



# AHVP Nursing Home Pilot Pre-Application



The Alternative Housing Voucher Program (AHVP) provides rental assistance vouchers to low income, non-elderly persons with disabilities. The voucher provides a subsidy that can be used to rent a private market apartment anywhere in Massachusetts. AHVP Participants receive one bedroom vouchers (except for an appropriate reasonable accommodation). For more information on the Alternative Housing Voucher Program, including general eligibility requirements you can visit

<https://www.mass.gov/service-details/alternative-housing-voucher-program-ahvp> or the CHAMP website, <https://publichousingapplication.ocd.state.ma.us/> .

This pre-application is for a pilot program using 50 AHVP vouchers for residents of Skilled Nursing (SNF) certified by Medicaid (MassHealth) who are eligible for AHVP to live in the community. If more than 50 eligible people apply, a lottery will be held to determine who will receive vouchers. If you are chosen, you may be contacted by MassHealth to discuss transition options. To be eligible, you must be

- 59 years old or younger
- A person with a disability
- Low-income (as defined at this link: <https://www.mass.gov/doc/ahvp-dmhrsp-income-limits-2021/download> . The lowest income limit across the state is currently \$47,150 for a single person)
- Continuously residing in a skilled nursing facility from June 1, 2021 to July 15, 2021

This pre-application does not put you on any waiting lists for standard AHVP. If you would also like to be added to a standard AHVP waitlist, you must do that through [CHAMP](#) or your local housing authority. If you pass the pre-screening for this pilot and are chosen, you will then continue to the standard eligibility screening process for AHVP.



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Medicaid defines a skilled nursing facility as “A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services” and skilled nursing care as “care like intravenous injections that can only be given by a registered nurse or doctor.” You can check if your place of residence is certified as a skilled nursing facility by going to <https://www.medicare.gov/care-compare/?providerType=NursingHome> and entering the name and location of your residence.

This application can be submitted online until July 15, 2021 at the following link: <https://tinyurl.com/AHVPapp> . You may also submit this application by mail by sending it to the following address:

Stavros, attn: AHVP pilot  
210 Old Farm Road  
Amherst, MA 01002

If sending by mail, it must be postmarked by July 15, 2021.

After submitting this application, it will be sent to the Center for Independent Living (CIL) in your area. They will follow up with you to confirm receipt and possibly request more details, including verification of your residence in a Skilled Nursing Facility. The following are equally acceptable forms of verification:

- A verifier fills out and signs the optional “verification” section on the pre-application. A verifier can be your social worker, case worker, care manager, nursing home staff, a doctor, RN, or medical practitioner
- Letter or email from a verifier stating that you reside in a particular skilled nursing facility
- Signature of CIL employee who has personal knowledge that you are a nursing home resident (“Personal knowledge” means that they have first-hand information such as having visited)
- MassHealth statement that establishes residence



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This program is an equal housing opportunity. In Massachusetts, it is unlawful for a housing provider to discriminate against a current or prospective tenant based on: Race, Color, National Origin, Religion, Sex, Familial Status, Disability, Source of Income, Sexual Orientation, Gender Identity, Age, Marital Status, Veteran or Active Military Status, and Genetic Information



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FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_

LAST NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ PRONOUNS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ VOICE  TTY

OTHER PHONE NUMBERS: \_\_\_\_\_ VOICE  TTY

NAME OF SKILLED NURSING FACILITY WHERE YOU RESIDE: \_\_\_\_\_

ADDRESS OF FACILITY: \_\_\_\_\_ CITY/TOWN: \_\_\_\_\_

STATE: \_\_\_\_ ZIP CODE: \_\_\_\_\_

Is anyone helping prepare this pre-application? Yes \_\_\_ No \_\_\_

If Yes: name and contact info of preparer: \_\_\_\_\_

## PROGRAM QUESTIONS

Are you 59 years old or younger? Yes \_\_\_ No \_\_\_

Are you a person with a disability? Yes \_\_\_ No \_\_\_ Unsure \_\_\_

Do you currently reside in a Skilled Nursing Facility?  
Yes \_\_\_ No \_\_\_ Unsure \_\_\_

If Yes: Admittance Date: \_\_\_\_\_

Do you have a disability for which you need an accommodation of an AHVP policy or procedure, or assistance completing this application? Yes \_\_\_ No \_\_\_

If Yes: please enter some additional details, attach additional sheet if necessary: \_\_\_\_\_

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By my signature, I certify that the information I have given in this pre-application is true and correct. I understand that any false statement or misrepresentation may result in the denial of my pre-application. I understand this pre-application is not an offer of housing. I recognize that this information will be shared with the Center for Independent Living and MassHealth in my area, and AHVP Administering Agency as appropriate, and agree they may contact me.

\_\_\_\_\_  
*APPLICANT SIGNATURE*

\_\_\_\_\_  
*DATE*

\_\_\_\_\_  
*PREPARER SIGNATURE (if applicable)*

\_\_\_\_\_  
*DATE*

**Optional: Verification of residence in a Medicaid or MassHealth Certified Skilled Nursing Facility (SNF)**

You may provide verification of your residence in an SNF by having a professional fill out and sign this portion of the form, as described on the front page. You can also attach any other form of acceptable verification to this pre-application. If you do not include verification with this pre-application, it will be requested later. Verification documentation must be received by the application deadline for an application to be considered.

VERIFIER NAME: \_\_\_\_\_

PREFERRED CONTACT: \_\_\_\_\_

Signatory is: (Check all that apply, include job title or other details if relevant)

Social worker, case worker, or nursing home staff \_\_\_\_\_

Doctor, nurse, or other medical provider \_\_\_\_\_

CIL Staff \_\_\_\_\_

Other: \_\_\_\_\_



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- Applicant currently resides in an SNF
- Applicant does not currently reside in an SNF
- I consent to be contacted by CIL staff with any further questions pertaining to verification of the applicant's residence
- By my signature, I certify that the information I have given in this section of the pre-application is true and correct. .

\_\_\_\_\_  
***VERIFIER SIGNATURE***

\_\_\_\_\_  
***DATE***

**For CIL Staff use**

Date recieved: \_\_\_\_\_

**Applicant's residence in an SNF has**       been verified       Not been verified

Eligibility notification date and method: \_\_\_\_\_

Name: \_\_\_\_\_      Date \_\_\_\_\_