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.

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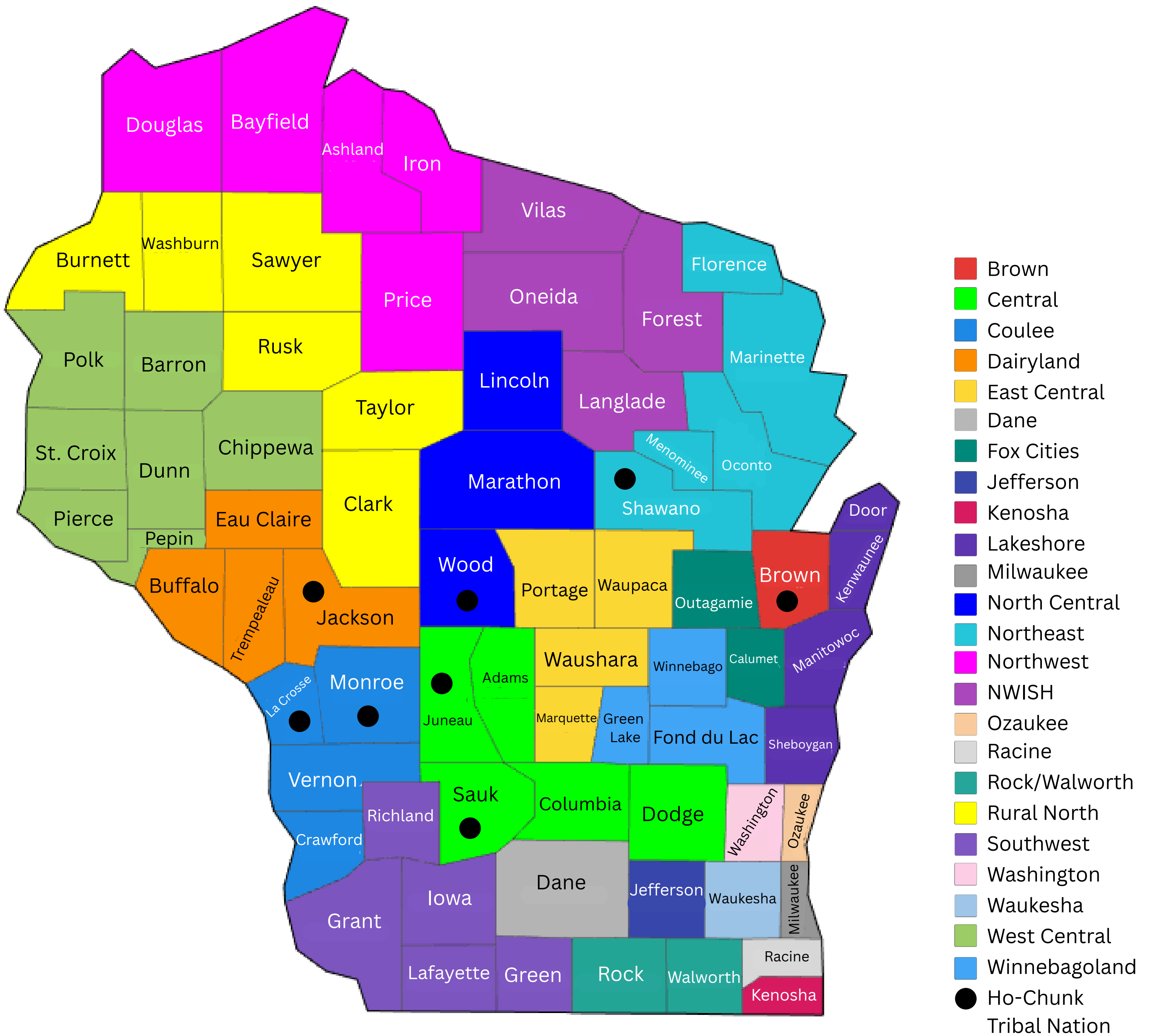
1. Our application is lengthy and requires a lot of information up front. This is due to the funding that we receive. Each question is important and helps us determine your eligibility. We also need the information to report back to our funders the demographics about those requesting assistance.
2. If 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.

Client Copy — Please Keep

Wisconsin Balance of State Continuum of Care (WIBOSCOC) Map

The WIBOS serves 69 counties in WI, all except Dane, Milwaukee, and Racine



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.

Head of Household Contact Information

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

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
Physical Disability
Developmental Disability
Chronic Health Condition
Substance use Disorder
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

WIBOSCOC

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

WIBOSCOC

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? ____________________

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 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.

Entity authorized to use, disclose, or receive information:

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: _____________________________________
Email: ______________________________________

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

Name: ____
Address: ____
City, State, Zip: ___________________________________
Phone: ____
Date of Birth: ______________________________________

*Other adult in household 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 ☐ Mail
☐ Text ☐ Email
☐ Fax ☐ 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.

.

Individual or legal guardian/representative:

Name (Print): ______________________________ Date: ______________________

Signature: _________________________________ Date of Birth: ________________

☐ Verbal Consent

Other adult (18 or older) in household:

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 is 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.

Lakeshore CAP

Home – ARP Intake Application

Program Overview:
This program is designed to prevent and/or combat homelessness in Sheboygan, Manitowoc, Kewaunee, and Door Counties. Lakeshore CAP is utilizing HOME-ARP funding to provide a holistic, client centered, medium-term to long-term assistance program. This includes supportive services to stabilize households and reduce housing instability. The program serves individuals and families who fall under one of the four qualifying populations outlined below

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Household Information:

Household Members

Full Name	Head of Household	Gender	Disabled	Race & Ethnicity	D.O.B	Veteran
	Self					
Full Name	Relationship to HoH	Gender	Disabled	Race & Ethnicity	D.O.B	Veteran
Full Name	Relationship to HoH	Gender	Disabled	Race & Ethnicity	D.O.B	Veteran
Full Name	Relationship to HoH	Gender	Disabled	Race & Ethnicity	D.O.B	Veteran
Full Name	Relationship to HoH	Gender	Disabled	Race & Ethnicity	D.O.B	Veteran
Full Name	Relationship to HoH	Gender	Disabled	Race & Ethnicity	D.O.B	Veteran

Contact Information

Phone Number: ______________________________________

Email: _______________________________________

Address: ____

Preferred Communication

☐ Call ☐ Text

☐ Voicemail ☐ Email

Income Information

☐ I certify that no one in my household currently receives any form of income. This includes wages, benefits, assistance, or financial support from any source. I understand that I must report any changes in income and that all information provided is true to the best of my knowledge.

	MONTHLY GROSS AMOUNT	NAME OF RECIPIENT(s)
Employment Wage	$__________________	________________________________
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 Benefit Information:

	MONTHLY GROSS AMOUNT		NAME OF RECIPIENT(s)
Food Share	$__________________		________________________________
WIC	$__________________		________________________________
VA Medical Services	☐ Yes	☐ No	________________________________
Medicaid *(Badger Care)*	☐ Yes	☐ No	________________________________
Medicare	☐ Yes	☐ No	________________________________
TANF	☐ Yes	☐ No	________________________________

Please Specify: ____

Section-8/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	☐ Yes	☐ No	________________________________

Qualifying Population *(Select All That Apply)*:

To be eligible for the HOME-ARP program, households must meet the criteria for at least one of the following qualifying populations:

1. ☐ Individuals or families experiencing homelessness
   - Category 1: Literally Homeless – Individuals and families lacking a fixed, regular, and adequate nighttime residence, including those living in places not meant for human habitation (cars, parks, abandoned buildings), emergency shelters, or transitional housing.
   - Category 2: Imminent Risk of Homelessness – Individuals or families who will imminently lose their primary nighttime residence (within 14 days) and lack resources or support networks to secure housing.
   - Category 3: Homeless under Other Federal Statutes – Unaccompanied youth under 25 years old, or families with children and youth, who meet federal definitions of homelessness (such as the Education Subtitle of the McKinney-Vento Act) and have experienced long-term instability and barriers to housing.
2. ☐ Individuals or families at risk of homelessness
   - Very low income (30% AMI or less) AND lacking sufficient resources/support networks AND experiencing housing instability such as:
     - Recent moves due to economic hardship
     - Doubling up with others
     - Imminent eviction
     - Living in overcrowded or unstable housing
3. ☐ Individuals or families fleeing or attempting to flee
   - Domestic violence, dating violence, sexual assault, stalking, or human trafficking *(No documentation of the trauma is required beyond self-certification or statement from service provider.)*
4. ☐ Other families requiring services or housing assistance to prevent homelessness or those at greatest risk of housing instability
   - Previously homeless and now receiving time-limited assistance
   - Paying more than 50% of monthly income toward housing
   - Income less than 30% or 50% AMI (as applicable) with documented housing instability

Screening Questions:

1. Do you currently have a lease in your name?
   ☐ Yes ☐ No
2. Are you currently working with any other housing assistance programs (e.g., CoC PSH, TBRA, EHH, Section-8)?
   ☐ Yes ☐ No
   If yes, please list: ____

3. Do you need assistance with:

☐ Rental Application Fees	☐ Short-Term Rental Assistance	☐ Utility Assistance *(arrears, deposits, payments)*	☐ Storage Costs	☐ Legal *(refer to Legal Action)*
☐ Security Deposit	☐ Long-Term Rental Assistance *(TBRA)*	☐ Moving Costs	☐ Child Care	

**Services are provided based on program guidelines and available funding; availability is not guaranteed.*

Main Contact for HOME-ARP Program at Lakeshore CAP:

Name: Sandra Bauer
Phone: (920)-803-6991
Email: sandrab@lakeshorecap.org

Acknowledgement & Signature:

By signing below, I affirm that the information provided is true and complete to the best of my knowledge. I understand this application is the first step in determining eligibility for HOME-ARP assistance.

Head of Household Signature: ________________________________

Date: ______________________

☐ **Verbal Consent**

Additional Household Member Signature: ______________________________

Date: ______________________

☐ **Verbal Consent**

Staff Signature: _______________________________

Date: ______________________