DATE: _____ ATTACHMENT 1

Client Name:_____

Address:_____

City:_____Zip_____

Rental Assistance amount:_____

Month/Date/Year:_____

I, _____ Certify that the above mentioned client qualifies for rental assistance under HAB Policy 99-02 "The use of Ryan White CARE Act funds for Housing Referral Services and Short-term or Emergency Housing Needs" and the Nebraska Ryan White policy "Housing Referral Services and Short Term or Emergency Housing Needs"

I also make the following assurances:

1. The client's housing assistance is essential to the client's ability to gain and/or maintain access to HIV-related medical care or treatment.

2. All other avenues to provide housing assistance have been explored to ensure the Ryan White funding is payer of last resort.

3. A Plan has been implemented and documented in the client's file to assist the client in identifying other sources of funding to pay for long term needs.

4. The above client is a Nebraska Resident and currently qualifies for Ryan White Title II Services. Date of last client application/update:_____ (Must be with in one year).

Authorized Signature_____