



LAKESHORE CAP, INC.

# Supportive Housing Program Application

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

- 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:
    - Income from the previous 30 days prior to your application;
    - Proof of any benefits that you receive, such as Food Share or Badgercare;
    - Documentation of your checking or savings account balances from the last 30 days;
    - Eviction notice;
    - Valid, written lease;
    - Copy of ID's for all adults and Social Security cards for all household members.
  - 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!

1. *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.*
2. *If you are eligible, it will take several weeks to go through our entire process.*
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.**

## 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.

**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 at time of assessment (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**       Never in the Service       Currently in the Service       Veteran  
    o *Veteran Benefit Status*       Currently receiving       Received in past but not now       Never received

**8. 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*

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):

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Brown        | <input type="checkbox"/> Kenosha       | <input type="checkbox"/> Rock-Walworth |
| <input type="checkbox"/> Central      | <input type="checkbox"/> Lakeshore     | <input type="checkbox"/> Rural North   |
| <input type="checkbox"/> Coulee       | <input type="checkbox"/> North Central | <input type="checkbox"/> Southwest     |
| <input type="checkbox"/> Dairyland    | <input type="checkbox"/> Northeast     | <input type="checkbox"/> Washington    |
| <input type="checkbox"/> East Central | <input type="checkbox"/> Northwest     | <input type="checkbox"/> Waukesha      |
| <input type="checkbox"/> Fox Cities   | <input type="checkbox"/> NWISH         | <input type="checkbox"/> West Central  |
| <input type="checkbox"/> Jefferson    | <input type="checkbox"/> Ozaukee       | <input type="checkbox"/> WinnebagoLand |

Please continue to the following pages 

## INCOME INFORMATION

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

	<i>MONTHLY GROSS AMT.</i>	<i>NAME OF RECIPIENT(s)</i>
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 _____	\$ _____	_____
<b>MONTHLY GROSS INCOME TOTAL</b>	<b>\$ _____</b>	
<b>ANNUAL INCOME</b>	<b>\$ _____</b>	

## NON-CASH BENEFITS

		<i>NAME OF RECIPIENT(s)</i>
Food Share	\$ _____	_____
WIC	\$ _____	_____
VA Medical Services	\$ _____	_____
Medicaid	\$ _____	_____
Medicare	\$ _____	_____
Badger Care (SCHIP)	\$ _____	_____
TANF Child Care Voucher	\$ _____	_____
TANF Transportation	\$ _____	_____
Other TANF Funded Services –	\$ _____	_____
	<i>please specify</i>	_____
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?	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal			<b>Unemployed?</b>			<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> <b>NOT WORKING</b>			<input type="checkbox"/> Retired						
Medical Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Adult <input type="checkbox"/> State Childrens <input type="checkbox"/> Employer <input type="checkbox"/> VA <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Other:															

#2 Name											Marital Status:					
In School?	Y	N	Highest grade?		Graduate?	Y	N	GED	Male	Female	Trans	Race		Hispanic?	Y	N
Employed	<input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Migrant Seasonal Farm			<b>Unemployed</b>			<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> <b>NOT WORKING</b>			<input type="checkbox"/> Retired						
Medical Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Adult <input type="checkbox"/> State Childrens <input type="checkbox"/> Employer <input type="checkbox"/> VA <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Other:															

#3 Name											Marital Status:					
In School?	Y	N	Highest grade?		Graduate?	Y	N	GED	Male	Female	Trans	Race		Hispanic?	Y	N
Employed?	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal			<b>Unemployed?</b>			<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> <b>NOT WORKING</b>			<input type="checkbox"/> Retired						
Medical Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Adult <input type="checkbox"/> State Childrens <input type="checkbox"/> Employer <input type="checkbox"/> VA <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Other:															

#4 Name											Marital Status:					
In School?	Y	N	Highest grade?		Graduate?	Y	N	GED	Male	Female	Trans	Race		Hispanic?	Y	N
Employed?	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal			<b>Unemployed?</b>			<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> <b>NOT WORKING</b>			<input type="checkbox"/> Retired						
Medical Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> State Adult <input type="checkbox"/> State Childrens <input type="checkbox"/> Employer <input type="checkbox"/> VA <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> 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:	<input type="checkbox"/> Stay <input type="checkbox"/> Move					
3. Do you have a written <b>EVICTION NOTICE</b> ?	YES / NO	Circle type:	5-day	14-day	28-day	Court Summons				
4. Explain why you are or were <b>unable</b> 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?	<b>YES / NO</b>	If YES, how?	
Type of Unit:	<input type="checkbox"/> Apartment Building <input type="checkbox"/> Duplex or Townhouse <input type="checkbox"/> Single Family <input type="checkbox"/> 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 <b>LONG TERM</b> or <b>SHORT TERM</b> ? <i>Please circle</i>	
Is the Disability: <input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Mental Health <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Drug Use <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Both Drug and Alcohol Use <input type="checkbox"/> Other	
Approximate year it started _____	Do they currently receive SSI/SSDI? <input type="checkbox"/> YES <input type="checkbox"/> No
Are they currently receiving medical services? <input type="checkbox"/> YES <input type="checkbox"/> No	

Child Welfare/Foster Care	
➤ Are you or anyone in your household formerly the ward of child welfare or a foster care agency?	
<b>If YES</b>	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](http://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 \_\_\_\_\_