Supportive Housing Program

Thank you for applying. There are a few things you should know regarding your application:

- Your application will be reviewed by a Case Manager in the order in which it was received. Because we receive many applications, it may be a week or two before you will be notified of your eligibility. **For your COUNTY**:
  - **MANITOWOC/KEWAUNEE/DOOR**: *Bring or Mail to 702 State St, PO Box 2315, Manitowoc, WI 54221-2315; Fax to 920-686-8700; or Email to info@lakeshorecap.org*
  - **SHEBOYGAN**: *Bring or Mail to: 621 S 8th St, PO Box 896, Sheboygan, WI 53082-0896; Fax to 920-694-0291; or Email to info@lakeshorecap.org*
  - **DOOR/KEWAUNEE**: *Bring or Mail to: 131 3rd Ave, PO Box 791, Sturgeon Bay, WI 54235-0791; Fax to 920-746-0142; or Email to info@lakeshorecap.org*

- You will be notified IN WRITING (by mail, if possible) of the outcome of your decision.
- Be sure to fill out **EVERY** answer in the application packet. Failure to do so will result in a delay of the decision.
- Our funding is based on State and Federal guidelines. We look at things such as:
  - Income. You generally need some income but need to fall below our income guidelines.
  - Homelessness. We are given specific definitions from the Federal government as to eligibility.
  - Sustainability. There are a few factors that may impact your decision, such as the amount of arrears that you owe or the cost of the apartment being unaffordable to you.
  - Rent Reasonableness/Fair Market Rent guidelines.
- We do NOT look at:
  - Criminal history
  - Eviction history
  - Gender, race, ethnicity, household makeup
- If you feel that a decision was made regarding your application in error, you may appeal the decision. This MUST BE DONE IN WRITING. Do not call the Case Manager listed on your Determination of Assistance Form. You were offered our Appeal Process when you initially applied for our assistance.
- If you feel that you were DISCRIMINATED against, you may also follow the process to file a complaint in WRITING. This process was also offered to you when you initially applied.
- Once you receive your determination, you will either be **Pending** or **Not Eligible**. If you are Not Eligible, your case will be closed. If your circumstances change, you will need to re-apply. Expired/closed applications are placed in storage and are not available. Do NOT call your Case Manager regarding a previous application. You must fill out a new one.

Most Important for You to Know:

Lakeshore CAP assistance can be difficult to receive because of the strict criteria. It should **NOT** be your “Plan A” when needing help with your rent. Please apply at other places AND work on your own plan to assist yourself, which in many cases means budget counseling! We also offer RRH (Rapid Re-housing), which has additional requirements, a different enrollment process and a waiting list.

If you are *PENDING*, it may take time to filter through our process -- it is *NOT* a quick solution to your rent problem.

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WI BALANCE OF STATE CoC
Pre-Screen Form

Are you a domestic violence victim or survivor? ☐ Yes ☐ No

If yes, would you like a referral to a local DV agency? ☐ Yes ☐ No

If yes, when last experience occurred? ____________________

If yes, are you currently fleeing a domestic violence situation? ☐ Yes ☐ No

Do you have a disability or need reasonable accommodations for us to provide services to you, including filling out this form? (this question is voluntary and does not affect your eligibility for services) ☐ Yes ☐ No

List Accommodations needed:

Do you need an interpreter? ☐ Yes ☐ No Language? ______________

Household members (List everyone living in your household, related & unrelated)

Head of Household ______________________________________ / /

Last First Middle Gender ☐ Disabled Date of birth

______________________________________ / /

Last Name First Name Middle Relationship to HH Gender ☐ Disabled Date of birth

______________________________________ / /

Last Name First Name Middle Relationship to HH Gender ☐ Disabled Date of birth

______________________________________ / /

Last Name First Name Middle Relationship to HH Gender ☐ Disabled Date of birth

______________________________________ / /

Last Name First Name Middle Relationship to HH Gender ☐ Disabled Date of birth

______________________________________ / /

Last Name First Name Middle Relationship to HH Gender ☐ Disabled Date of birth

Current Address: ______________________________________

Street Apt. # City State Zip Code

Telephone No: ______________ Email: ______________________

Living situation last night

- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- ☐ Place not meant for habitation inclusive of "non-housing service site (outreach programs only)"
- ☐ Safe haven

When did this homelessness experience start (not necessarily when you entered shelter)? ___/___/___

- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Staying or living in a family member's room, apartment or house
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Rental by client, no housing subsidy
- ☐ Rental by client, with VASH housing subsidy
- ☐ Rental by client, with other housing subsidy (including RRH)
- ☐ Jail, prison, or juvenile detention facility
- ☐ Transitional housing for homeless persons (including homeless youth)
- ☐ Permanent housing (other than RRH) for formerly homeless persons
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Substance abuse treatment facility or detox center
- ☐ Other ____________________
- ☐ Residential project or halfway house with no homeless criteria
- ☐ Long term care facility or nursing home
- ☐ Rental by client with GPD or TIP subsidy
- ☐ Foster care home or foster care group home
- ☐ Hospital (non-psychiatric)
- ☐ Owned by client, no housing subsidy
- ☐ Owned by client, with housing subsidy

WI BALANCE OF STATE CoC
Pre-Screen Form

Length of time in last night's living situation:

- ❑ One night or less
- ❑ 2-6 nights
- ❑ One week but less than a month
- ❑ One to three months
- ❑ More than three months, but less than one year
- ❑ One year or longer

Estimate how much longer you expect to reside there.

- ❑ Can't go back
- ❑ More than a year
- ❑ It's a day-by-day arrangement
- ❑ Until shelter/housing is received
- ❑ Less than 3 months
- ❑ 3 months to a year

Number of times you have been on the Street, in an Emergency Shelter, on a motel voucher, or in a Safe Haven in the past three years including today: _____ times

Number of months homeless on the Street, in an Emergency Shelter, on a motel voucher, or in a Safe Haven in the past three years: _______ (not exceeding 36 months)

Veteran Status ❑ Never in the Service ❑ Currently in the Service ❑ Veteran

Veteran Benefit Status ❑ *Currently receiving* ❑ *Currently not receiving* ❑ *Never received*

Cause of homelessness (check all that apply).

- ❑ Divorce/Separation
- ❑ Loss of job
- ❑ Parole/incarceration
- ❑ Other_____________________
- ❑ Domestic Violence
- ❑ Low income
- ❑ Ran Away
- ❑ Eviction
- ❑ Mental illness
- ❑ Exiting Foster care
- ❑ Thrown out
- ❑ Substance abuse
- ❑ Rent increase

FUP Eligible Family__________ **FUP Eligible Youth**__________
**For public child welfare agencies only, FUP eligibility must be determined by the PCWA in your county*

INCOME: (Please list all sources of income)

Source:____________________ Gross monthly amount $____________
Source:____________________ Gross monthly amount $____________
Source:____________________ Gross monthly amount $____________

NO INCOME – Do you certify that you do not have any income from any source at this time?

☐ Yes ☐ No ☐ VERBAL

Do you give consent that this agency may share information with other agencies such as, but not limited to, your situation, household demographics, and any questions asked during this assessment for the purpose of providing a referral to Coordinated Entry Prioritization Lists?

☐ Yes ☐ No ☐ VERBAL

I understand that the information contained on this form is provided voluntarily. The information is true and correct to the best of my knowledge. If I provide any false information, I understand that services may be denied. I understand that completion of this form does not guarantee that I will receive assistance.

☐ VERBAL

Signature of Applicant______________________________________ Date:________________

Signature of CoC Agency Rep __________________________________ Date:________________

NOTES:

Approved by WI BOS COC 02/27/2019

Household Members *List yourself and everyone living in your household, related & unrelated.*

Circle 'IN SCHOOL" (Y or N) for everyone. Check "NOT WORKING" for every household member it applies to, INCLUDING children.

#1 Head of Household (You):				Marital Status:	
Social Security #:		Race:		Hispanic or Latino?	**Y / N**
IN SCHOOL?	**Y / N**	Highest grade completed?		Graduate? **Y / N**	Circle: Male Female Transgender
Employed?	☐ Full Time ☐ Part Time ☐ Seasonal	**Unemployed?**	☐ 6 mo or more / ☐ 6 mo or less ☐ **NOT WORKING** ☐ Retired		
Medical Insurance	☐ Medicare ☐ Medicaid ☐ State Adult ☐ State Childrens ☐ Employer ☐ VA ☐ Private ☐ None ☐ Other:				

#2 Name:				Marital Status:	
Social Security #:		Race:		Hispanic or Latino?	**Y / N**
In School?	**Y / N**	Highest grade completed?		Graduate? **Y / N**	Circle: Male Female Transgender
Employed	☐ FT ☐ PT ☐ Migrant Seasonal Farm	**Unemployed**	☐ 6 mo or more / ☐ 6 mo or less ☐ **NOT WORKING** ☐ Retired		
Medical Insurance	☐ Medicare ☐ Medicaid ☐ State Adult ☐ State Childrens ☐ Employer ☐ VA ☐ Private ☐ None ☐ Other:				

#3 Name:				Marital Status:	
Social Security #:		Race:		Hispanic or Latino?	**Y / N**
In School?	**Y / N**	Highest grade completed?		Graduate? **Y / N**	Circle: Male Female Transgender
Employed?	☐ Full Time ☐ Part Time ☐ Seasonal	**Unemployed?**	☐ 6 mo or more / ☐ 6 mo or less ☐ **NOT WORKING** ☐ Retired		
Medical Insurance	☐ Medicare ☐ Medicaid ☐ State Adult ☐ State Childrens ☐ Employer ☐ VA ☐ Private ☐ None ☐ Other:				

#4 Name:				Marital Status:	
Social Security #:		Race:		Hispanic or Latino?	**Y / N**
In School?	**Y / N**	Highest grade completed?		Graduate? **Y / N**	Circle: Male Female Transgender
Employed?	☐ Full Time ☐ Part Time ☐ Seasonal	**Unemployed?**	☐ 6 mo or more / ☐ 6 mo or less ☐ **NOT WORKING** ☐ Retired		
Medical Insurance	☐ Medicare ☐ Medicaid ☐ State Adult ☐ State Childrens ☐ Employer ☐ VA ☐ Private ☐ None ☐ Other:				

#5 Name:				Marital Status:	
Social Security #:		Race:		Hispanic or Latino?	**Y / N**
In School?	**Y / N**	Highest grade completed?		Graduate? **Y / N**	Circle: Male Female Transgender
Employed?	☐ Full Time ☐ Part Time ☐ Seasonal	**Unemployed?**	☐ 6 mo or more / ☐ 6 mo or less ☐ **NOT WORKING** ☐ Retired		
Medical Insurance	☐ Medicare ☐ Medicaid ☐ State Adult ☐ State Childrens ☐ Employer ☐ VA ☐ Private ☐ None ☐ Other:				

Request additional page if needed

Non-Cash Benefits

☐ SNAP (**FoodShare**) $___________/Mo	☐ WIC (Women & Children)	☐ LIHEAP/WHEAP (Energy Asst)	☐ Childcare Voucher
☐ Housing Choice Voucher (**Section 8**)	☐ Public Housing (Low Income)	☐ HUD-VASH (Veterans)	☐ Other
☐ Permanent Supportive Housing (Mental Health Housing Program)		☐ Affordable Care Act Subsidy	

Disability — ☐ Long Term ☐ Short Term

If you indicated **Disabled** on Page 1, please check:	☐ **Physical** ☐ **Developmental** ☐ **Mental Health** ☐ **HIV/AIDS**		
☐ **Chronic Health Condition** ☐ **Drug Abuse** ☐ **Alcohol Abuse** ☐ **Both Drug & Alcohol Abuse** ☐ **Other:**			
First name of person(s):		Approximate year it started:	
Do they currently receive **SSI** or **SSDI**?	**Y / N**	Are they currently receiving other medical services?	**Y / N**

NECESSARY INFORMATION!

Current or Future Rental Housing

What kind of help are you requesting from us?					
How much are you behind in rent?	$		Do you plan to:	☐ **Stay** ☐ **Move**	
Do you have a written **EVICTION NOTICE**?	**YES / NO**	Circle type:	**5-day 14-day 28-day Court Summons**		
Why are/were you unable to pay your rent (or security deposit)?					
How will you pay future rent?					
What other agencies have you contacted for help?					
What was the outcome?					

Unit Details

1. Landlord Name			
2. Landlord Phone #			
3. Are you related to your landlord?	**YES / NO**	If **YES**, how?	
4. How many persons live in household?			
5. What is your monthly rent?	$	No of bedrooms?	
6. What utilities are included?			

IF APPLICABLE

Domestic Abuse	
➢ If you indicated "**YES**" for domestic violence or abuse on **Page 1**, when did the abuse occur?	
	Within the past 3 months
	3-6 months ago
	6-12 months ago
	More than 12 months ago

Child Welfare/Foster Care	
➢ Are you or is anyone in your household formerly the ward of a child welfare or foster care agency?	
YES	*Name(s):*
	Age(s) of child(ren) when they left the foster care system:

Lakeshore Community Action Program, Inc.

AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

I/we give Lakeshore CAP, Inc. permission to contact landlords, social service agencies and other sources to obtain information necessary regarding my household's housing situation, income/budget, program eligibility and status of my case. I/we authorize the exchange of information between agencies to determine eligibility and/or on-going case management to determine program assistance.

Entity authorized to use, disclose, or receive information:

Lakeshore CAP
702 State Street, PO Box 2315
Manitowoc, WI 54221-2315
Phone: 920-682-3737
Fax: 920-686-8700

This authorization permits the use or disclosure of information:

- For the length of duration of services with Lakeshore CAP, or 12 months from the below signed date, whichever comes first.

NOTICE OF RIGHTS WITH RESPECT TO RELEASE OF INFORMATION AUTHORIZATION

- ***Right to refuse to sign this authorization***: You are not required to sign a release of information and you may refuse to do so. Signing this form is not a condition of participation in Lakeshore CAP supportive housing programming.
- ***Right to receive a copy of this authorization***: You have the right to receive a copy of your release of information if you choose to sign it and request a copy verbally.
- ***Right to revoke this authorization***: You have the right to revoke your release of information at any time. Revocation of this release of information must be made in writing to Lakeshore CAP. The written revocation will be effective upon receipt *except* for any use or disclosure of information that took place prior to its receipt.

I understand the contents of this form. I agree that a photocopy or facsimile copy of this authorization is as valid as the original. I understand that I may request a copy of this form.

I am the person/household whose information is authorized to be used or disclosed. This form accurately reflects my wishes and I authorize the use or disclosure of information as described in this form.

- **To be signed by everyone in your household over 18.** *(Use reverse side if necessary.)*

Print Name____ Date of Birth_______________
Signature____ Date_____________________

Print Name____ Date of Birth_______________
Signature____ Date_____________________

LCAP Staff Signature________________________________ Date_____________________

Acknowledgement of Appeal Process, Grievance Procedure & Non-Discrimination Policies

SIGN HERE . . .

By signing this form, I acknowledge that I have received a copy of the:

- Lakeshore CAP Appeal Process
- Lakeshore CAP Grievance Procedure & Non-Discrimination Policy

Head of Household Signature ____________________ Date ____________

OR SIGN HERE IF . . .

You are **NOT** accepting the Appeal Process or Grievance Policy & Non-Discrimination pages.

I acknowledge that I have been offered a copy of the Lakeshore CAP policies and procedures listed above but have declined to take a copy today. I understand that if I request a copy in the future, I will be provided one.

Head of Household Signature ____________________ Date ____________

Lakeshore CAP Staff Signature ____________________ Date ____________

GRIEVANCE PROCEDURE & NON-DISCRIMINATION POLICY

Lakeshore CAP, Inc. has an appeal/grievance procedure. Be advised that if the level of service provided is not satisfactory, all clients have the right to file a grievance and appeal the decision with the Lakeshore CAP office listed below:

Lakeshore CAP, Inc. 702 State Street, PO Box 2315, Manitowoc, WI 54221-2315 – Phone: 920-682-3737 or 1-800-924-0510

Any applicants or participants have the right to appeal decisions when they feel they have been treated unfairly with regard to agency services. It is preferable that complaints be filed as soon as possible after the incident. The prompt filing of a complaint will result in a more accurate and effective investigation. Applicants or participants should provide a written complaint to the program supervisor, who will review the complaint. If a participant cannot complete a written statement, reasonable accommodations can be made or they may provide an oral statement to the department supervisor.

The person to whom the complaint/grievance is submitted will have ten (10) working days to act on the complaint. It is this person's responsibility to meet with all parties concerned, gather necessary information and attempt to work out a satisfactory solution. This person will document their efforts to resolve the grievance in writing and submit it to Lakeshore CAP's EEO/Affirmative Action Officer.

The EEO/Affirmative Action Officer then has ten (10) working days to act on the complaint/grievance. If the EEO/Affirmative Action Officer does not arrive at a solution the complaint/grievance will be submitted to the agency's Chief Executive Officer (CEO).

The CEO has twenty (20) working days from receipt of the complaint/grievance to act on it. If a grievance remains unresolved past the level of the CEO the grievance will be submitted to the Chairperson of the Board of Directors, who will take the matter to the Executive Committee for consideration.

The Executive Committee will have twenty (20) working days from its receipt to resolve the grievance. Applicants or participants may be asked to be present. All decisions made by the Executive Committee are final.

Non-Discrimination Policy

It is the policy of Lakeshore CAP, Inc. not to discriminate against any applicant/participant requesting services because of age, race, religion, color, handicap, gender, physical condition, developmental disability, marital status, political affiliation, criminal convictions, sexual orientation, family status, lawful source of income, status as a victim of domestic abuse, sexual abuse or stalking, or national origin. Eligibility for services will be determined by stipulations of funding sources and program policies/procedures.

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APPEAL PROCESS

Lakeshore CAP, Inc. has an appeal procedure. Be advised that if the level of service provided is not satisfactory, all clients have the right to file an appeal of the decision with the Lakeshore CAP office listed below:

Lakeshore CAP, Inc., 702 State Street, PO Box 2315, Manitowoc, WI 54221-2315

Any applicants or participants have the right to appeal decisions that were determined if they believe the outcome was determined in error. The prompt filing of an appeal will result in a more accurate and effective investigation. Listed below is the process in which to file an appeal:

- **Step One: W*ritten Statement*:** Applicant must submit a written statement outlining the specific reasons why they believe the determination in their case was made in error. If a person is unable to complete a written statement, reasonable accommodations can be made or they can provide an oral statement to the department supervisor.

- **Step Two: *Supervisor Review*:** Written appeal statement will be presented to the department supervisor and supervisor will be allowed 5 business days to gather information and respond in writing to applicant.

- **Step Three: *Resubmission of Statement*:** Applicant will have an additional 5 business days to submit arguments. Upon submission, statement will be presented to the Lakeshore CAP CEO to review. CEO will submit a written response within 5 business days of receipt to the applicant.

- **Step Four: *Final Review*:** If applicant is dissatisfied with this ruling and previous steps have been addressed, a review meeting may be scheduled to discuss and provide a final ruling on the appeal. Lakeshore CAP Board may be in attendance.

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