



**LAKESHORE CAP, INC.**

# Supportive Housing Program Application

<b>Manitowoc County</b>	<b>Sheboygan County</b>	<b>Door/Kewaunee County</b>
<p><b>BRING</b> your application to our office at: 702 State Street- 2<sup>nd</sup> floor (corner of State and 7<sup>th</sup> streets)</p> <p><b>MAIL</b> to PO Box 2315, Manitowoc, WI 54221-2315</p> <p><b>FAX</b> to 920.686.8700</p> <p><b>EMAIL</b> to <a href="mailto:info@lakeshorecap.org">info@lakeshorecap.org</a></p> <p><b>CALL</b> 920.682.3737</p>	<p><b>BRING/MAIL</b> your application to our office inside the <u>Sheboygan County Job Center</u> at 3620 Wilgus Avenue, PO Box 896, Sheboygan, WI 53082- 0896</p> <p><b>FAX</b> to 920.694.0291</p> <p><b>EMAIL</b> to <a href="mailto:info@lakeshorecap.org">info@lakeshorecap.org</a></p> <p><b>CALL</b> 920.803.6991</p>	<p><b>BRING</b> to 131 S. 3<sup>rd</sup> Ave., Sturgeon Bay (<i>limited open office hours</i>)</p> <p><b>MAIL</b> to PO Box 896, Sheboygan, WI 53082- 0896</p> <p><b>FAX</b> to 920.694.0291</p> <p><b>EMAIL</b> to <a href="mailto:info@lakeshorecap.org">info@lakeshorecap.org</a></p> <p><b>CALL</b> 920.803.6991</p>

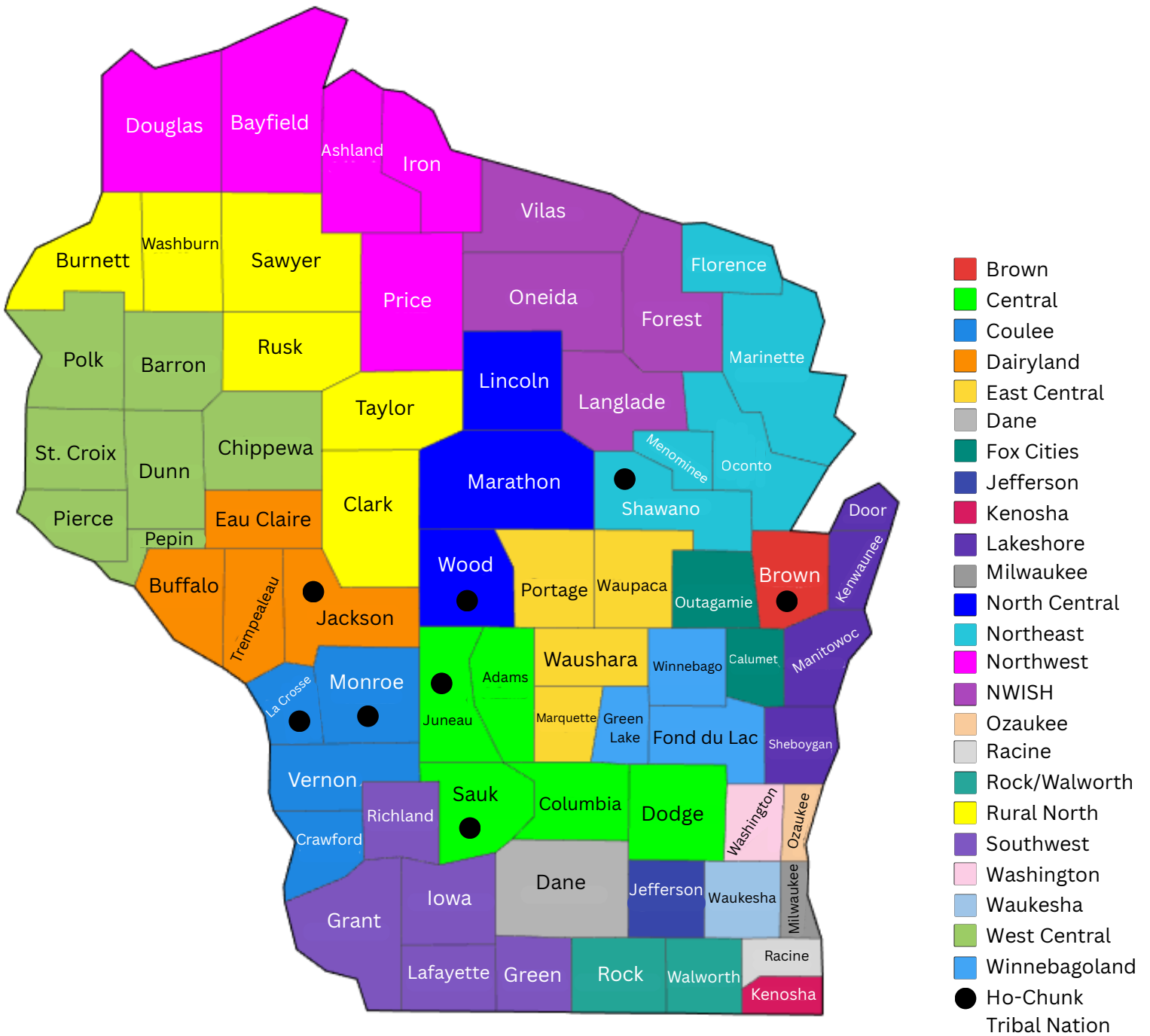
- Your application will be reviewed by a Case Manager in the order in which it was received. Because we receive many applications, it may be a week or two before you will be notified of your eligibility.
- You will be notified **IN WRITING** (by mail, if possible) of the outcome of your decision within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

- |  |   |
|--|---|
| <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher       | <input type="checkbox"/> Owned by client, no housing subsidy                                  |
| <input type="checkbox"/> Foster care home or foster care group home                      | <input type="checkbox"/> Owned by client, with housing subsidy                                |
| <input type="checkbox"/> Staying or living in a family member's room, apartment or house | <input type="checkbox"/> Residential project or halfway house with no homeless criteria       |
| <input type="checkbox"/> Staying or living in a friend's room, apartment or house        | <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) |
| <input type="checkbox"/> Rental by client, no ongoing housing subsidy                    |   |
| <input type="checkbox"/> 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: \_\_\_\_\_

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:**

- |   |   |
|---|---|
| <input type="checkbox"/> One night or less              | <input type="checkbox"/> More than three months, but less than one year |
| <input type="checkbox"/> 2-6 nights                     | <input type="checkbox"/> One year or longer                             |
| <input type="checkbox"/> One week but less than a month | <input type="checkbox"/> Client doesn't know                            |
| <input type="checkbox"/> One to three months            | <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?**

- 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):**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Divorce/separation | <input type="checkbox"/> Domestic violence, sexual assault, and/or human trafficking | <input type="checkbox"/> Eviction                     | <input type="checkbox"/> Asked or forced to leave residence |
| <input type="checkbox"/> Loss of job        | <input type="checkbox"/> Low income  | <input type="checkbox"/> Rent increase                | <input type="checkbox"/> Parole/incarceration               |
| <input type="checkbox"/> Mental illness     | <input type="checkbox"/> Substance Use Disorder                                      | <input type="checkbox"/> Ran away                     | <input type="checkbox"/> Exiting foster care                |
| <input type="checkbox"/> Other: _____       | <input type="checkbox"/> Client doesn't know   | <input type="checkbox"/> 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):

- |                                       |  |  |
|---------------------------------------|--|--|
| <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	\$ _____	_____
<b>MONTHLY GROSS INCOME TOTAL</b>	<b>\$ _____</b>	
<b>ANNUAL INCOME</b>	<b>\$ _____</b>	

## 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 <b>EVICTION NOTICE</b> ?	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 <b>unable</b> 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?	<b>YES / NO</b>	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.

*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
- 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.**

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 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.