Collected

If Institutional Setting, then:

Did you stay less than 90 days: ❑Yes ❑No

If less than 90 days, **on the night before did you stay on the streets, ES, or SH?** ❑Yes ❑No

If yes:

Approximate Date Homelessness Started: _____/_____/_____

Regardless of where they stayed last night, number of times the client has been on the streets, in ES, or SH in the past three years including today:

❑ One Time
❑ Two Times
❑ Three Times
❑ Client Doesn't Know
❑ Client Refused
❑ Data Not Collected

❑ Four or More Times

Total Number of Months Homeless on the street, in ES or SH in the Past Three Years:

❑ One Month (this time is the first month)
❑ 2 Months
❑ 3 Months
❑ 4 Months
❑ 5 Months
❑ 6 Months
❑ 7 Months
❑ 8 Months
❑ 9 Months
❑ 10 Months
❑ 11 Months
❑ 12 Months
❑ More than 12 Months
❑ Client Doesn't Know
❑ Client Refused
❑ Data Not Collected

If Transitional or Permanent Housing Situation:

Did you stay less than 7 nights? ❑Yes ❑No

***If less than 7 nights,* on the night before did you stay on the streets, ES, or SH?** ❑Yes ❑No

If yes:

Approximate Date Homelessness Started: _____/_____/_____

Regardless of where they stayed last night, number of times the client has been on the streets, in ES, or SH in the past three years including today:

❑ One Time
❑ Two Times
❑ Three Times
❑ Four or More Times
❑ Client Doesn't Know
❑ Client Refused
❑ Data Not Collected

Total Number of Months Homeless on the street, in ES or SH in the Past Three Years:

❑ One Month (this time is the first month)
❑ 2 Months
❑ 3 Months
❑ 4 Months
❑ 5 Months
❑ 6 Months
❑ 7 Months
❑ 8 Months
❑ 9 Months
❑ 10 Months
❑ 11 Months
❑ 12 Months
❑ More than 12 Months
❑ Client Doesn't Know
❑ Client Refused
❑ Data Not Collected

Zip code of last permanent address: _____
(where the client last lived for 90 days or more)

Zip Code data quality: ❑ Full or Partial ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

Receiving Income from any source? ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑Data Not Collected

Receiving Income	**Source of Income** (*Check all that apply*)	**Income Amount**
❑Yes ❑No	Earned Income	$
❑Yes ❑No	Unemployment Insurance	$
❑Yes ❑No	Supplemental Security Income (SSI)	$
❑Yes ❑No	Social Security Disability Income (SSDI)	$
❑Yes ❑No	VA Service Connected Disability Compensation	$
❑Yes ❑No	Private Disability Insurance	$
❑Yes ❑No	Worker's Compensation	$
❑Yes ❑No	Temporary Assistance for Needy Families (TANF)	$

❑Yes ❑No	General Assistance	$

Income Info (cont.)

❑Yes ❑No	Retirement Income From Social Security	$
❑Yes ❑No	VA Non-Service Connected Disability Pension	$
❑Yes ❑No	Pension or Retirement Income from Another Job	$
❑Yes ❑No	Child Support	$
❑Yes ❑No	Alimony or Other Spousal Support	$
❑Yes ❑No	Other – Specify Source _____	$

Receiving Non-Cash Benefit from any source? ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑Data Not Collected

Receiving Benefit	**Source of Non-Cash Benefit** (*Check all that apply)*	**Benefit Amount** *(when applicable)*
❑Yes ❑No	Supplemental Nutrition Assistance Program (SNAP – Food Stamps)	$
❑Yes ❑No	Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	$
❑Yes ❑No	TANF Child Care services	$
❑Yes ❑No	TANF transportation services	$
❑Yes ❑No	Other TANF-funded services	$
❑Yes ❑No	Section 8, public housing, or other ongoing rental assistance	$
❑Yes ❑No	Temporary Rental Assistance	$
❑Yes ❑No	Other Source – Specify Source _____	$

Is Client Covered by Health Insurance? ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑Data Not Collected

Covered	**Health Insurance Type** (*Check all that apply)*
❑Yes ❑No	MEDICAID
❑Yes ❑No	MEDICARE
❑Yes ❑No	State Children's Health Insurance Program
❑Yes ❑No	Veteran's Administration (VA) Medical Services
❑Yes ❑No	Employer-Provided Health Insurance
❑Yes ❑No	Health Insurance obtained through COBRA
❑Yes ❑No	State Health Insurance for Adults
❑Yes ❑No	Private Pay Health Insurance
❑Yes ❑No	Indian Health Services Program
❑Yes ❑No	Other – Specify: _____

Do you have a disability of long duration? ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑Data Not Collected

Disability Type	**Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently**	**Documentation of the disability and severity on file?**	**Currently Receiving Treatment or Services?**
Physical ❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No

❑Client Doesn't Know ❑Client Refused	❑Client Doesn't Know ❑Client Refused		

Disability Info (cont.)

Developmental ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No
Chronic Health Condition ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No
HIV/AIDS ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No
Mental Health Problem ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No
Alcohol Abuse ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No
Drug Abuse ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No
Both Alcohol and Drug Abuse ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No

Residential Move-In Date: _____/_____/_____

STEP Application Addendum – DATA REQUIREMENTS for Children

Please complete one sheet for each child served

First Name: _____ **MI**: _____ **Last Name**: _____ **Suffix**: _____

Primary Race:
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black/African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Client Doesn't know
- ❑ Client Refused
- ❑ Data Not Collected

Secondary Race:
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black/African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Client Doesn't know
- ❑ Client Refused
- ❑ Data Not Collected

Ethnicity:
- ❑ Hispanic/Latino
- ❑ Non-Hispanic /Latino)
- ❑ Client Doesn't Know
- ❑ Client Refused
- ❑ Data Not Collected

Zip code of last permanent address: _____
(where the client last lived for 90 days or more)

Zip Code data quality: ❑ Full or Partial ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

Is Client Covered by Health Insurance? ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused ❑Data Not Collected

Covered	Health Insurance Type (*Check all that apply)*
❑Yes ❑No	MEDICAID
❑Yes ❑No	MEDICARE
❑Yes ❑No	State Children's Health Insurance Program
❑Yes ❑No	Veteran's Administration (VA) Medical Services
❑Yes ❑No	Employer-Provided Health Insurance
❑Yes ❑No	Health Insurance obtained through COBRA
❑Yes ❑No	State Health Insurance for Adults
❑Yes ❑No	Private Pay Health Insurance
❑Yes ❑No	Indian Health Services Program
❑Yes ❑No	Other – Specify: _____

Disability Type	Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently	Documentation of the disability and severity on file?	Currently Receiving Treatment or Services?
Physical ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No
Developmental ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No
Chronic Health Condition ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No

Disability Info (cont.)

HIV/AIDS ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No
Mental Health Problem ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No
Alcohol Abuse ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No
Drug Abuse ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No
Both Alcohol and Drug Abuse ❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No ❑Client Doesn't Know ❑Client Refused	❑Yes ❑No	❑Yes ❑No

Residential Move-In Date: _____/_____/_____