



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

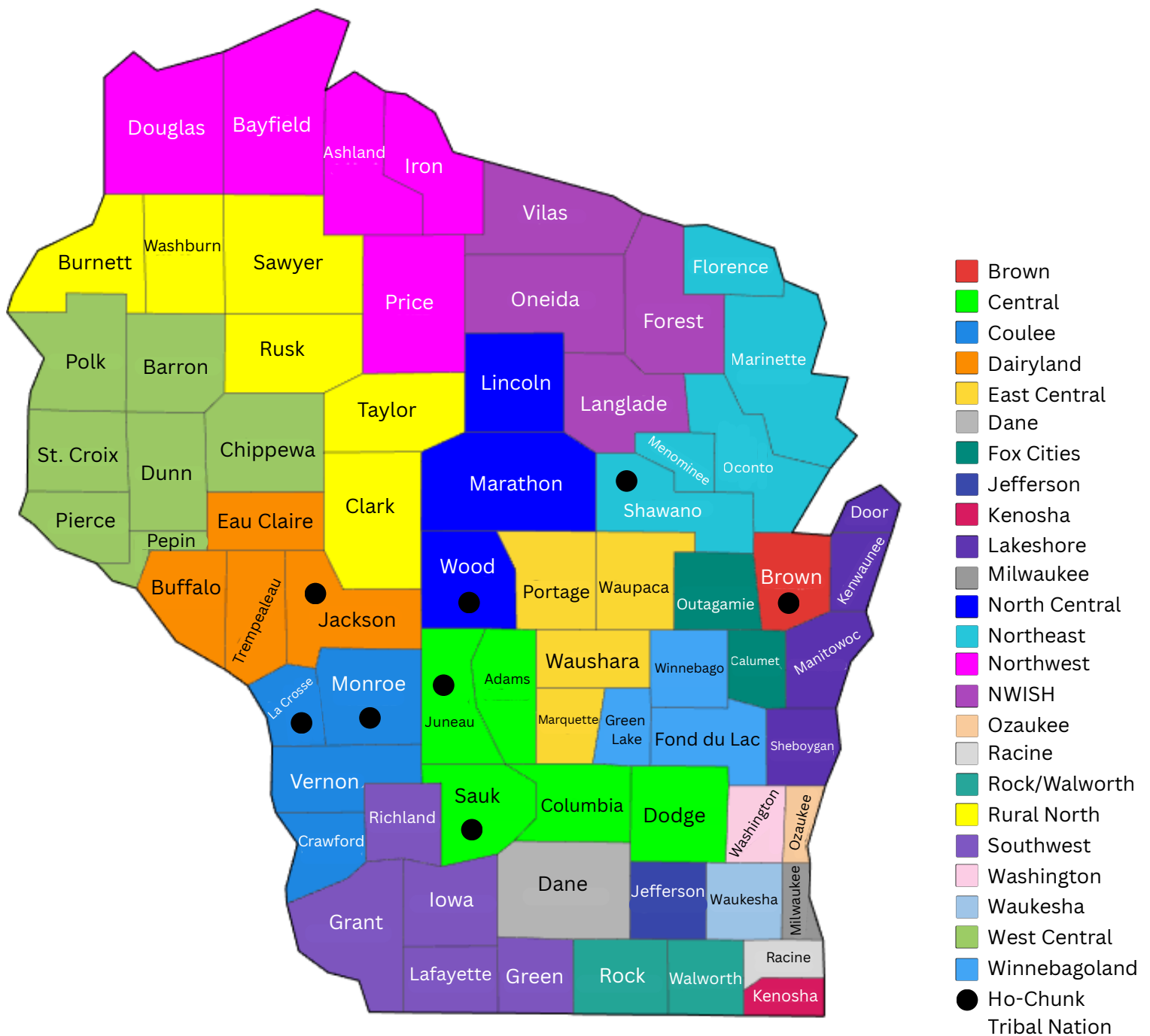
- Your application will be reviewed by a Case Manager in the order in which it was received. Because we receive many applications, it may be a week or two before you will be notified of your eligibility.
- You will be notified IN WRITING (by mail, if possible) of the outcome of your decision within 14 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.

Wisconsin Balance of State Continuum of Care (WIBOSCO) 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

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
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

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 | ☐ Owned by client, no housing subsidy |
| ☐ Foster care home or foster care group home | ☐ Owned by client, with housing subsidy |
| ☐ Staying or living in a family member's room, apartment or house | ☐ Residential project or halfway house with no homeless criteria |
| ☐ Staying or living in a friend's room, apartment or house | ☐ Transitional housing for homeless persons (including homeless youth) |
| ☐ Rental by client, no ongoing housing subsidy | |
| ☐ Rental by client, with ongoing housing subsidy | |
| Rental Subsidy Type: | Institutional Setting: |
| ☐ GPD TIP housing subsidy | ☐ Psychiatric hospital or other psychiatric facility |
| ☐ VASH Housing subsidy | ☐ Hospital (non-psychiatric) |
| ☐ RRH or equivalent subsidy | ☐ Jail, prison, or juvenile facility |
| ☐ HCV voucher (tenant or project based) detention (not dedicated) | ☐ Substance use treatment facility or detox center |
| ☐ Public Housing Unit | ☐ Long-term care facility or nursing home |
| ☐ 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: _____

Length of living situation in the place marked above:

- | | |
|---|---|
| ☐ One night or less | ☐ More than three months, but less than one year |
| ☐ 2-6 nights | ☐ One year or longer |
| ☐ One week but less than a month | ☐ Client doesn't know |
| ☐ One to three months | ☐ 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)

☐ Client doesn't know (answer next 4 questions)

☐ No (skip next 4 questions)

☐ 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)

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.

	<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	☐ 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	_____
<i>Please Specify:</i> _____		
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
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
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
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
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
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
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 EVICTIION 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



Authorization for Release of Information

Participant Name: _____ Date of Birth: _____

I authorize Lakeshore CAP, Inc. to **obtain, share, and discuss information** related to my housing stability and participation in services with organizations and individuals involved in assisting me.

This authorization includes communication with (*initial all that apply*):

- Landlords, property owners, property managers, and housing inspectors
- Public Housing Authorities and housing assistance programs
- Homeless service providers, shelters, outreach programs, and coordinated entry agencies
- Federal, state, county, tribal, and local government agencies providing housing, financial assistance, or supportive services
- Social service agencies, including income, food, child and family, disability, aging, and veterans' programs
- Health care providers, hospitals, clinics, pharmacies, behavioral health providers, and community health organizations
- Mental health, substance use treatment, and recovery support providers
- Medicaid, Medicare, managed care organizations, and health insurers
- Employers, vocational rehabilitation, workforce development agencies, and educational institutions
- Utility companies and other service providers necessary to establish or maintain housing
- Legal aid organizations, courts, probation/parole, correctional institutions, and law enforcement when related to my housing or case management needs
- Emergency contacts, family members, caregivers, advocates, representative payees, guardians, or other persons I identify as involved in my housing plan
- Other/notes: _____

Information that may be shared includes only what is reasonably necessary for housing case management, including: contact information, eligibility, housing status, rental assistance, income and benefits, employment, disabilities or functional limitations affecting housing, service participation, attendance, safety concerns, progress toward housing goals, and other information needed to coordinate services and maintain housing.

Purpose of this authorization: To coordinate services, determine eligibility, obtain or maintain housing and benefits, reduce duplication of services, improve communication among providers, and assist me in achieving housing stability.

I understand:

- I am not required to sign this form to receive services unless the information is necessary to determine eligibility or provide services.
- I may revoke this authorization at any time by providing written notice to Lakeshore CAP. Revocation will not affect information already disclosed before the revocation was received.
- This authorization expires **one (1) year** from the date signed, or when I am no longer participating in Lakeshore CAP supportive housing services, whichever occurs first.

Participant Signature: _____ Date: _____

If signed by a personal representative:

Name: _____

Relationship/Authority: _____

Signature: _____ Date: _____

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

Household Information:

Household Members

Self

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

Preferred Communication

Phone Number: _____

☐ Call ☐ Text

Email: _____

☐ Voicemail ☐ Email

Address: _____

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 (<i>Badger Care</i>)	☐ Yes ☐ No	_____
Medicare	☐ Yes ☐ No	_____
TANF	☐ Yes ☐ No	_____
<i>Please Specify:</i> _____		
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: _____