



Supportive Housing Program Application

MANITOWOC County

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

SHEBOYGAN County

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

DOOR/KEWAUNEE Co

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:
 - 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.
 - 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. 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, when did the last experience occur? _____

If yes, are you currently fleeing a domestic violence, sexual assault, &/or human trafficking situation? Yes No

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

How many times have you left or attempted to leave your 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.

Current Address: _____

Street
Apt. #
City
State
Zip Code

Phone Number: _____ Email: _____

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)? _____

Living situation at time of assessment (continued):

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

Length of living situation in the place marked above:

- | | |
|---|---|
| <input type="checkbox"/> One night or less | <input type="checkbox"/> More than three months, but less than one year |
| <input type="checkbox"/> 2-6 nights | <input type="checkbox"/> One year or longer |
| <input type="checkbox"/> One week but less than a month | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> One to three months | <input type="checkbox"/> Client refused |

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?

- | | |
|--|--|
| <input type="checkbox"/> Yes (answer next 4 questions) | <input type="checkbox"/> Client doesn't know (answer next 4 questions) |
| <input type="checkbox"/> No (skip next 4 questions) | <input type="checkbox"/> Client refused (answer next 4 questions) |

Have you found a new place to live?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> No | <input type="checkbox"/> Client refused |

Do you have resources or support networks to obtain other permanent housing?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> No | <input type="checkbox"/> Client refused |

Have you had a lease or other permanent place to live in the last 60 days?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> No | <input type="checkbox"/> Client refused |

Have you moved 2 or more times in the last 60 days?

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> No | <input type="checkbox"/> Client refused |

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 Received in past but not now Never received

Cause of homelessness (check all that apply):

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Eviction | <input type="checkbox"/> Thrown out |
| <input type="checkbox"/> Loss of job | <input type="checkbox"/> Low income | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Parole/incarceration | <input type="checkbox"/> Ran away | <input type="checkbox"/> Exiting foster care | <input type="checkbox"/> Rent increase |
| <input type="checkbox"/> 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 want to be referred to the Coordinated Entry Priority Lists in the following area(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"/> Winnebago |

I understand that I am responsible for my own transportation as necessary if I am offered housing services in another area.

Yes No **VERBAL**

I understand that being offered housing services in another area does not guarantee immediate access to housing or emergency shelter during housing search.

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.**

Yes No **VERBAL**

Signature of Applicant _____ Date _____

Signature of CoC Agency Rep _____ Date _____

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 TOTAL	\$ _____	
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 –	\$ _____	_____
	<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				Unemployed?			<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> NOT WORKING <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				Unemployed			<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> NOT WORKING <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				Unemployed?			<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> NOT WORKING <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				Unemployed?			<input type="checkbox"/> 6 mo or more <input type="checkbox"/> 6 mo or less <input type="checkbox"/> NOT WORKING <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 EVICTION NOTICE ?	YES / NO	Circle type:	5-day Summons	14-day	28-day	Court
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?						

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



LAKESHORE CAP, INC.

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 _____