Transitional Living Services
of Northern New York
610 Cedar Street Ogdensburg NY 13669 Tel: (315) 393-4610 Fax: (315) 394-1815

APPLICATION FOR HOUSING

Dear Applicant:

Thank you for your interest in housing and services available through TLS, Inc. This application will be used for housing through TLS, as well as for recommendations for placement with other landlords. Information on this application will not be shared with other landlords. To assure that the North Country Transitional Living Services, Inc. will acquire the best residents possible, TLS will perform a thorough investigation of all applicants, including anyone listed on the application that is also being considered for housing, with the exclusion of anyone less than eighteen (18) years of age. A checklist has been provided to insure that all applicable forms be submitted along with your application. Employment Verification Form, Landlord Verification Form, Release of Information, and Criminal History Form are required as part of this process.

Please make sure that all questions are answered fully. Once your application has been received in its entirety and reviewed with the Property & Accounts Manager to ensure your application is complete and all necessary documentation has been received. It will then be processed if we have a unit available. It is your responsibility to keep us informed of any changes, including mailing address, telephone number, changes in family size, and income.

If you have any questions or experience difficulty completing the enclosed application, please feel free to contact Property Management at (315) 393-4610.

Good luck in your housing search!

Sincerely,

TLS Staff

Making the Best Care Better
www.tlsnny.com

PRELIMINARY APPLICATION

PLEASE COMPLETE ALL SECTIONS.

CONTACT INFORMATION

1. APPLICANTS NAME: _____
First Middle Last

2. PRESENT ADDRESS: _____

3. SOCIAL SECURITY: _____ - _____ - _____

4. HOME PHONE: (____) _____- _____ WORK PHONE: (_____) _____- _____

5. BIRTHDATE: _____ / _____ / _____

6. REFERRED BY: _____

Cause of homelessness or why are you at risk of being homeless: _____

_____

Please list all agencies you are currently receiving assistance from or have received assistance from in the past six (6) months: (Neighborhood Center, DSS, St. Vincent DePaul, United Helpers, Catholic Charites, etc.)_____

_____

HOUSEHOLD MEMBERS

7. PLEASE LIST ANYONE THAT WILL BE LIVING WITH YOU:

NAME	SS #	RELATIONSHIP	BIRTHDATE

HOUSING PREFERENCE

8. Please check all that you would like to be considered for:

☐ Lake St. ☐ Waddington ☐ Heuvelton ☐ Heuvelton

☐ Gaslight Village ☐ Any TLS owned property ☐ Other

How many bedrooms needed? _____

Handicap Unit Require: ☐ NO ☐ YES If yes, describe reason: _____

_____

INCOME SOURCE

9. Please list income for ALL household members before deductions and indicate whether payment is weekly, biweekly, monthly, or yearly. Income includes employment, unemployment, public assistance, social security, disability, pension, alimony, child support, veteran's benefits, etc.

Type of Income	Amount

10. Please list other rental assistance (HUD, UH Supportive Housing, etc.)

Type of assistance: _____ Amount: $_____

MONTHLY EXPENSES

11. Please list all monthly expenses including any delinquent accounts (utility, loans, outstanding debt, etc.).

COMPANY/LENDER	AMOUNT	IF DELINQUENT AMOUNT OWED
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$

REFERENCES

12. Please provide two (2) credit references and two (2) personal references:

CREDIT REFERENCE	PERSONAL REFERENCE
1). Name:	1). Name:
Address:	Address:
Phone:	Phone:
2). Name:	2). Name:
Address:	Address:
Phone:	Phone:

PREVIOUS HOUSING

13. Please list your last three (3) residences starting with the most current:

PREVIOUS ADDRESS	RENT AMT	DATE OF RESIDENCY	REASON FOR LEAVING
	$	From: To:	

PREVIOUS ADDRESS	RENT AMT	DATE OF RESIDENCY	REASON FOR LEAVING
	$	From: To:	

PREVIOUS ADDRESS	RENT AMT	DATE OF RESIDENCY	REASON FOR LEAVING
	$	From: To:	

MOTOR VEHICLES

14. Please list information for all vehicles in household. **PLEASE SUBMIT A COPY OF REGISTRATION(S) FOR EACH VEHICLE WITH YOUR APPLICATION.**

YEAR / MAKE	COLOR	LICENSE PLATE NUMBER

PETS

15. Pets are **NOT PERMITTED** in housing through TLS. If applying for help in locating housing through other landlords and you own a pet, please describe the type of pet(s) owned: _____

EMERGENCY CONTACT

16. In case of an emergency, please list two people we may contact:

Name:	Name:
Address:	Address:
Phone:	Phone:
Relationship:	Relationship:

GOALS

17. Please give a brief statement of the short and long term goals for your family, and how residency and/or services provided through TLS can assist you in meeting these goals.

SHORT TERM GOALS:_____

_____

_____

LONG TERM GOALS: _____

_____

_____

How will TLS be to assist you in meeting these goals? _____

_____

_____

ESSAY

18. Please write a short narrative about why you feel your family would benefit from housing through TLS. This information will be used by the housing committee to determine which applicants have the "GREATEST NEED", and who would benefit the most from living in TLS housing. This information will also assist us in evaluating your family needs and how we may be able to better address them.

_____

_____

_____

_____

_____

_____

_____

_____

_____

EDUCATION

19. Please list all education you have obtained._____

_____

_____

_____

GENERAL HEALTH

20. Does anyone in your family suffer from any medical condition? _____

_____

_____

_____

STABILIZATION

21. How many times have you or your family been in a homeless situation and for how long._____

_____

_____

Thank you for taking the time to complete an application for housing. Please be advised that the completion of this application does not guarantee housing. Approval is provisional until you have signed a lease and receive keys to your apartment.

_____

CERTIFICATION

I hereby affirm that, to the best of my knowledge, the foregoing information is true, accurate and complete. I understand that misleading or false statements, misrepresentations, or incomplete information in this application could be grounds for denial.

Signature:_____Date: _____

Co-Applicant
Signature: _____ Date: _____

NORTH COUNTRY TRANSITIONAL LIVING SERVICES, INC.
610 Cedar Street, Ogdensburg, NY 13669
Tele: 315-393-4610 Fax: 315-394-1815

LANDLORD VERIFICATION FORM

I hereby authorize the release of the requested information, which will be kept confidential and used for program purposes only.

_____ _____

Applicant's Name (printed) Applicant's Signature

Dear Landlord:
The North Country Transitional Living Services, Inc. has been authorized to verify the information provided by the individual who signature appears above. We ask your cooperation by promptly completing this form.

Please return form to:
North Country Transitional Living Services, Inc. or Fax: (315) 394-1815
610 Cedar Street
Ogdensburg, NY 13669

Landlord, please answer the following questions regarding the above named person:

1. Resides, or once resided, at the following apartment (list address):_____
_____

2. Length and date of residence: _____

3. Monthly Rent Amount: _____ Timeliness of Rent Payment:_____

4. Care pf Premises: _____

5. Would you rent to this applicant again:_____.

6. Do you plan to, or did you, return the applicant's security deposit in full: YES NO (circle one)

If no, why? _____

7. Are you aware of any incidents relating to the applicant that required police presence at the premises?_____

If yes, please explain: _____

8. Other Comments: _____

This information was provided in confidence by:

_____ _____

PRINT Name Signature

_____ _____

Title Address

_____ _____

Phone Number Date

NORTH COUNTRY TRANSITIONAL LIVING SERVICES, INC.
610 Cedar Street, Ogdensburg, NY 13669
Tele: 315-393-4610 Fax: 315-394-1815

EMPLOYMENT VERIFICATION FORM

I hereby authorize the release of the requested information, which will be kept confidential and used for program purposes only.

_____ _____

Applicant's Name (printed) Applicant's Signature

Dear Supervisor / HR Department Representative:
The North Country Transitional Living Services, Inc. has been authorized to verify the information provided by the individual who signature appears above. We ask your cooperation by promptly completing and returning this form.

Please return form to:
North Country Transitional Living Services, Inc. or Fax: (315) 394-1815
610 Cedar Street
Ogdensburg, NY 13669

Supervisor/HR Dept. Representative, please answer the following questions regarding the above named person:

1. Employee's Start Date:_____Still Employed?_____If no, late date worked _____
2. Position / Job Title _____ Probability of Continued Employment _____
3. Year to Date Gross Earnings: $_____ through _____/_____/_____
4. Average Gross Pay $ _____ per week / bi- weekly / monthly (circle one)
5. Average Hours per Week: _____Hourly Pay Rate $ _____ (if applicable)
6. Current Rate of Overtime (OT) Pay $ _____/ hr. (if applicable)
8. Anticipated Tips, Commissions, Bonuses $ _____
9. Do you anticipate any changes in salary in the next 12 months? YES NO (circle one)
10. If work is seasonal or sporadic, please indicate likely layoff periods: _____

_____

This information is provided in strict confidence by:

_____ _____

Signature of Employer Printed Name of Employer / Title

_____ _____

Company Name Company Address

_____ _____

Phone Number Date

Transitional Living Services
of Northern New York
610 Cedar Street Ogdensburg NY 13669 Tel: (315) 393-4610 Fax: (315) 394-1815

Date: _____

TENANT / APPLICANT RELEASE AND CONSENT

I/We, the undersigned, hereby authorize all persons or companies in the categories listed below to release, without liability, information regarding employment, income, and/or assets to North Country Transitional Living Services, Inc. (agent), for purposes of verifying information on my/our apartment rental application or tenant recertification.

INFORMATION COVERED

I/We understand that previous or current information regarding me/us may be needed. Verifications and inquiries that may be requested include, but are not limited to: personal identity, employment, income and assets, rental history/references. I also understand this authorization will be used to obtain Social Security Benefits Information on my behalf. I/We understand that this authorization cannot be used to obtain any information about me/us that is not pertinent to my eligibility for and continued participation as a qualified tenant.

Groups or Individuals that may be contacted

The groups or individuals that may be asked to release the above information include, but are not limited to:

Past and present employers	Dept. of Social Services	Landlords
Veterans Administration	Worker's Compensation	State Unemployment Agencies
Social Security Administration	Support & Alimony providers	Banks/Other Financial Institutes
Public Housing Agency	SLC Comm. Devel. Program	Utility Companies

Conditions

I/We agree that a photocopy of this authorization may be used for purposes stated above. The original of this authorization is on file and will stay in effect for one year from the date signed. I/We understand that I/We have the right to review this file and correct any information that is incorrect.

Signatures

Head of House Hold	Date	Other Adult	Date
Print Name	Date	Print Name	Date

Maximizing Independence through Wellness
www.tlsnny.com

Transitional Living Services
of Northern New York

610 Cedar Street Ogdensburg, NY 13669 Tel: (315) 393-4610 Fax: (315) 394-1815

APPLICATION PROCESSING
UTILITY VERIFICATION

Applicant: _____ or _____

SS#: XXX-XX-_____ or XXX-XX-_____

Current Address: _____

_____

In order to determine an applicant's eligibility for Housing, Federal Law requires us to determine their ability to comply with the **Housing Annual Lease** concerning utility services. The applicant is requesting the following information.

As of _____, the above applicant has an outstanding past due balance owed to

- ☐ National Grid in the amount of: $_____
- ☐ Enbridge St. Lawrence Gas in the amount of: $_____

Is this applicant permitted to obtain utility service in his/her name: ☐ ***YES*** ☐ ***NO***

Will a Security Deposit be required to obtain service: ☐ ***YES*** ☐ ***NO***

Comments:_____

_____

_____ _____

Completed By Date

The applicant identified above hereby declares and represents that he/she has completed an application for housing under North Country Transitional Living Services (NCTLS) and that all statements made therein are complete and true to the best of his/her knowledge. The applicant hereby authorizes NCTLS to make inquiries regarding Utility Services in conjunction with his/her rental housing application at the time of intake and again at the time of unit offer.

**** I understand the utility provider may and can require past due balances currently in my name be paid in full prior to receiving a new service account.***

_____ _____

Applicant Signature Date

_____ _____

Applicant Signature Date

REQUEST FOR CRIMINAL HISTORY RECORD INFORMATION

Complete address of requesting Agency:
North Country Transitional Living Services, Inc.
610 Cedar Street
Ogdensburg, NY 13669

OR Number

Fax: 315-394-1815

Please conduct a name search of your files and forward a copy of any Criminal History Record Information you have regarding the name subject, which meets discrimination criteria for the stated purpose.

TYPE OR PRINT ALL INFORMATION

Name				SBI #
(Last name in caps) Maiden (if applicable) First Name Middle				
Address:				FBI #
DOB	Sex	Race	Social Security #	Requesting Agency Use
(Month) (Day) (Year)				**HOUSING**

SECURITY CHECK AUTHORIZATION (WAIVER)

As indicated above, I have applied for Housing. For the purposes of this application, I hereby authorize the release of any Criminal History Records Information maintained by your agency to:

NORTH COUNTRY TRANSITIONAL LIVING SERVICES, INC.

Any such information released as a result of this information shall be used for the express purpose of processing the above indicted application.

_____ _____
Date Signature of Applicant

History records:_____

_____ _____
Date Signature of Police Officer

_____ DOCS _____ Print out attached Y / N
Date Information Search DIN #

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North Country Transitional Living Services, Inc.
610 Cedar Street
Ogdensburg, NY 13669

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(Last name in caps) Maiden (if applicable) First Name Middle				
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DOB	Sex	Race	Social Security #	Requesting Agency Use
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NORTH COUNTRY TRANSITIONAL LIVING SERVICES, INC.

Any such information released as a result of this information shall be used for the express purpose of processing the above indicted application.

_____ _____
Date Signature of Applicant

History records:_____

_____ _____
Date Signature of Police Officer

_____ DOCS _____ Print out attached Y / N
Date Information Search DIN #

Homeless Verification Form

DATE: _____ PROJECT / BUILDING: _____

APPLICATION PROFILE FOR : _____

REFERRAL SOURCE: _____

Documentation MUST be attached to this form from Referral Source indicating at minimum the applicant's nature of homelessness.

NATURE OF HOMELESSNESS:

- ☐ Transient Living on the Street
- ☐ Currently in emergency shelter
- ☐ Currently in hotel / motel
- ☐ Currently in transitional facility
- ☐ Currently in institutional facility
- ☐ Domestic violence
- ☐ Documented imminent eviction / evicted
- ☐ Current residence condemned / dangerous with documented code issues
- ☐ Overcrowding verified by referral source
- ☐ Other:_____

Name and address of current housing (as noted above) _____

_____

Applicant has been in their current housing status since what date: _____

RESIDENT'S SOURCE(S) OF INCOME and/or SUBSIDY and AMOUNT(S) AT INTAKE:

Source:_____ Monthly / Per Diem Amount: $_____

Source:_____ Monthly / Per Diem Amount: $_____

AMOUNT OF RENT TO BE CHARGED PER MONTH AT INTAKE: $ _____

COMMENTS: _____

_____

_____

COMPLETED BY: (Print Name) _____

(Signature) _____

(Organization) _____

(Job Title) _____

*Developed for use with Homeless Housing and Assistance Program (HHAP) funded projects/units.

NOTE: Although the applicant may qualify under HHAP, they may not qualify for HUD's definition of homelessness. Please see 24 CFR 576. This form is intended only to verify homelessness. HHAP sponsors should use a separate intake/screening tool for determination the prospective residents' eligibility for housing and assessment tool for developing an individualized support services plan for residents.

CHECKLIST

This is a checklist that you can use to ensure that you are submitting a complete application. ***Incomplete applications will not be processed.*** All applicable forms and/or documents must be submitted.

1. **APPLICATION**

   ___Please fill out completely, sign and date. Drop off or return to:

   North Country Transitional Living Services, Inc.
   610 Cedar Street
   Ogdensburg, NY 13669

2. **EMPLOYMENT VERIFICATION FORM**

   ___If you are working, please have your employer fill out the enclosed Employment Verification form.

   ___Provide payroll stubs for the past 4-6 weeks.

   ___Provide proof of income (Social Security, SSI, pensions, veteran's benefits, retirement, child support, public assistance, etc.

3. **LANDLORD VERIFICATION FORM**

   Please have your past and current landlord fill out the enclosed landlord verification form. If you receive rental assistance (such as HUD, public assistance), please provide proof (letter) and return it with your application.

4. **IDENTIFICATION**

   Provide the following forms of identification for all individuals that will reside in the apartment:

   ___Photo ID

   ___Social Security Card

   ___Birth Certificate

   ___Back ground check for anyone 18 or older. (Please request extra copies if needed).

5. **MOTOR VEHICLE VERIFICATION**

   Provide a copy of vehicle registration

PLEASE RETURN ALL INFORMATION AND FORMS WITH YOUR COMPLETED APPLICATION

Transitional Living Services of Northern New York
610 CEDAR Street
Ogdensburg, NY 13669
(315) 393-4610
FAX (315) 394-1815

The following questions are for Homeless Management Information System (HMIS). What is HMIS you may ask? It is a federal government database that is a tool used in helping with homelessness in the area. This data may assist TLS in obtaining grants to continue to offer subsidized housing.

HMIS was developed in the 1990s in response to a mandate by Congress requiring states to collect data in order to receive funds from the Department of Housing and Urban Development (HUD) to address homelessness.

Broad utilization of HMIS can help provide a consistent and accurate snapshot of a region's homeless population, including a population count, information on service use, and a measurement of the effectiveness of homeless programs, as HMIS also helps track the number of chronically homeless clients and placements into permanent housing. This information can have important impacts on policy at the federal, state, and local levels.

Thank you for taking the time in completing the following packet.

HMIS INTAKE – Permanent Supportive Housing or Rapid Rehousing

*INTAKE DATE	PRIMARY WORKER
____/____/____	

*FIRST NAME	MIDDLE NAME	*LAST NAME (and Suffix)

*NAME DATA QUALITY	ALIAS
❑ Full Name Reported ❑ Partial Name, Street Name or Code Name Reported ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected	

*SOCIAL SECURITY NUMBER	*SSN DATA QUALITY
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	❑ Full SSN Reported ❑ Approximate or Partial SSN Reported ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*GENDER

❑ Male ❑ Female ❑ Trans Male (FTM)
❑ Trans Female (MTF) ❑ Gender Non-Conforming (i.e. not exclusively male or female)
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*BIRTHDATE	*BIRTHDATE DATA QUALITY
____/____/____	❑ Full DOB Reported ❑ Approximate or Partial DOB Reported ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*ETHNICITY

❑ Hispanic ❑ Non-Hispanic
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*RACE (choose all that apply)

❑ American Indian/Native Alaskan ❑ Black ❑ White
❑ Asian ❑ Native Hawaiian or Other Pacific Islander
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*VETERAN STATUS

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

***LIVING SITUATION**

*Based on the client's living situation the night before project entry, record responses in **one (1) section** below, EITHER Homeless Situation, Institutional Situation OR Transitional/Permanent Situation.*
If the client's living situation the night before project entry is unknown, fill in the section called Unknown.

HOMELESS SITUATIONS:

TYPE OF RESIDENCE NIGHT BEFORE PROJECT ENTRY:	LENGTH OF STAY IN PREVIOUS PLACE
❑ Place not meant for human habitation (vehicle, abandoned building, bus/train/subway station etc) ❑ Emergency shelter, including hotel or motel paid for with emergency shelter voucher ❑ Safe Haven ❑ Interim Housing	❑ 1 night or less ❑ 2 to 6 nights ❑ 1 week or more, but less than 1 month ❑ 1 month or more, but less than 90 days ❑ 90 days or more, but less than 1 year ❑ 1 year or longer ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

APPROXIMATE DATE HOMELESSNESS STARTED:	NUMBER OF TIMES THE CLIENT HAS BEEN ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS INCLUDING TODAY:
____/____/____	❑ 1 ❑ 2 ❑ 3 ❑ 4+ ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR SH IN LAST THREE YEARS:

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

OR

INSTITUTIONAL SITUATIONS:

TYPE OF RESIDENCE NIGHT BEFORE PROJECT ENTRY:	DID YOU STAY LESS THAN 90 DAYS
❑ Foster care home or foster care group home ❑ Hospital or other residential non-psychiatric medical facility ❑ Jail, prison or juvenile detention facility ❑ Long-term care facility or nursing home ❑ Psychiatric hospital or other psychiatric facility ❑ Substance abuse treatment facility or detox center	❑ No ❑ Yes (If Yes) On the night before did you stay on the streets, ES, or SH? ❑ No ❑ Yes

IF YES TO 'ON THE NIGHT BEFORE DID YOU STAY ON THE STREETS, ES OR SH?' PROVIDE DETAILS OF PREVIOUS HOMELESSNESS:

APPROXIMATE DATE HOMELESSNESS STARTED:	NUMBER OF TIMES THE CLIENT HAS BEEN ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS INCLUDING TODAY:
____/____/____	❑ 1 ❑ 2 ❑ 3 ❑ 4+ ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR SH IN LAST THREE YEARS:

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

OR

TRANSITIONAL AND PERMANENT HOUSING SITUATIONS:

TYPE OF RESIDENCE NIGHT BEFORE PROJECT ENTRY:

❑ Hotel or Motel paid for without emergency voucher	❑ Rental by client with VASH subsidy
❑ Owned by client, no ongoing subsidy	❑ Rental by client with other ongoing housing subsidy
❑ Owned by client WITH ongoing subsidy	❑ Residential project or halfway house with no homeless criteria
❑ Perm. Supportive housing for formerly homeless persons (CoC project, HUD legacy program, HOPWA)	❑ Staying or in a family member's room, apartment or house
❑ Rental by client, no ongoing subsidy	❑ Staying or in a friend's room, apartment or house
❑ Rental by client with GPD TIP subsidy	❑ Transitional housing for homeless persons (incl. homeless youth)

DID YOU STAY LESS THAN 7 DAYS?

❑ No ❑ Yes (If Yes) On the night before did you stay on the streets, ES, or SH? ❑ No ❑ Yes

IF YES TO 'ON THE NIGHT BEFORE DID YOU STAY ON THE STREETS, ES OR SH?' PROVIDE DETAILS OF PREVIOUS HOMELESSNESS:

APPROXIMATE DATE HOMELESSNESS STARTED:	NUMBER OF TIMES THE CLIENT HAS BEEN ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS INCLUDING TODAY:
____/____/____	❑ 1 ❑ 2 ❑ 3 ❑ 4+ ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR SH IN LAST THREE YEARS:

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

OR

UNKNOWN OPTIONS:

TYPE OF RESIDENCE NIGHT BEFORE PROJECT ENTRY:

❑ Client doesn't know ❑ Client refused ❑ Data not collected

*INCOME FROM ANY SOURCE (monthly)

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

❑ Earned Income..... $_____	❑ Unemployment Insurance..... $_____
❑ SSI..... $_____	❑ SSDI..... $_____
❑ VA Service-Connected Disability Compensation..... $_____	❑ VA Non-Service Connected Disability Pension..... $_____
❑ Private Disability Insurance..... $_____	❑ Worker's Compensation..... $_____
❑ TANF..... $_____	❑ General Public Assistance..... $_____
❑ Retirement from SSA..... $_____	❑ Pension or Retirement from former job..... $_____
❑ Child Support..... $_____	❑ Alimony or Other Spousal Support..... $_____
❑ Other..... $_____	

*NON-CASH BENEFITS FROM ANY SOURCE

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

❑ SNAP
❑ Special Supplemental Nutrition Program for Women, Infants and Children
❑ TANF Child Care Services
❑ TANF Transportation Services
❑ Other TANF Funded Srvcs
❑ Other Source

*COVERED BY HEALTH INSURANCE

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

MEDICAID ..... ❑ No ❑ Yes
State Children's Health Insurance Program ..... ❑ No ❑ Yes
Employer provided Health insurance ..... ❑ No ❑ Yes
Private Pay Health Insurance..... ❑ No ❑ Yes
Indian Health Services ..... ❑ No ❑ Yes
MEDICARE..... ❑ No ❑ Yes
VA Medical Services..... ❑ No ❑ Yes
Health ins. via COBRA ..... ❑ No ❑ Yes
State Health Ins. Adults ..... ❑ No ❑ Yes
Other (if yes please specify_____) .. ❑ No ❑ Yes

*PHYSICAL DISABILITY

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to substantially impair ability to live independently:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*DEVELOPMENTAL DISABILITY

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*CHRONIC HEALTH CONDITION

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*HIV/AIDS

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to substantially impair ability to live independently:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*MENTAL HEALTH

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*SUBSTANCE ABUSE PROBLEM

❑ Alcohol Abuse ❑ Drug Abuse ❑ Both Alcohol and Drug Abuse
❑ No ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*DOMESTIC ABUSE VICTIM/SURVIVOR

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

When Experience Occurred:	**Are you currently fleeing?**

❑ Within the past 3 months ❑ 3 to 6 months ago ❑ From 6 to 12 months ago ❑ More than a year ago ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected	❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*HAS CLIENT BEEN PLACED INTO PERMANENT HOUSING	IF YES: DATE	RESIDENCE UNIT
❑ No ❑ Yes	_____/_____/_____	

*ZIP CODE OF LAST PERMANENT ADDRESS
_____ _____ _____ _____ _____

SERVICES SOUGHT		
❑ Shelter/Housing	❑ Drug Treatment	❑ Mental Health Care
❑ Medical Care	❑ Legal Aid - CRJS/Civil	❑ Legal Aid - Immigration

CRHMIS Client Informed Consent and Release of Information

_____ (agency name) _____ participates in the CARES Regional Homeless Management Information System (CRHMIS). This means that we collect information about your household and input it into a secure and private database that allows us to keep track of that information to better assess and serve your needs.

The CRHMIS is dedicated to the privacy and safeguarding of the information collected and input into the HMIS database and does not publish identifying, client level data. For more information, please see our complete policy and procedure manual, which includes information on opting out of the HMIS, data ownership and a list of research and coordination projects that use HMIS information at **www.caresny.org/HMIS-policies.**

To better assist in the coordination and provision of services, we are requesting your permission to share limited information about you with other homeless services providers. As the owner of your own information within the CRHMIS, you have the right to choose whether or not other users of the system can see any of your personal information and on what level. HIV/AIDS information, Domestic Violence information, Behavioral health (mental illness and substance abuse) and client notes are NOT shared through the HMIS. This consent will be in effect for a minimum of 36 months but may be revoked at any time.

Please check the (1) box below which indicates the level at which you are willing to share your information with the homeless services coordinators and providers in the community;

___ I agree to share my name, gender and program enrollment history through the HMIS with other provider homeless services agencies.

___ I agree to share my name, gender, program enrollment history, demographic, income and contact information through the HMIS with other partner homeless services agencies.

___ I do NOT agree to share any of my information through the HMIS with other partner homeless services agencies.

By signing this form, I agree to share the above level of information with other partner agencies via the HMIS Computer System:

_____

PRINTED name of Client

_____ _____

Signature of Client, Guardian or Power of Attorney | Signature of Witness

_____ _____

Date | Date

INSTRUCTIONS:

1) These are two separate forms sharing one page for convenience and resource conservation.

2) A form must be filled out for EACH household member. Minors may NOT sign for themselves or their children, even if they are the head of household. The additional MINOR consent should be filled out and signed by a parent or guardian for all minors or adult household members with developmental disabilities which would preclude them from signing the consent themselves.

CRHMIS Inclusion Disclosure

The CRHMIS has moved from *inferred consent* (a posted sign) to an *inclusion disclosure* for the HMIS. **No consumer consent is required by the CRHMIS to enter consumer data**. This disclosure replaces the posted sign but fulfills the same purpose. Consumers are asked to initial that they received the information. This is in addition to any agency specific or CoC specific forms that may be presented upon intake.

While individual agencies and projects may have their own, overriding policies, refusing to initial the inclusion disclosure does **NOT** indicate a refusal to be included in the HMIS and does not automatically disqualify consumers from receiving services from the agency or project; agency and CoC policy regarding how to handle that situation should still be followed as it has been in past years.

CRHMIS Client Release of Information

The CRHMIS is not an open system and does not automatically share data between agencies. In order to better coordinate case care; however, the CRHMIS Advisory Committee has agreed to a stepped implementation of consumer-driven data sharing. If your project allows data sharing (please contact kclark@caresny.org if you are not sure) the consumer may choose to share some or most of their data within the HMIS. This data is shared only to other HMIS users who have been through training in the system and agreed to all privacy and security polies. Special needs (i.e. mental health, HIV status, substance abuse status) are NEVER Shared between agencies.

If your agency or project DOES NOT participate in data sharing, you must check option 3 on this sheet and have the consumer sign, indicating that they understand that their data will NOT be shared regardless of preference. When entering the intake into HMIS, "No Sharing" is the default and, in this circumstance will be left at the default and the intake processed. Monitoring will include checking to ensure that physical forms and HMIS records match.

If your agency and project DOES participate in data sharing, you must give the consumer the choice to share at level 1 (most restrictive but still shared), 2 (less restrictive) or 3 (no sharing at all). The consumer must then sign and date the form. Monitoring will include checking to ensure that physical forms and HMIS records match

HMIS INTAKE – Transitional Housing
Household Member Under 18

*INTAKE DATE	*RESIDENCE UNIT	PRIMARY WORKER
____/____/____		

*FIRST NAME	MIDDLE NAME	*LAST NAME (and Suffix)

*NAME DATA QUALITY	ALIAS
❑ Full Name Reported ❑ Partial Name, Street Name or Code Name Reported ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected	

*SOCIAL SECURITY NUMBER	*SSN DATA QUALITY
(enter "9" for any missing numbers in an Approximate or Partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	❑ Full SSN Reported ❑ Approximate or Partial SSN Reported ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

***GENDER**

❑ Male ❑ Female ❑ Transgender Male (FTM)
❑ Transgender Female (MTF) ❑ Gender Non-Conforming (i.e. not exclusively male or female)
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*BIRTHDATE	*BIRTHDATE DATA QUALITY
____/____/____	❑ Full DOB Reported ❑ Approximate or Partial DOB Reported ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

***ETHNICITY**

❑ Hispanic ❑ Non-Hispanic
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

***RACE (choose all that apply)**

❑ American Indian/Native Alaskan ❑ Black ❑ White
❑ Asian ❑ Native Hawaiian or Other Pacific Islander
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

***COVERED BY HEALTH INSURANCE**

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

MEDICAID	❑ No ❑ Yes	MEDICARE.....	❑ No ❑ Yes
State Children's Health Insurance Program	❑ No ❑ Yes	VA Medical Services.....	❑ No ❑ Yes
Employer provided Health insurance	❑ No ❑ Yes	Health ins. via COBRA	❑ No ❑ Yes
Private Pay Health Insurance.....	❑ No ❑ Yes	State Health Ins. Adults	❑ No ❑ Yes
Indian Health Services	❑ No ❑ Yes	Other (if yes please specify_____) ..	❑ No ❑ Yes

***PHYSICAL DISABILITY**

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to substantially impair ability to live independently:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

***DEVELOPMENTAL DISABILITY**

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

***CHRONIC HEALTH CONDITION**

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*HIV/AIDS

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to substantially impair ability to live independently:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*MENTAL HEALTH

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*SUBSTANCE ABUSE PROBLEM

❑ Alcohol Abuse ❑ Drug Abuse ❑ Both Alcohol and Drug Abuse

❑ No ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

SERVICES SOUGHT

❑ Shelter/Housing	❑ Drug Treatment	❑ Mental Health Care
❑ Medical Care	❑ Legal Aid - CRJS/Civil	❑ Legal Aid - Immigration

For Household Members Under the Age of 18 and Adults Who are Unable to Sign on Their Own

To better assist in the coordination and provision of services, we are requesting your permission to share limited information about you with other homeless services providers. As the owner of your own information within the CRHMIS, you have the right to choose whether or not other users of the system can see any of your personal information and on what level. HIV/AIDS information, Domestic Violence information, Behavioral health (mental illness and substance abuse) and client notes are NOT shared through the HMIS. This consent will be in effect for a minimum of 36 months but may be revoked at any time.

Please check the (1) box below which indicates the level at which you are willing to share your information with the homeless services coordinators and providers in the community;

1) ___ I agree to share my name, gender and program enrollment history through the HMIS with other provider homeless services agencies.
2) ___ I agree to share my name, gender, program enrollment history, demographic, income and contact information through the HMIS with other partner homeless services agencies.
3) ___ I do NOT agree to share any of my information through the HMIS with other partner homeless services agencies.

PRINTED NAMES OF ALL MINOR CHILDREN OR DEVELOPMENTALLY DISABLED HOUSEHOLD MEMBERS COVERED BY THIS AGREEMENT:

_____
_____
_____
_____
_____
_____
_____
_____

By signing this form, I agree to share the above level of information with other partner agencies via the HMIS Computer System:

_____
Print name of Guardian or Power of Attorney

_____
Signature of Client, Guardian or Power of Attorney

_____
Date

_____
Print name of Witness

_____
Signature of Witness

_____
Date

Client Score: _____

Client Code: _____

Points North Housing Coalition
Jefferson, Lewis, St. Lawrence Counties NY

HOUSING/HOMELESS ASSESSMENT TOOL

Opening Script

HAVE YOU COMPLETED THIS SURVEY WITH ANOTHER AGENCY? IF YES WHICH AGENCY? _____

- The name of the assessor and their organization
- The purpose of this form being completed
- That it usually takes less than 10 minutes to complete
- That only YES, NO or one word answers are being sought
- That any question can be skipped or refused
- Inform the participant where the information is being stored
- That if the participant does not understand a question or the assessor does not understand the question that clarification can be provided
- The importance of relaying accurate information to the assessor and not feeling that there is a not a right or wrong answer that they need to provide, nor information they need to conceal

RESIDENCE INFORMATION

I understand that the information on this form may be shared with other agencies participating in the continuum of care.

_____ _____

Signature of Head of Household Date

1. Name: _____ Date: _____
2. Phone Number: (___) ___ - _____ Alt. Phone: (___) ___ - _____
3. Number of people in the household: _____
4. Ages and Gender of those seeking housing:

DOB	SEX	DOB	SEX
_____	(self)	_____	
_____		_____	

IF THE PERSON IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1. **Score:** _____

IF A FAMILY WITH DEPENDENT CHILDREN, THEN SCORE 5 **Score:** _____

IF THE PERSON IS 24 OR UNDER, THEN SCORE 2. **Score:** _____

5. When did you become homeless: _____
6. How many separate times in the past 3 years have you been without a regular place to stay (including right now)?

   ____1 time ____2-3 times ____4 or more times

IF THE PERSON HAS EXPERIENCED 2-3 EPISODES OF HOMELESSNESS, THEN SCORE 2. **Score**_____

IF THE PERSON HAS EXPERIENCED 4 + EPISODES OF HOMELESSNESS, THEN SCORE 3. **Score**_____

7. Has it been more than a year since you had a regular place to stay? _____

IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESSSTHEN SCORE 3. Score: _____

8. Where did you stay last night and what is the address: _____

_____

IF they said (car or other vehicle, street or woods, camper or tent), THEN SCORE 2 **Score _____**

9. What was your last permanent address and how long did you live there: _____

_____

10. Why are you no longer living at your last permanent address; what changed in the household to create this emergency: nonpayment of rent, destruction of property, other_____

_____

11. Do you have any friends or family that you can stay with for at least the next 14 days, or longer? ☐ Yes ☐ No

IF "NO" THEN SCORE 1 **Score_____**

12. Do you have any physical or mental limitations that would prevent you from obtaining housing? (circle all that apply)

Physical/Medical Developmental Disability Mental Health Drug or Alcohol Addiction

HIV/AIDS Other:_____

Score one point for each disability. **Score _____**

13. Is anyone in your household a veteran: ☐ Yes ☐ No

IF "YES" THEN SCORE 53 **Score _____**

14. Do you have any legal issues that will make it more difficult to rent a place to live? (Circle all that apply)

Registered Sex Offender Released from Jail/Prison On probation/Parole

Pending charges/ Fines

SCORE 1 point for each legal issue **Score _____**

15. Are you being sanctioned through a public assistance program: ☐ Yes ☐ No

IF "YES" , THEN SCORE 3 **Score _____**

16. Are you or anyone in your household currently employed: ☐ Yes ☐ No If so, who in the house is employed and what is the name, address, and phone number of the employer: _____

_____

IF "NO" THEN SCORE 1 **Score _____**

17. Do you have any other available income or resources at this time? These include, but are not limited to; Child Support Payments, Unemployment Insurance Benefits, Disability Benefits, Social Security Benefits, SSI Payments or Advance on Wages:

☐ Yes ☐ No If yes, indicate what type of income it is, the date it was last received on and the amount it was for:

_____

IF "NO" THEN SCORE 1 **Score _____**

18. Do you have your own transportation? ☐ Yes ☐ No

IF "NO" THEN SCORE 1 **Score _____**

19. Are you fleeing Domestic Violence? ☐ Yes ☐ No

IF "YES" THEN SCORE 3

Score _____

I understand by signing below I agree to any investigation made to verify or confirm the information I have given or any other investigation made by them in connection with my request for Services. I further understand if additional information is requested, I will provide it. I swear and affirm under the penalties of perjury that the information I have given or will give is correct.

Signature _____ Date _____

LEVEL 1: No/Few Barriers

- Score 0-3
- Complete Housing Application
- Refer to Diversion/Prevention Programs/ Rapid Re-housing: help with deposits, rent and other move-in costs; provide short-term assistance.
- Referral for Utility assistance such as HEAP and TANF, SNAP (Food Stamps)

Level 2: Moderate Barriers

- Score 4-7
- Complete Housing Application
- Refer to Diversion/Prevention Programs/ Rapid Re-housing: help with deposits, rent and other move-in costs; provide medium- term assistance.
- Referral for Utility assistance such as HEAP and TANF, SNAP (Food Stamps)
- Provide case management, living skills and community resource referral
- Case management contact at least once/month for 1 year

Level 3: Significant Barriers

- Score 8+
- Complete Housing Application
- Ensure that applicant will be provided one-one assistance with applications, referrals assistance to resource sites as needed.
- Referral to substance abuse recovery programs as needed.
- Referral to Shelter Plus Care rental programs.
- Refer to Diversion/Prevention Programs/ Rapid Re-housing: help with deposits, rent and other move-in costs; provide medium- term assistance.
- Referral for Utility assistance such as HEAP and TANF, SNAP (Food Stamps)
- Provide case management, living skills and community resource referral
- Case management contact at least once/month for 18-24 months or longer as needed.