LAKESHORE CAP, INC.

Supportive Housing Program Application

Once completed, you may select one of the following ways to deliver your application to us:

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*

Door County Emergency Response Fund

A partnership of

United Way & Door County Community Foundation, Inc.

- 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 up to two weeks before you will be notified of your potential eligibility.
- Be sure to fill out **EVERY** answer in the application packet. Failure to do so will result in a delay of the decision.
- You will be notified IN WRITING (by mail, if possible) of the outcome of the application within 14 days.
- 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:
        - Income from the previous 30 days prior to your application;
        - Proof of any benefits that you receive, such as Food Share or Badgercare, if applicable;
        - Documentation of your checking or savings account balances from the last 30 days;
        - Eviction notice; if applicable.
        - Valid, written lease;
        - Copy of ID's for all adults.
    - You will have 14 days to provide the requested information or your application will automatically close.

1. *Our application is lengthy and requires a lot of information up front. 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.*
2. *If you are eligible, it will take several weeks to go through our entire process. Payment will be made directly to your landlord.*
3. *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.*
4. *Feel free to call our office 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

- **Are you a victim or survivor of domestic violence, sexual assault, &/or human trafficking?** ☐ Yes ☐ No
  - *If yes, would you like a referral to a local victim services agency?* ☐ Yes ☐ No
  - *If yes, are you currently fleeing a domestic violence, sexual assault, &/or human trafficking situation?* ☐ Yes ☐ No
  - *If yes, when did the last experience occur:* _____
- *What is the approximate date that you began to make plans to look for housing to leave your current abusive situation?* _____
- **The following question is voluntary and does not affect your eligibility for services:**
  - *Do you have a disability or need reasonable accommodations for us to provide services to you, including filling out this form?* ☐ Yes ☐ No
  - *List accommodations needed:*

Do you need an interpreter? ☐ Yes ☐ No Language: _____

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

			Self					
Last Name	**First Name**	**Middle**	**Relationship to HH**	**Gender**	**Disabled**	**Race**	**Ethnicity**	**D.O.B.**
Last Name	First Name	Middle	Relationship to HH	Gender	Disabled	Race	Ethnicity	D.O.B.
Last Name	First Name	Middle	Relationship to HH	Gender	Disabled	Race	Ethnicity	D.O.B.
Last Name	First Name	Middle	Relationship to HH	Gender	Disabled	Race	Ethnicity	D.O.B.
Last Name	First Name	Middle	Relationship to HH	Gender	Disabled	Race	Ethnicity	D.O.B.
Last Name	First Name	Middle	Relationship to HH	Gender	Disabled	Race	Ethnicity	D.O.B.

ADDRESS: _____

Street **Apt. #** **City** **State** **Zip Code**

PHONE NUMBER: **EMAIL:**

1. Living situation **at time of assessment**:

☐ 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 (this is a specific type of supportive housing located in Waukesha County)

If one of the above situations, when did this homelessness experience start (not necessarily when you entered shelter)? _____/_____/_____

Continues on page 2>

2. Living situation <u>at time of assessment</u> *(continued):*

☐ 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
☐ Other: _____
☐ Psychiatric hospital or other psychiatric facility
☐ Substance abuse treatment facility or detox center
☐ 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

3. Length of living situation in the 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
☐ Client doesn't know
☐ Client refused

4. If you stayed somewhere other than emergency shelter, a place not meant for human habitation, or a safe haven, will you have to leave this living situation within 14 days?

☐ Yes (answer next 4 questions)
☐ No (skip next 4 questions)
☐ Client doesn't know (answer next 4 questions)
☐ Client refused (answer next 4 questions)

Have you found a new place to live?
☐ Yes
☐ No
☐ Client doesn't know
☐ Client refused

Do you have resources or support networks to obtain other permanent housing?
☐ Yes
☐ No
☐ Client doesn't know
☐ Client refused

Have you had a lease or other permanent place to live in the last 60 days?
☐ Yes
☐ No
☐ Client doesn't know
☐ Client refused

Have you moved 2 or more times in the last 60 days?
☐ Yes
☐ No
☐ Client doesn't know
☐ Client refused

5. 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

6. 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)

7. Veteran Status
- *Veteran Benefit Status*

☐ Never in the Service ☐ Currently in the Service ☐ Veteran
☐ *Currently receiving* ☐ *Received in past but not now* ☐ *Never received*

8. Cause of homelessness (check all that apply):

☐ Divorce/Separation ☐ Domestic violence ☐ Eviction ☐ Thrown out
☐ Loss of job ☐ Low income ☐ Mental illness ☐ Substance abuse
☐ Parole/incarceration ☐ Ran away ☐ Exiting foster care ☐ Rent increase
☐ Other

FUP Eligible Family_____ **FUP Eligible Youth**_____

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

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**

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 finding a permanent housing solution for you/your family***?

☐ Yes ☐ No ☐ **VERBAL**

Victim Service programs must also follow state and federal confidentiality laws and secure a VAWA-compliant Release of Information and Waiver of non-Disclosure (for domestic abuse victims) in order to share information.

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***.

☐ Yes ☐ No ☐ **VERBAL**

Signature of Applicant _____ Date _____

Signature of CoC Agency Rep _____ Date _____

For agency use only:

Referred to

Type of service

Referred to the following Coordinated Entry Region(s):

☐ Brown	☐ Kenosha	☐ Rock-Walworth
☐ Central	☐ Lakeshore	☐ Rural North
☐ Coulee	☐ North Central	☐ Southwest
☐ Dairyland	☐ Northeast	☐ Washington
☐ East Central	☐ Northwest	☐ Waukesha
☐ Fox Cities	☐ NWISH	☐ West Central
☐ Jefferson	☐ Ozaukee	☐ Winnebagoland

Please continue to the following pages

INCOME INFORMATION

☐ **I certify that I do not have any current household income.**

	MONTHLY GROSS AMT.	*NAME OF RECIPIENT(s)*
Employment Wages	$_____	_____
TANF (W2 or W2T)	$_____	_____
Child Support	$_____	_____
SSDI	$_____	_____
SSI	$_____	_____
Unemployment Benefits	$_____	_____
Pension / Retirement	$_____	_____
Retirement Disability	$_____	_____
Self-employment Wages	$_____	_____
Workers Compensation	$_____	_____
Social Security	$_____	_____
Alimony	$_____	_____
Veteran Non-Svc Conn Disability	$_____	_____
Veteran Service Conn Disability	$ _____	_____
Cash Income	$ _____	_____
Other _____	$ _____	_____
MONTHLY GROSS INCOME <u>TOTAL</u>	**$ _____**	
ANNUAL INCOME	**$ _____**	

NON-CASH BENEFITS

	NAME OF RECIPIENT(s)
Food Share $_____	_____
WIC $_____	_____
VA Medical Services $_____	_____
Medicaid $_____	_____
Medicare $_____	_____
Badger Care (SCHIP) $_____	_____
TANF Child Care Voucher $_____	_____
TANF Transportation $_____	_____
Other TANF Funded Services – $_____	_____
please specify _____	
Section 8/Public Housing/Rental Subsidy $_____	_____
DVR $_____	_____
Healthy Start $_____	_____
Energy Assistance (LIHEAP/WHEAP) $_____	_____
WIA – Workforce Investment Act $_____	_____
HUD-VASH- Veterans $_____	_____
Other Benefits or Subsidies – $_____	_____

Household Members *List yourself and everyone living in your household.*

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

#1 YOU								Marital Status:			
In School?	**Y N**	Highest grade?		Graduate?	**Y N GED**	**Male Female Trans**	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								Marital Status:			
In School?	**Y N**	Highest grade?		Graduate?	**Y N GED**	**Male Female Trans**	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								Marital Status:			
In School?	**Y N**	Highest grade?		Graduate?	**Y N GED**	**Male Female Trans**	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								Marital Status:			
In School?	**Y N**	Highest grade?		Graduate?	**Y N GED**	**Male Female Trans**	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:										

REQUIRED INFORMATION

Current or Future Rental Housing

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:			
5. How will you pay future rent?			
6. What other agencies have you contacted for help?			
7. What was the outcome?			

Unit Details

Landlord Name		Landlord Phone #			
Are you related to your landlord?	**YES / NO**	If **YES**, how?			
Type of Unit:	☐ Apartment Building ☐ Duplex or Townhouse ☐ Single Family ☐ Mobile Home				
How many persons in household?		# of bedrooms?		Monthly rent?	**$**

ADDITIONAL INFORMATION

Disability Information		
If a member of your household is disabled, is the disability **LONG TERM** or **SHORT TERM**? *Please circle*		
Is the Disability: ☐Physical ☐Developmental ☐Mental Health ☐HIV/AIDS ☐Chronic Health Condition ☐Drug Use ☐Alcohol Use ☐Both Drug and Alcohol Use ☐Other		
Approximate year it started_____	Do they currently receive SSI/SSDI? ☐YES ☐No	
Are they currently receiving medical services? ☐ YES ☐ No		

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

I have provided this information to the best of my ability and understand that I may be asked to provide verification of the information described within this application.

I also understand that Lakeshore CAP has a **Grievance Procedure, Non-Discrimination Policy and Appeal Process**. They are located on the Lakeshore CAP web site: www.lakeshorecap.org, displayed in our offices and available by request by calling 920.682.3737. They are also offered for review when submitting this application.

_____ _____
Signature of Adult #1 Date

_____ _____
Signature of Adult #2 Date

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_____