



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 County

BRING to 131 S. 3rd Ave., Sturgeon Bay (*limited open office hours*)

MAIL to PO Box 896, Sheboygan, WI 53082- 0896

FAX to 920.694.0291

EMAIL to info@lakeshorecap.org

CALL 920.803.6991

- 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, and you will need to reapply. Program rules for households applying include, but are not limited to:
 - Funding sources do not allow us to assist with paying rent for units that are considered subsidized.
 - Funding sources require that to receive rental assistance to keep you from losing your housing, there must be enough income to allow you to pay your rent moving forward.
 - Funding sources require all programs to have income thresholds.
 - Found sources require all units to meet the federal standard for Fair Market Rent.
 - If you are **Pending**, you will receive a request to complete an assessment and be referred to Coordinated Entry.

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 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 this can be found on the homepage of Lakeshore CAP's website.
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 your household.



WI BALANCE OF STATE CoC Pre-Screen Form

The following questions are voluntary. However, missing or unanswered questions may affect your ability to qualify or prioritize for housing programs.

Are you a survivor of domestic violence, sexual assault, and /or human trafficking? Yes No
If yes, when did the last experience occur? _____

Would you like a referral to a local victim services agency? Yes No

Are you currently fleeing domestic violence, sexual assault, and/or human trafficking? Yes No

If yes to the question above, answer the following additional questions:

- How many times have you left or attempted to leave your abusive situation in the last 3 years? _____
- What is the approximate date that you began to make plans to look for housing to leave your current abusive situation? _____

Do you need reasonable accommodations for us to provide services to you, including filling out this form? Yes No

List accommodations needed: _____

Translation Assistance Needed: Yes No Preferred Language: _____

Household Members (List everyone living in your household, related and unrelated)

Self								
Last Name	First Name	Middle	Head of Household	Gender	Disabled	Race & Ethnicity	D.O.B.	Age
Last Name	First Name	Middle	Relationship to HoH	Gender	Disabled	Race & Ethnicity	D.O.B.	Age
Last Name	First Name	Middle	Relationship to HoH	Gender	Disabled	Race & Ethnicity	D.O.B.	Age
Last Name	First Name	Middle	Relationship to HoH	Gender	Disabled	Race & Ethnicity	D.O.B.	Age
Last Name	First Name	Middle	Relationship to HoH	Gender	Disabled	Race & Ethnicity	D.O.B.	Age

Head of Household Contact Information

Please check which ones are safe to contact:

Phone Number: _____ Call Text Voicemail

Email: _____

Current Address: _____

Living Situation at time of assessment: (Cat. 1)

- Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- Place not meant for human habitation, inclusive of “non-housing service site (outreach programs only)”

If yes to any of the above situations, what is the approximate date that this episode of homelessness started? _____

Living situation at time of assessment:

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Staying or living in a family member’s room, apartment or house <input type="checkbox"/> Staying or living in a friend’s room, apartment or house <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with ongoing housing subsidy | <ul style="list-style-type: none"> <input type="checkbox"/> Owned by client, no housing subsidy <input type="checkbox"/> Owned by client, with housing subsidy <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) |
|--|--|

Rental Subsidy Type:

Institutional Setting:

- GPD TIP housing subsidy
- VASH Housing subsidy
- RRH or equivalent subsidy
- HCV voucher (tenant or project based) (not dedicated)
- Public Housing Unit
- Rental by client, with other ongoing housing Subsidy
- Family Unification Program Voucher (FUP)
- Foster Youth to Independence Initiative (FYI)
- Permanent Supportive Housing
- Other permanent housing dedicated for formerly Homeless person

- Psychiatric hospital or other psychiatric facility
- Hospital (non-psychiatric)
- Jail, prison, or juvenile detention facility
- Substance use treatment facility or detox center
- Long-term care facility or nursing home

Other: _____

Length of living situation in the place marked above:

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> One night or less <input type="checkbox"/> 2-6 nights <input type="checkbox"/> One week but less than a month <input type="checkbox"/> One to three months | <ul style="list-style-type: none"> <input type="checkbox"/> More than three months, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn’t know <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?

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Yes (answer next 4 questions) <input type="checkbox"/> No (skip next 4 questions) | <ul style="list-style-type: none"> <input type="checkbox"/> Client doesn’t know (answer next 4 questions) <input type="checkbox"/> Client prefers not to answer (answer next 4 questions) |
|---|---|



Have you found a new place to live?

- Yes
- Client doesn't know
- No
- Client prefers not to answer

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

- Yes
- Client doesn't know
- No
- Client prefers not to answer

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

- Yes
- Client doesn't know
- No
- Client prefers not to answer

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

- Yes
- Client doesn't know
- No
- Client prefers not to answer

Number of times/episodes you have been on the street, a place not meant for human habitation, in an emergency shelter, or on a motel voucher, or in a Safe Haven in the past three years, including today: _____ times

Number of months homeless on the street, a place not meant for human habitation, in an emergency shelter, on a motel voucher or in a Safe Haven in the past three years: _____ (not exceeding 36 months)

Veteran Status: Have you ever served in the military in any capacity? Yes No

Do you have a chronic disabling condition? Yes No
If yes, how many of the following apply? (0-6) _____

Mental Health Disorder
Physical Disability

Developmental Disability
Chronic Health Condition

Substance use Disorder
HIV/AIDS

If there were housing services available for people living with HIV/AIDS, is that something you'd be interested in? Yes No

If there were housing services available for people recovering from Substance Use Disorders, is that something you'd be interested in? Yes No

Do you have non-chronic medical needs? Yes No

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 question 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 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"/> WinnebagoLand |

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 in 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 _____ Verbal

Signature of Agency Staff Member _____ Date _____
(signature or typed name of staff member filling out the form)

Name of Agency _____

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	\$ _____	_____
Alimony	\$ _____	_____
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	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Badger Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
TANF Child Care Voucher	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
TANF Transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other TANF Funded Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<i>Please Specify:</i> _____		
Section 8/Public Housing/Rental Subsidy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
DVR	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Healthy Start	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Energy Assistance (LIHEAP/WHEAP)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
WIA – Workforce Investment Act	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
HUD-VASH- Veterans	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other Benefits or Subsidies	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

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	<input type="checkbox"/> Unemployed?	<input type="checkbox"/> 6 Moor 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"/> Other <input type="checkbox"/> None								
#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	<input type="checkbox"/> Unemployed?	<input type="checkbox"/> 6 Moor 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"/> Other <input type="checkbox"/> None								
#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	<input type="checkbox"/> Unemployed?	<input type="checkbox"/> 6 Moor 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"/> Other <input type="checkbox"/> None								
#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	<input type="checkbox"/> Unemployed?	<input type="checkbox"/> 6 Moor 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"/> Other <input type="checkbox"/> None								
#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	<input type="checkbox"/> Unemployed?	<input type="checkbox"/> 6 Moor 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"/> Other <input type="checkbox"/> None								
#6 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	<input type="checkbox"/> Unemployed?	<input type="checkbox"/> 6 Moor 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"/> Other <input type="checkbox"/> None								

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 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:	<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:

Grievance and Appeal

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 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.

Signature of Adult #1

Date

Signature of Adult #2

Date

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? YES NO

Lakeshore CAP Inc. Of Wisconsin – Housing Programs

Authorization for Release and Exchange of Confidential Information

I, _____ give consent for the following entities to disclose and discuss with each other pertinent economic, housing, health, social or other information about my household as it pertains to my participation in Lakeshore CAP's Housing Programs. **This authorization permits the use or disclosure of information for one year from the date of the authorized signature.** This consent is subject to revocation upon my request, as of receipt by Lakeshore CAP Inc. and the Housing Program

Entity authorized to use, disclose, or receive economic, housing, health, social or other pertinent information:

Supportive Housing Related Programs
Lakeshore CAP, Inc.
702 State St., P.O. Box 2315
Manitowoc, WI 53221-2315
920-682-3737

Entity receiving/sharing information:

Agency Name: _____

Contact Person: _____

Address: _____

City, State, Zip: _____

Phone: _____

Person whose information is authorized to be used or disclosed:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Date of Birth: _____

Additional Person whose information is authorized to be used or disclosed:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Date of Birth: _____

Information that I want shared:

- Related to obtaining or maintaining housing
- Related to accessing or maintaining benefits
- Health information to determine program eligibility, obtain or access services
- Other: _____

My household information may be shared by:

- Phone Conversation
- Text
- Fax
- Mail
- Email
- In Person

I have read this form. I have received a copy of this form. I understand the contents of this form. I agree that a photocopy or facsimile of the authorization is as valid as an original.

I am the authorized representative of the person whose information is authorized to be used or disclosed. This form accurately reflects my wishes and I authorize the use or disclosure of authorized information as described on this form.

Information about the Authorized Representative:

Name (Print): _____

Date: _____

Signature: _____

Date of Birth: _____

Verbal Consent

Information about the Additional Household Member:

Name (Print): _____

Date: _____

Signature: _____

Date of Birth: _____

Verbal Consent

NOTICE OF RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Refuse to Sign this Authorization: You are not required to sign this authorization and you may refuse to do so.

Right to Receive a copy of this Authorization: You have a right to receive a copy of this authorization if you choose to sign it.

Right to Revoke this Authorization: You have the right to revoke this authorization at any time. Revocation of this authorization must be made in writing to Lakeshore CAP. The written revocation will be in effect on receipt *except* for any use or disclosure of information that took place prior to receipt.

Right to Notice Regarding Disclosure: The health information use or disclosed pursuant to this authorization may be disclosed by the recipient, and the disclosed information may no longer be protected under the terms of this authorization.

Right to Notice Regarding Marketing Activities: It is our policy not to use personal information to market products to our clients.