



LAKESHORE CAP, INC.

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.

Coordinated Entry Priority List

Break Down per Coalition

Coordinated Entry Priority Lists	Counties within that area
<input type="checkbox"/> Brown	Brown
<input type="checkbox"/> Central Coalition	Adams, Colombia, Dodge, Juneau, & Sauk
<input type="checkbox"/> Coulee	Crawford, LaCrosse, Monroe, & Vernon
<input type="checkbox"/> Dairyland	Buffalo, Eau Claire, Jackson, & Trempealeau
<input type="checkbox"/> East Central	Marquette, Portage, Waupaca & Waushara
<input type="checkbox"/> Fox Cities	Calumet & Outagamie
<input type="checkbox"/> Jefferson	Jefferson
<input type="checkbox"/> Kenosha	Kenosha
<input type="checkbox"/> Lakeshore	Door, Kewaunee, Manitowoc, & Sheboygan
<input type="checkbox"/> North Central	Lincoln, Marathon, & Wood
<input type="checkbox"/> Northeast	Florence, Marinette, Menominee, Oconto, & Shawano
<input type="checkbox"/> Northwest	Ashland, Bayfield, Douglas, Iron, & Price
<input type="checkbox"/> N*WISH	Forest, Langlade, Oneida, & Vilas
<input type="checkbox"/> Ozaukee	Ozaukee
<input type="checkbox"/> Rock Walworth	Rock & Walworth
<input type="checkbox"/> Rural North Coalition	Burnett, Clark, Rusk, Sawyer, Taylor, & Washburn
<input type="checkbox"/> Southwest	Grant, Green, Iowa, Lafayette, & Richland
<input type="checkbox"/> Washington	Washington
<input type="checkbox"/> Waukesha	Waukesha
<input type="checkbox"/> West Central	Barron, Chippewa, Dunn, Pepin, Pierce, Polk, & St. Croix
<input type="checkbox"/> Winnebago	Fond du Lac, Green Lake, & Winnebago
<p>➤ Refer to this break down of varying counties priority list when completing the fourth page of Lakeshore CAP's Supportive Housing application.</p> <p>➤ Check all coalitions that you would be interested in being referred to.</p>	

Head of Household Contact Information			
First Name		Last Name	
Phone Number		Email	
Preferred Communication	<input type="checkbox"/> Phone Call <input type="checkbox"/> Email <input type="checkbox"/> Text		
<p>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.</p> <p>I also understand that Lakeshore CAP has a Grievance Procedure, Non-Discrimination Policy and Appeal Process. They are located on the Lakeshore CAP website: https://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.</p>			
_____ Signature of Adult #1		_____ Date	
_____ Signature of Adult #2		_____ Date	

INCOME INFORMATION

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

	<i>MONTHLY GROSS AMOUNT</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	\$ _____	_____
MONTHLY GROSS INCOME TOTAL	\$ _____	
ANNUAL INCOME	\$ _____	

NON-CASH BENEFITS

	<i>MONTHLY AMOUNT</i>	<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	\$ _____	_____
	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?	<input type="checkbox"/>	FT	<input type="checkbox"/>	PT	<input type="checkbox"/>	Migrant/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?	None										<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"/>	Other	<input type="checkbox"/>
#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	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?	None										<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"/>	Other	<input type="checkbox"/>
#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"/>	FT	<input type="checkbox"/>	PT	<input type="checkbox"/>	Migrant/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?	None										<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"/>	Other	<input type="checkbox"/>
#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"/>	FT	<input type="checkbox"/>	PT	<input type="checkbox"/>	Migrant/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?	None										<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"/>	Other	<input type="checkbox"/>
#5 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	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?	None										<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"/>	Other	<input type="checkbox"/>

Required Information

Current or Future Rental History:

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:		<input type="checkbox"/>	5-day	<input type="checkbox"/>	14-day	<input type="checkbox"/>	28-day
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:	<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 LONG TERM or SHORT TERM ? <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?	
If YES	Name(s):
	Age(s) of child(ren) when they left the foster care system:

Opioid Use Diagnosis	
➤ Do you have a documented opioid use diagnosis?	
If YES	Name:
➤ Have you received treatment for an opioid use disorder in the past 12 months?	
If YES	Name:
➤ Are you interested in residing in a Recovery Residence? <input type="checkbox"/> YES <input type="checkbox"/> NO	