

AOD Housing Readiness program

IVSN's AOD Housing Readiness program is a rental subsidy program for candidates who have completed an AOD treatment program within the last 18 months in San Mateo County. If approved, program participants are eligible for a rental subsidy and case management services for up to 18 months.

Program participants will rent an approved, apartment, or home in San Mateo County and sign a lease with a landlord. The rental subsidy structure is as follows:

- Months 1-4 = 100% subsidy (Example: 100% of participant's rent will be paid by IVSN)
- Months 5-9 = 75% subsidy (Example: Participant will be responsible for paying 25% of their rent to their Landlord)
- Months 10-14 = 50% subsidy
- Months 15-18 = 25% subsidy

Eligibility Requirements

- Completed an AOD treatment program in San Mateo County within the last 18 months
- Applicant must be currently homeless or exiting a residential treatment program, with no viable housing option
- Applicants must have sustainable and verifiable income (SSI/SSDI/SDI, TANF and GA do not qualify)
- Must actively participate in IVSN case management services including...
 - Required savings plan and financial education (i.e. budgeting and saving workshops)
 - If job searching, appropriate job development activities (i.e. Resume workshop, job searching, etc.).
- Must have a realistic relapse prevention plan
- Complete the AOD Housing Readiness Application
- Low-income housing, hotels, and SLEs are not eligible. Rooms for rent will be considered only if ALL housemates are AOD Housing Readiness participants
- Once housing is secured, applicant will be required to obtain a completed W9 form and lease from their prospective Landlord. **Rental units and leases must be approved by program staff before any payments can be made**

Please include the following documents with your application:

- ___ Certificate of Completion of a San Mateo County AOD treatment program
- ___ Proof of Income/Employment
- ___ Copy of Photo Identification (must be visible)
- ___ Proof of Homelessness
- ___ Projected Budget

Please **scan and email documents** to Teresa Brown at tbrown@ivsn.org for review.

If you are unable to email documents you may fax them to **Teresa Brown at 650-685-5881**.

It is required that you follow-up with a confirmation email to confirm that your fax has been received.

Referring Case Manager's portion

Applicant's Name: _____ **DOB:** _____ **Referral Date:** _____

Applicant's Phone: _____ **Email:** _____

Referring Agency/Program: _____ **Entry Date:** _____ **Exit Date:** _____

Referring CM: _____ **Phone:** _____

Agency Contact Email: _____

Applicant's Portion (please use additional paper if necessary)

Additional Household Members

Name: _____ Relation: _____ Age: _____

Name: _____ Relation: _____ Age: _____

Name: _____ Relation: _____ Age: _____

Name: _____ Relation: _____ Age: _____

Have you graduated from an AOD Treatment program within the last 18 months? **Yes** _____ **No** _____

List Treatment Programs with dates of program stay and outcome

Program	Dates	Outcome
1. _____	_____	_____
2. _____	_____	_____

Please list 3 ways you are going to support your Recovery and remain clean and sober

1. _____

2. _____

3. _____

Program Goals

Please list 3 ways the AOD Housing Readiness program will help you

- 1. _____

- 2. _____

- 3. _____

List 3 goals you would like to accomplish in the AOD Housing Readiness program

- 1. _____
- 2. _____
- 3. _____

List any diplomas, degrees or certificates you have obtained (include H.S. Diploma/G.E.D.)

Current Employment and Income

Total Monthly Income (entire household): _____ Savings Amount: _____

Current Employer: _____ Position: _____

Hours/week: _____ Salary/Wage: _____ Length of Employment: _____

How much can you afford to spend on rent? _____

Amount of Debt: _____ Evictions? _____ Dates: _____

AOD Housing Readiness Application

Please list income from all household members (use additional paper if necessary)

Applicant: _____ Amount: _____ Source: _____

Additional: _____ Amount: _____ Source: _____

Additional: _____ Amount: _____ Source: _____

Please discuss any plans to increase your income while in the program

Please discuss any plans to attend school or vocational training while in program

What is your housing plan if you are not accepted into the program?

What is your available support system? _____

----- **IVSN use only** -----

Date Referral Received: _____ Assigned to: _____ Date: _____

Contact Attempts: _____

Projected Monthly Budget

This budget is designed to help you determine how much you can afford to pay for housing by estimating what your projected income and expenses will be each month.

MONTHLY Household Income (after taxes)		Monthly Expenses	
Wages (Adult 1)	\$ _____	Projected Rent	\$ _____
Wages (Adult 2)	\$ _____	Groceries	\$ _____
Wages (Adult 3)	\$ _____	PG&E/Utilities	\$ _____
Wages (Adult 4)	\$ _____	Phone/Cell	\$ _____
GA	\$ _____	Cable/Internet	\$ _____
SSI	\$ _____	Water/Garbage	\$ _____
SSDI	\$ _____	Renter's Insurance	\$ _____
Social Security	\$ _____	Gas	\$ _____
Veterans Benefits	\$ _____	Bus/Train Tickets	\$ _____
Unemployment Benefits	\$ _____	Car Payment	\$ _____
Food Stamps	\$ _____	Car Insurance	\$ _____
Child Support	\$ _____	Laundry	\$ _____
Other (Specify)	\$ _____	Medical/Dental	\$ _____
_____	\$ _____	Toiletries	\$ _____
_____	\$ _____	Infant Supplies	\$ _____
		Cleaning/Household Supplies	\$ _____
Total Monthly Income	\$ _____	School Lunches/Eating out	\$ _____
		Entertainment	\$ _____
		Restitution/Loans	\$ _____
		Credit Card Payments	\$ _____
		Other Debt	\$ _____
		Savings DON'T TOUCH	\$ _____
		Savings- Emergencies	\$ _____
		Savings- Clothing/Shoes	\$ _____
		Savings- Car Repairs	\$ _____
		Savings for Gifts/Toys	\$ _____
Total Monthly Income	\$ _____	Other: _____	\$ _____
Less Total Expenses	\$ _____	Other: _____	\$ _____
Balance	\$ _____	Other: _____	\$ _____
		Total Expenses	\$ _____

HOMELESS CERTIFICATION INNVISION SHELTER NETWORK RENTAL SUBSIDY PROGRAMS

Client name _____, SSN _____ is currently:

(Check one)

- In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street).
- In an emergency shelter.
Name/Location of Shelter: _____
- In transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters.
Name/Location of Shelter: _____
- In any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution.
Name/Location of Institution: _____
- Is being discharged within 30 calendar days from an institution, such as a mental health or substance abuse treatment facility or a jail/prison, in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing.
Name/Location of Institution: _____
- Is living in housing but is within one week of being evicted from the dwelling by the lease holder.

I certify that the above information is correct to the best of my knowledge and that I have the appropriate documentation on file. Verification of homelessness will be available upon request.

Signature

Agency Name

Printed Name

Address

Title

City, State, Zip

Date

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Phone Number