Community Housing Program (CHP)
Application/Referral Guidance

How do you know if someone is appropriate for a CHP Referral?

✓ To meet referral requirements:

1. Applicant must have a Diagnosed Substance Use Disorder (SUD);
2. Applicant must be under active supervision by
   a. Parole from a State Prison; OR
   b. State Drug Court (DC) or Family Treatment Court (FTC)
   and;
3. Applicant must be Homeless or at Risk of Homelessness*
   Note (*): *for the intent of the Community Housing Program "risk of homelessness" is defined as someone who is at risk of losing their housing due to lack of means or resources. This also extends to those who are in unsafe housing and are without means to relocate to safer housing.*

✓ CHP Support is solely bridge support. An applicant would only be appropriate if they are willing to be engaged in efforts towards self-sustainability.

Who would NOT be appropriate for a referral?

- Someone who expresses no interest in employment or putting effort to be self-sustainable, would not be an appropriate referral.
- Someone with a Severe and Persistent Mental Illness that is symptomatic would not be appropriate. Once their SPMI is considered to be managed, they may be appropriate for CHP support.
- Someone who is capable of paying housing costs, not at risk for homelessness, but is "trying to save money" or just has poor/inappropriate budgeting habits.

IDENTIFY DURATION NEEDED - *Our support is designed to work with the unique needs of the qualified individual – the mission is for the participant's successful transition from CHP support to self-sustainable housing.*

The duration of support requested should reflect the earliest, realistic goal for the applicant to be capable of self-payments, if actively engaged in doing so.

SUPPORT EXTENSIONS - *If the participant is approaching the anticipated end of support date and the CJSA assesses that an extension of support is needed for the participant to successfully make this transition, the CJSA may complete a* ***Request to Extend Support Form****.* ***Please reach out to the CHP Coordinator for further guidance.***

New Hampshire Judicial Branch Application for Substance Use Disorder (SUD) Community Housing Program (CHP) Subsidy

- Please do not leave anything blank: if not applicable, put "NA" –

Applicant Full Name (Please print clearly):	**DOB:**	**Gender:** ☐ Male ☐ Female ☐ Gender Neutral	
Referring State Prison (DOC):	**Has this applicant applied for CHP Support before?** ☐ Yes ☐ No ☐ Not Sure		
OR Referring DOC District Office:	**DOC Agent Name:**	**DOC Agent Contact #:**	**Email:**
Referring Drug Court (DC) or Family Treatment Court (FTC):	**DC/FTC Case Manager Name:**	**DC/FTC Case Manager Contact #:**	**Email:**

Client Race: ☐ White/Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Other (specify) _______________

Ethnicity: ☐Hispanic ☐ Non-Hispanic **U.S. Military Veteran**? ☐ Yes ☐ No

SUD Diagnosis Clinically Confirmed: ☐ Yes ☐ No

EXPECTED RELEASE DATE: ☐ N/A	**DATE OF DRUG COURT PLEA:** ☐ N/A
Supervision Upon Release or Current: ☐ State Parole ☐ State Probation ☐ N/A	**Please Identify:** Registered Sex Offender: ☐ Yes ☐ No Arson: ☐ Yes ☐ No
PPO E-Mail:	**PPO Contact #:**

TO BE COMPLETED BY THE DOC, DC, or FTC AGENT: Describe Reason For Referral:

____

____

____

____

____

List any Housing Restrictions (restricted or required: addresses, counties, towns, etc.)

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Please identify two locations within the State of New Hampshire that the client would like to obtain housing. List them in priority order:

1. ____

2. ____

What type of SUD services is the client currently participating in (such as residing in the Focus unit, intensive outpatient treatment, individual/group treatment, or weekly self-help support groups)?

____

____

Does this applicant have a diagnosed Severe and Persistent Mental Illness (SPMI)? ☐ Yes ☐ No ☐ Unknown
If applicant has a diagnosed SPMI is there a treatment plan? Please define:

____

____

Has the applicant ever been evicted from housing? If yes, please describe:

____

____

Has this client ever lived in a sober living facility? ☐ Yes ☐ No
Was the client ever involuntarily exited/discharged from a sober living facility? If yes, please explain reason:

____

Does the client have a history of homelessness? ☐ Yes ☐ No
If yes, please identify duration: ______________________

Does the client currently have an active Driver's License in the state of NH? ☐ Yes ☐ No

If yes, does the client have a street legal and operable motor vehicle? ☐ Yes ☐ No

If no, what is the client's plan for transportation? ______________________________________

Is applicant actively employed: ☐ Yes ☐ No
If yes, list name of current employer:__________________ Total verifiable income/month: __________

If not currently employed, who is the prospective employer: ____________________________________

Is this client actively receiving SSDI/SSI? ☐ Yes ☐ No ☐ Needs to Reactivate ☐ Applying

If actively receiving SSI/SSDI or TANF, what is the total amount per month? ____________________

Please list any other income not otherwise mentioned above: ______________________________________

UNIT OCCUPANCY - MUST BE COMPLETED FULLY for Apartment Support

Notice: CHP Support is intended for **single-occupancy units only**. Without exceptional approval, **no other occupants are permitted to reside in the unit while the unit is under CHP Support.**

In rare and exceptional circumstances, and by referral from the CJSA, exceptional situations may be considered. A CJSA must complete the CHP Exceptional Circumstances Request Form and attach it to this application. Rare exceptions require approval by the DOC, HHS, and the NHJB. In this event, the CHP Coordinator will present the request made by the CJSA on the participant's behalf to the DOC, HHS, and the NHJB for consideration. The CJSA may reach out to the CHP Coordinator for further direction.

Name:	DOB:	Relationship	Gender

List all Housing that you have attempted to attain prior to submission of this referral:

Housing #1:		Contact Method:	
Housing #2:		Contact Method:	
Housing #3:		Contact Method:	

Details of Attempts:

Certification: I certify, under penalty of unsworn falsification, that all of the information in this application is true and complete to the best of my knowledge and belief. False information will result in return of referral.

X	
Client Signature	**Date of Referral Submittal**
X	
Case Manager, Witness/Review of Referral	**Date of Witness/Review of Referral**

<u>Apartment/Rooming House Support</u>

- to be completed only by those applying for apartment support -

Housing History

(All fields required – must not be left blank. If not applicable, put “N/A”)

Previous Address (1)	
Date of Start	
Date of End	
Reason for End	☐ **Eviction**

Previous Address (2)	
Date of Start	
Date of End	
Reason for End	☐ **Eviction**

Please identify any areas, locations, or regions in which applicant has a history of drug activity and/or triggering relationships:

____

____

Please identify any areas, locations, or regions in which applicant has positive supports or the potential of:

____

____

Additional Housing Considerations

Does the applicant have a clear mental health plan for reentry addressing any and all prevalent, clinical diagnoses? ☐ Yes ☐ No

Please identify any physical or mental health diagnoses that a perspective landlord should be made aware of:

____

____

If applicable, the applicant agrees to work in compliance with the SOAR program.
Applicant signature:_________________________________Date:_______________
Witness signature:__________________________________Date: ______________