LAKESHORE CAP, INC.

Supportive Housing Program Application

MANITOWOC COUNTY	SHEBOYGAN COUNTY	DOOR/KEWAUNEE CO
BRING your application to our office at: 702 State Street- 2nd floor (corner of State and 7th streets) **MAIL** to PO Box 2315, Manitowoc, WI 54221-2315 **FAX** to 920.686.8700 **EMAIL** to info@lakeshorecap.org **CALL** 920.682.3737	**BRING/MAIL** your application to our office inside the Sheboygan County Job Center at 3620 Wilgus Avenue, PO Box 896, Sheboygan, WI 53082-0896 **FAX** to 920.694.0291 **EMAIL** to info@lakeshorecap.org **CALL** 920.803.6991	**BRING** to 131 S. 3rd Ave., Sturgeon Bay *(limited open office hours)* **MAIL** to PO Box 791, Sturgeon Bay, WI 54235-0791 **FAX** to 920.746.0142 **EMAIL** to info@lakeshorecap.org **CALL** 920.743.0192 **May also send to Manitowoc office*

- 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.
- You will be notified IN WRITING (by mail, if possible) of the outcome of your decision within 14 days.
- Be sure to fill out **EVERY** answer in the application packet. Failure to do so will result in a delay of the decision.
- Once your application is reviewed, it 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.
    - If you are Pending, you will receive a request to provide us some additional information, including:
        1. Income from the previous 30 days prior to your application;
        2. Proof of any benefits that you receive, such as Food Share or Badgercare, if applicable;
        3. Documentation of your checking and/or savings account balances from the last 30 days;
        4. Eviction notice, if applicable;
        5. Valid, written lease.
    - You will have 14 days to provide the requested information or your application will automatically close. You can speed up the determination process if you provide the information with this application!

- *Our application is lengthy and requires a lot of information up front. This is due to the funding that we receive. Each question is important and helps us determine your eligibility. We also need the information to report back to our funders the demographics about those requesting our assistance.*
- *If you are eligible, it will take several weeks to go through our entire process.*
- *You may also Appeal the decision or file a Grievance if you feel that you were treated unfairly. The information to do so is attached to this application and you should keep it.*
- *Feel free to call one of our offices with any questions.*

Thank you for taking the time to apply for our assistance. We will make every effort to direct you to resources that may be helpful to you and your family.

Client Copy — Please Keep

WI BALANCE OF STATE CoC
Pre-Screen Form

WIBOSCOC

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

What is the approximate date that you began to make plans to look for housing to leave your current abusive situation? _____

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 Race Ethnicity Date of birth

_____ / /

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

_____ / /

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

_____ / /

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

_____ / /

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

_____ / /

Last Name First Name Middle Relationship to HH Gender ☐ Disabled Race Ethnicity 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

WIBOSCOC

Length of living situation in place marked above.

- ❑ 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
- ❑ 14 days or less
- ❑ Less than 3 months
- ❑ 3 months to a year
- ❑ More than a year
- ❑ Until shelter/housing is found

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. I am aware that providing false information or not reporting pertinent information is fraud. 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:_____

Household Members *List yourself (HOH) 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 YOU (HOH)				Cir:	Male Female Trans	Marital Status:	
In School?	Y N	Highest grade?		Graduate?	Y N GED	Race	Hispanic? Y N
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				Cir:	Male Female Trans	Marital Status:	
In School?	Y N	Highest grade?		Graduate?	Y N GED	Race	Hispanic? Y N
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				Cir:	Male Female Trans	Marital Status:	
In School?	Y N	Highest grade?		Graduate?	Y N GED	Race	Hispanic? Y N
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				Cir:	Male Female Trans	Marital Status:	
In School?	Y N	Highest grade?		Graduate?	Y N GED	Race	Hispanic? Y N
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				Cir:	Male Female Trans	Marital Status:	
In School?	Y N	Highest grade?		Graduate?	Y N GED	Race	Hispanic? Y N
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:						

#6 Name				Cir:	Male Female Trans	Marital Status:	
In School?	Y N	Highest grade?		Graduate?	Y N GED	Race	Hispanic? Y N
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:						

Use back side for more household members or 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!

1. What kind of help are you requesting?				
2. How much are you behind in rent?	$	Do you plan to:	☐ Stay ☐ Move	
3. Do you have a written **EVICTION NOTICE**?	☐Yes ☐No	Circle Type:	5 Day 14 Day 28 Day Court Summons	
4. Explain why you are or were **unable** to pay your rent or security deposit:				
5. How will you pay your future rent?				
6. What other agencies have you contacted for help?				
7. What was the outcome?				

Unit Details

Landlord Name			Landlord Phone Number		
Are you related to your landlord?	☐ YES ☐ NO		If YES, how?		
Type of Unit:	☐ Apartment Building ☐ Townhouse/Condo ☐ Single Family ☐ Mobile Home ☐ Other:				
How many persons in household?		# of Bedrooms		Monthly Rent	$

Utilities & Appliances

	Provided by Owner	Provided by Tenant
Heating (circle) Natural Gas Electric Bottled Gas Other:	☐	☐
Cooking (circle) Natural Gas Electric Bottled Gas Other:	☐	☐
Electricity	☐	☐
Air Conditioning	☐	☐
Water Heating (circle) Natural Gas Electric Bottled Gas Other:	☐	☐
Sewer	☐	☐
Trash Collection	☐	☐
Range	☐	☐
Refrigerator	☐	☐
Microwave	☐	☐
Other:	☐	☐

If Applicable

Domestic Abuse			
➢ If you indicated "**Yes**" to Domestic Abuse on Page 1, when did the abuse occur? (check one)			
☐	Within the past 3 months	☐	6-12 months ago
☐	3-6 months ago	☐	More than 12 months ago

Child Welfare/Foster Care	
➢ Are you or anyone in your household the former ward of child welfare or a foster care agency?	
☐	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, Inc.
702 State Street, PO Box 2315
Manitowoc, WI 54221-2315
Phone: 920.682.3737
Fax: 920.686.8700

LAKESHORE CAP, INC.

This authorization permits the use or disclosure of information:

- For the length of duration of services with Lakeshore CAP, or twelve (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 eighteen (18).** *(Use reverse side if necessary.)*

Print Name_____ Date of Birth_____
Signature_____ Date_____

Print Name_____ Date of Birth_____
Signature_____ Date_____

LCAP Staff Signature_____ Date_____

LAKESHORE CAP, INC

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

SIGN HERE IF . . .

You are **KEEPING/ACCEPTING** the Grievance Policy & Non-Discrimination and Appeal Process pages.

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

LAKESHORE CAP, INC.

GRIEVANCE PROCEDURE & NON-DISCRIMINATION POLICY

Grievance Procedure

Lakeshore Community Action Program (Lakeshore CAP) 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.

CLIENT COPY — PLEASE KEEP

LAKESHORE CAP, INC.

APPEAL PROCESS

Lakeshore Community Action Program (Lakeshore CAP) 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:

***Written 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. Applicants have thirty (30) days from the date they received the denial to file an appeal. Any appeals filed after thirty (30) days will not be addressed.

Step Two:

***Supervisor Review*:** Written appeal statement will be presented to the department supervisor and supervisor will be allowed ten (10) business days to gather information and respond in writing to applicant.

Step Three:

***Resubmission of Statement*:** Applicant will have an additional five (5) business days to submit arguments. Upon submission, statement will be presented to the Lakeshore CAP Executive Director to review. The Executive Director will submit a written response within five (5) business days of receipt to the applicant.

CLIENT COPY — PLEASE KEEP