LAKESHORE CAP, INC.

Supportive Housing Program Application

Manitowoc County	Sheboygan County	Door/Kewaunee 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	**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	**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.

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Pre-Screen Form

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

Head of Household Contact Information

Self

Last Name	First Name	Middle	Head of Household	Sex-M/F	Disabled-Y/N	Race/Ethnicity	D.O.B.	Age
Last Name	First Name	Middle	Relationship to HoH	Sex-M/F	Disabled-Y/N	Race/Ethnicity	D.O.B.	Age
Last Name	First Name	Middle	Relationship to HoH	Sex-M/F	Disabled-Y/N	Race/Ethnicity	D.O.B.	Age
Last Name	First Name	Middle	Relationship to HoH	Sex-M/F	Disabled-Y/N	Race/Ethnicity	D.O.B.	Age
Last Name	First Name	Middle	Relationship to HoH	Sex-M/F	Disabled-Y/N	Race/Ethnicity	D.O.B.	Age
Last Name	First Name	Middle	Relationship to HoH	Sex-M/F	Disabled-Y/N	Race/Ethnicity	D.O.B.	Age

Please check which ones are safe to contact:

☐ Phone Number:_____ ☐ Call ☐ Text ☐ Voicemail

☐ Email:_____

☐ Current Address:_____

Do you have a chronic disabling condition? ☐ Yes ☐ No

If yes, how many of the following apply? (0-6) _____

**Note: do not identify/circle any disabling conditions listed below*

Mental Health Disorder	Developmental Disability	Substance use Disorder
Physical Disability	Chronic Health Condition	HIV/AIDS

Do you have non-chronic medical needs? ☐ Yes ☐ No

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: _____

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

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

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: *(Cat. 2)*

- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Foster care home or foster care group home
- ☐ 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 ongoing housing subsidy
- ☐ Rental by client, with ongoing housing subsidy

Rental Subsidy Type:

- ☐ GPD TIP housing subsidy
- ☐ VASH Housing subsidy
- ☐ RRH or equivalent subsidy
- ☐ HCV voucher (tenant or project based)
- ☐ detention (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

☐ Other: _____

- ☐ Owned by client, no housing subsidy
- ☐ Owned by client, with housing subsidy
- ☐ Residential project or halfway house with no homeless criteria
- ☐ Transitional housing for homeless persons (including homeless youth)

Institutional Setting:

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

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

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 prefers not to answer (answer next 4 questions)

Have you found a new place to live?

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

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

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

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

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

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

☐ Yes
☐ No
☐ Client doesn't know
☐ 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)

Cause(s) of homelessness or housing instability (at-risk):

☐ Divorce/separation	☐ Domestic violence, sexual assault, and/or human trafficking	☐ Eviction	☐ Asked or forced to leave residence
☐ Loss of job	☐ Low income	☐ Rent increase	☐ Parole/incarceration
☐ Mental illness	☐ Substance Use Disorder	☐ Ran away	☐ Exiting foster care
☐ Other:_____		☐ Client doesn't know	☐ Client prefers not to answer

Domestic Violence, Sexual Assault, and/or Human Trafficking

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? _____

WIBOSCOC

FUP Eligible Family ☐ Yes ☐ No FUP Eligible Youth ☐ Yes ☐ No

***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):

☐ 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

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.**

	MONTHLY GROSS AMOUNT	*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	$_____	_____
Alimony	$_____	_____
Veteran Service Conn Disability	$_____	_____
Cash Income	$_____	_____
Other	$_____	_____
MONTHLY GROSS INCOME TOTAL	$_____	
ANNUAL INCOME	$_____	

NON-CASH BENEFITS

	MONTHLY AMOUNT		*NAME OF RECIPIENT(s)*
Food Share	$_____		_____
WIC	$_____		_____
VA Medical Services	$_____		_____
Medicaid	☐ Yes	☐ No	_____
Medicare	☐ Yes	☐ No	_____
Badger Care	☐ Yes	☐ No	_____
TANF Child Care Voucher	☐ Yes	☐ No	_____
TANF Transportation	☐ Yes	☐ No	_____
Other TANF Funded Services	☐ Yes	☐ No	_____
Please Specify: _____			
Section 8/Public Housing/Rental Subsidy	☐ Yes	☐ No	_____
DVR	☐ Yes	☐ No	_____
Healthy Start	☐ Yes	☐ No	_____
Energy Assistance (LIHEAP/WHEAP)	☐ Yes	☐ No	_____
WIA – Workforce Investment Act	☐ Yes	☐ No	_____
HUD-VASH- Veterans	☐ Yes	☐ No	_____
Other Benefits or Subsidies	☐ Yes	☐ 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?	☐ FT ☐ PT ☐ Migrant/Seasonal			**Unemployed?**	☐ 6 Moor More ☐ 6 Mo or Less ☐ Not Working ☐ Retired				
Medical Insurance?	☐ Medicare ☐ Medicaid ☐ State Adult ☐ State Childrens ☐ Employer ☐ VA ☐ Private ☐ Other ☐ None								
#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			**Unemployed?**	☐ 6 Moor More ☐ 6 Mo or Less ☐ Not Working ☐ Retired				
Medical Insurance?	☐ Medicare ☐ Medicaid ☐ State Adult ☐ State Childrens ☐ Employer ☐ VA ☐ Private ☐ Other ☐ None								
#3 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			**Unemployed?**	☐ 6 Moor More ☐ 6 Mo or Less ☐ Not Working ☐ Retired				
Medical Insurance?	☐ Medicare ☐ Medicaid ☐ State Adult ☐ State Childrens ☐ Employer ☐ VA ☐ Private ☐ Other ☐ None								
#4 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			**Unemployed?**	☐ 6 Moor More ☐ 6 Mo or Less ☐ Not Working ☐ Retired				
Medical Insurance?	☐ Medicare ☐ Medicaid ☐ State Adult ☐ State Childrens ☐ Employer ☐ VA ☐ Private ☐ Other ☐ None								
#5 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			**Unemployed?**	☐ 6 Moor More ☐ 6 Mo or Less ☐ Not Working ☐ Retired				
Medical Insurance?	☐ Medicare ☐ Medicaid ☐ State Adult ☐ State Childrens ☐ Employer ☐ VA ☐ Private ☐ Other ☐ None								
#6 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			**Unemployed?**	☐ 6 Moor More ☐ 6 Mo or Less ☐ Not Working ☐ Retired				
Medical Insurance?	☐ Medicare ☐ Medicaid ☐ State Adult ☐ State Childrens ☐ Employer ☐ VA ☐ Private ☐ Other ☐ 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:**	☐ **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:

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 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_____