Erin Kimball Memorial Foundation

H.O.M.E! Transitional Housing Program Application

Instructions

Thank you for your application to the Erin Kimball Memorial foundation H.O.M.E.! Transitional Housing Program. Please submit the following documentation with your completed application, and signed policy and procedures. If you prequalify, you will be scheduled for an interview. Please contact us if you need to reschedule your interview or will be late. **We will not reschedule your interview if you do not contact us.**

1. **This is an independence and empowerment program that requires your time and commitment.**
2. **All applicants will be screened through a background criminal history check.**
3. **After you have been placed on our waiting list, you may be required to submit a drug test.**

Please Submit the Following Documentation with Completed Application:

- ☐ Letter from referring agency (if applicable)
- ☐ Social Security cards for applicant and children
- ☐ Picture IDs for everyone in the household over 18
- ☐ Proof of legal custody (if determination made)
- ☐ Divorce decree (if applicable)
- ☐ Documentation of domestic violence: (police report, protective order, witness statements, or written report)
- ☐ Department of Workforce Services Application for Food Stamps, Financial Assistance, Child Care, and Medical Assistance.
- ☐ Most current pay statement, or letter from employer indicating start date, hours worked per week, rate of pay, and supervisor's name and phone number).
- ☐ Printout of other income (ORS, TANF, SSI, etc.)
- ☐ Signed Policy and Procedures

Date and Time of Interview: ______________________

PLEASE DO NOT SUBMIT THIS PAGE WITH YOUR APPLICATION. Retain for your own records.

Explanation of the H.O.M.E! Transitional Housing Program

The Erin Kimball Memorial Foundation's H.O.M.E.! Housing Program is a one to two year program (length of stay is determined on an individual basis) that is designed to help homeless families achieve self-sufficiency and break the cycle of domestic violence. Rent is collected each month to provide a two or three bedroom apartment, laundry facilities, family advocate services, and group meetings. Residents set self-sufficiency goals with a family advocate and work toward the achievement of those goals by participating fully in the program.

Criteria for Acceptance and Participation:

1. Applicant must be fleeing a situation of domestic violence or abuse and be homeless. Priority will be given to individuals and families currently residing in an emergency shelter. Applicant may also be referred from other community agencies, service providers, clergy, or others.

2. If under the age of 18, applicant must be emancipated.

3. Applicant must be able to function within a community setting, caring for self and children without requiring assistance with activities of daily living or mental health services other than those provided through referral by the Erin Kimball Memorial Foundation's Housings Program family advocate. Applicants must also be able to monitor their own and their children's medication(s).

4. Applicant must have the ability and desire to become self-sufficient and end the cycle of domestic violence.

5. Applicants must be willing to take the necessary steps to provide for the safety of self, their children, and the H.O.M.E.! housing community. Those steps **may** include the acquisition and enforcement of a protective order.

6. Applicant must demonstrate ability to pay rent and an initial deposit.

7. Applicant must be currently involved or demonstrate capability of involvement in employment, employment training, school, volunteer work, or in-agency work incentives programs. Funding by general assistance, emergency work program, or disability is acceptable as long as the resident is actively involved in a training program, school, or job search.

8. Applicant must be willing to actively participate in the H.O.M.E.! program. Specifically, applicant must work on an individualized Self Sufficiency plan with the Family Advocate; and attend parenting, community, and educational meetings. Applicant's children will be required to meet with the Children's Advocate one-on-one, in sibling and youth groups, at the discretion of the Children's Advocate.

   Furthermore, applicant will be willing to participate in Interdisciplinary Team meetings set up with all of the necessary agencies involved with becoming self sufficient. These agencies may include: Workforce Services, Clergy, Case Managers, Counselors, Therapists, etc…

9. Applicant must be free from drug or alcohol dependence for six months prior to admission to program. If applicant has a history of alcohol or drug dependence, or there is suspicion of current use, random urine tests may be administered. Residents will be responsible for the cost of any tests administered. If analysis comes back positive, applicant will be asked to leave. **Applicant must remain drug free and sober while in the program, or they will be asked to leave.**

10. Applicant must agree to comply with Erin Kimball Memorial Foundation's Housing Program Agreement.

11. Applicant must demonstrate the ability to live with a diverse population and respect others.

12. Applicant must complete a program application, supplying all information requested, and complete an interview with the Erin Kimball Memorial Foundation's Housing Program staff.

13. The first 90 days of program participation is a probationary period. Appropriateness for the program will be evaluated during that period. It if is determined that an individual or family is not appropriate for the program, or that the program cannot meet the participants' needs, the participant/ family will be asked to leave. If appropriate, staff will assist such with locating other housing.

    30 Days Probationary Items:

    a) Implement a Safety Plan.
    b) Children enrolled in local school.
    c) Individual Self Sufficiency plan in place (meet with Family Advocate monthly).
    d) Pay rent on time.
    e) Start LearnKey and maintain monthly requirement.
    f) Establish a documented case with Workforce Services, and provide EKMF with the documents.
    g) Attend all EKMF support/educational groups.
    h) Be in compliance with apartment lease. No violations within the first 30 days of entry to the program.

    90 Days Probationary Item:

    a) Review Self Sufficiency plan.

Agreement to Participate in Services

I, ____________________________________(please print) have applied for the H.O.M.E.! Housing Program through the Erin Kimball Memorial Foundation. If accepted into the program, I agree to abide by the conditions listed above and understand that the purpose of the program is to help me achieve greater independence.

Applicant_______________________________(signature)

Date _____________________

Updated 10/1/2009

Erin Kimball Memorial Foundation

System Input Date: ___________Input by: ______Application Activated: ☐

HAVE YOU PREVIOUSLY APPLIED TO THE ERIN KIMBALL MEMORIAL FOUNDATION? IF SO, WHEN? __________________________

Print information. Fill out form completely. (For Adults and Unaccompanied Youth)

Each person entering the program must complete his/her own form.

Application Date:	Application Number (if applicable)	Staff Accepting Application:
Referral Source (How you were referred to this agency):		Contact Person Name and Telephone Number:

Group Application

Group Application:	☐ Yes	☐ No	Are you considered head of household?		
			☐ Yes	☐ No	☐ Other

Please list the names of those members who will be living with you and receiving services:

Child #1	ss#	Date/place of birth	Age
Ethnicity	☐ Female ☐ Male	School name	School grade
Who has custody of this child?		Does this child live with you? ☐ Full time	☐ Part time ☐ Not at all
Child #2	ss#	Date/place of birth	Age
Ethnicity	☐ Female ☐ Male	School name	School grade
Who has custody of this child?		Does this child live with you? ☐ Full time	☐ Part time ☐ Not at all
Child #3	ss#	Date/place of birth	Age
Ethnicity	☐ Female ☐ Male	School name	School grade
Who has custody of this child?		Does this child live with you? ☐ Full time	☐ Part time ☐ Not at all
Child #4	ss#	Date/place of birth	Age
Ethnicity	☐ Female ☐ Male	School name	School grade
Who has custody of this child?		Does this child live with you? ☐ Full time	☐ Part time ☐ Not at all
Child #5	ss#	Date/place of birth	Age
Ethnicity	☐ Female ☐ Male	School name	School grade
Who has custody of this child?		Does this child live with you? ☐ Full time	☐ Part time ☐ Not at all

Name and Identification Information

Last Name:	First Name:	Middle Name:	Suffix (Ex: Jr.):
Street Address:	City	State	Zip
Home Phone Number	Work Phone Number	Other (Cell) Number	

Name Used to Receive Services Previously

Last Name:	First Name:	Middle Name:	Suffix (Ex: Jr.):

Birthdate:	Maiden Name (if appropriate):		
Social Security Number:	Gender:	☐ Male	☐ Female

Ethnicity and Race

Do you consider yourself Hispanic or Latino?	
☐ Yes	☐ No

Race (Check all that apply)

☐ American Indian/Alaska Native	☐ Black or African American	☐ White
☐ Asian	☐ Hawaiian or Pacific Islander	Primary Race/Ethnicity:

Veteran Information

Veteran Status ☐ Yes ☐ No	If Yes, to Veteran Status, From/To dates of Military Service:		
Branch of Military Service:	Military Discharge Status:	Duration of Active Duty (in Months)	
Served in War Zone: ☐ Yes ☐ No	War Zone of Service:	Duration of War Zone Service (in Months):	Received Hostile / Friendly Fire: ☐ Yes ☐ No

Health

Disabling Condition:	☐ Yes	☐ No	If yes, identify condition:
Talk with a staff member if you are unsure how to answer this question.			

Physical Disability:	☐ Yes	☐ No	If yes, identify physical disability:
A physical disability is a physical problem that is not temporary and limits your ability to get around or work, or limits your ability to live on your own.			

Developmental Disability:	☐ Yes	☐ No	If yes, identify developmental disability:

A developmental disability is a severe, chronic disability that is caused by a mental and/or physical impairment that occurred before age 22 that limits your ability to live on your own or to care for yourself financially.

HIV/AIDS: Have you been diagnosed with AIDS or tested positive for HIV?	☐ Yes	☐ No

Mental Illness:	☐ Yes	☐ No	Expected long term mental illness:	☐ Yes	☐ No

List any medications you are currently taking.

Medication name	Reason taken	How taken	When taken
Medication name	Reason taken	How taken	When taken
Medication name	Reason taken	How taken	When taken
Physician's name		Physician's phone	

Are you currently seeing a counselor or therapist?	☐ Yes ☐ No
Therapist/agency name	Phone number
Address	

Have you had any history of hospitalization for physical or mental illness (other than childbirth)?		☐ Yes ☐ No
Hospital Name	Entry date	Discharge Date
Diagnosis		
Hospital Name	Entry date	Discharge Date
Diagnosis		

Do any of your children have any physical, mental, or emotional issues that they are receiving treatment for?	☐ Yes ☐ No
If yes, please identify the child, issue, and treatment being received.	

Substance Abuse

Alcohol	☐ Yes	☐ No	If yes to either question, do you feel this abuse problem will last for a long time and limits your ability to live on your own?	☐ Yes ☐ No
Drug	☐ Yes	☐ No		

Domestic Violence

Have you experienced domestic or intimate partner violence?		If yes, how long ago did you have this experience?
☐ Yes	☐ No	Number of domestic violence incidents in past 12 months________.

Please explain the most recent incident(s) of domestic violence:	Date(s) of incidents:
Abuser's Name and Address	Abuser's social security number

Other Information

Special Needs:		Type of Special Needs:
☐ Yes	☐ No	

Marital Status ☐ Married	☐ Single	☐ Divorced	☐ Legally Separated

List your last two landlords Name:	Address:	Telephone	Residency Dates
Name:			

Have you ever received housing assistance? ☐ Yes ☐ No	If yes, when (dates received)?	If yes, where (city, state)?

Do you have any current utility bills or other debts? ☐ Yes ☐ No	If yes, what is the total amount due and to whom?	Are you in the process of repaying these debts?

Have you ever been arrested for any reason? ☐ Yes ☐ No	Misdemeanors	Felonies

Please list any arrests/convictions that would appear on a criminal history/background report. (You may be required to submit court papers or police reports).	
Date	Incident
Date	Incident
Date of Birth (MM/DD/YYYY):	Place of Birth:
Who cares for your children while you are at work, school, or are unable to care for them?	
Have any of your children been involved with the juvenile court?	☐ Yes ☐ No
If yes, please explain.	

General Health Status

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor	☐ Very Poor	☐ Failing

Pregnant:	☐ Yes	☐ No	If yes, Due Date:

Additional Client Information

Employment

☐ Employed:	Number of hours worked in the past week:		
Type of job:	☐ Permanent	☐ Temporary	☐ Seasonal

☐ Not Employed	Looking for work:	☐ Yes	☐ No

Describe your last two occupations, listing the most recent first.

Employer #1		Position Held
Address		Phone number
Supervisor	Start date	End date
Employer #2		Position Held
Address		Phone number
Supervisor	Start date	End date

Education and Training

Enrolled in school / Working on degree		Received vocational training or apprenticeship certificates		Highest level of school completed (ex.: 11th Grade, HS Diploma, Assoc Degree, etc.)
☐ Yes	☐ No	☐ Yes	☐ No	

What is the highest level of education received?

☐ Less than high school diploma ☐ High school diploma ☐ GED ☐ Certification (Please specify)_______________	☐ Some college courses ☐ Associates degree ☐ Undergraduate degree ☐ Some graduate work ☐ Graduate degree

Please list any reason(s) why you feel you cannot work and/or go to school.

Income/Benefits Information

☐ Receiving income or other cash benefits. Complete Income Summary information below.	☐ Receiving **no income or other cash benefits**. Proceed to Non-Cash Benefits section.

Income Summary (In the last 30 days)

Dollar amount of the total gross (pre-tax) **monthly** cash **individual** income:	If gross income is greater than zero ($0), identify the Sources and Amount of Cash Income below:

Income from Employment:	Veteran's Pension:
Unemployment Insurance (UI):	Private Pension from Employment:
Worker's Compensation:	Temporary Assistance to Needy Families:
Private Disability Insurance:	General Public Assistance:
Veteran's Disability Payments:	Alimony or Spousal Support:
Social Security Disability Insurance (SSDI):	Child Support:
Supplemental Social Security (SSI):	Other Source of Income:
Social Security Retirement Income:	

Non-Cash Benefits (During the last 30 days)

☐ Receiving non-cash benefits. Identify the benefit(s) received below.	☐ Receiving **no non-cash benefits**.

☐ Food Stamps or Benefit Card:	☐ State Children's Health Insurance Program
☐ Women, Infants, Children (WIC):	☐ TANF Child Care Services
☐ MedicAID Health Insurance	☐ TANF Transportation Services
☐ MediCARE Health Insurance:	☐ Other TANF Funded Services
☐ Veteran's Administration (VA) Medical Services	☐ Section 8 Public Housing or Rental Assistance

☐ Other Non-Cash Benefits (Identify the benefit):

Have you been terminated from cash assistance within the last year?

☐ Yes ☐ No	If yes, when?

Housing Information

Current Address:		Apt/Lot Number:	Zipcode:
City:	Length of time at address:	Home Phone Number:	

If no current address, provide the living/housing situation the night before coming to the Erin Kimball Memorial Foundation

Housing Situation (Family, Friends, Shelter, etc.)	Duration of prior living/housing situation (1 day, 1 month, 3 months, etc.):

Last Permanent Address (more than 90 days):

City	State	Zipcode:

First time homeless?	
☐ Yes	☐ No

Primary Reason for Homelessness (Loss of Job, Eviction, New to Area, etc.)

What is the number of times you have been homeless?
Number of times in the last year.
Number of times in your lifetime.

Is your experience with homelessness either of the following?
☐ 4 or more times in 3 years
☐ Continuously for 1 or more years

Certification of Information and Signature

I certify that the above information is true and correct.

Signature	Printed Name
Signature of Witness	Witness Name

EKMF CONFIDENTIALITY AGREEMENT

I, _______________________, am aware of the risk of harm and the critical need to maintain the confidentiality of other program participants who are using the services provided by the Erin Kimball Memorial Foundation Program, and I agree:

- To not reveal or discuss participants' names, their children's names, their histories or stories with anyone outside of the organization. I am aware that even without specific names, our community is small and families may be recognized by their circumstances.
- To keep apartment locations confidential from the general knowledge of the community.
- When in public, to allow participants to acknowledge me if they choose, rather than approaching them.
- To ask EKMF staff if I have any questions about the appropriate action/or interaction.

Date:______________Signature:_____________________________

Print Name:____

AUTHORIZATION FOR RELEASE OF INFORMATION CONSENT

I authorize and direct any Federal, State, or local agency organization, business, or individual to release to The H.O.M.E.! Housing Program any information or materials needed to complete and verify my application for participation, and/or to maintain my continued assistance under the Section 8, Rental Rehabilitation, Low-income Public and Indian Housing and/or other housing assistance program. I understand and agree that this authorization or the information obtained with its use may be given to and used by the Department of Housing and Urban Development (HUD) in administration and enforcing program rules and policies.

INFORMATION COVERED

I understand information regarding me or my household may be needed for verification, and inquires that may be requested include, but are not limited to:

- Identity and marital status
- Employment, income and assets
- Residences and rental activity
- Medical or child care allowances
- Credit and criminal activity
- Appropriateness for program

I understand that this authorization cannot be used to obtain any information about me that is not pertinent to my eligibility for and continued participation in a housing assistance program.

GROUPS OR INDIVIDUAL THAT MAY BE ASKED

The groups or individuals that may be asked to release the above information (depending on program requirements) include but are not limited to:

Previous Landlords	Past and Present Employers	Veterans Administration
Welfare Agencies	Retirement Systems	Schools and Colleges
Courts and Post Offices	State Unemployment Agencies	Law Enforcement Agencies
Aging Service	Credit Bureaus	Support and Alimony
Child Care Providers	Utility Companies	Credit Providers
Medical Providers	Banks	Div. of Child & Fam. Services
Emergency Shelters	Bishops or Clergy	Dept. of Workforce Services

CONDITIONS

I agree that a photocopy of this authorization may be used for the purposes stated above. If I do not sign this authorization, I also understand that my housing assistance may be denied or terminated.

____
(today's date)

__________________	__________________	____________	__________________
head of household (signature)	(print name)	(date of birth)	(social security #)
__________________	__________________	____________	__________________
adult member (signature)	(print name)	(date of birth)	(social security #)

APPLICANT RELEASE FORM

I understand that by submitting my application for assistance with the Erin Kimball Memorial Foundation H.O.M.E.! Housing Program and by signing this form, I am giving the H.O.M.E.! Program staff permission to conduct a thorough background check on me.

I understand that the background check by the H.O.M.E.! Housing Program or its agents includes checking my criminal history, if any. I further understand that the background check will include reviewing my employment, housing and shelter history. I hereby waive any rights or privileges that I may have pursuant to State or Federal Privacy Acts. Any information obtained will be used only for processing the application.
I certify that all information I have provided to the H.O.M.E.! Housing Program, including any information provided on my application or through interviews, is true and correct, and made without mental reservations of any kind. If any of the information changes, I understand that it is my responsibility to notify the Erin Kimball Memorial Foundation of those changes.

I release the H.O.M.E.! Housing Program from any and all liability to the collection, use and dissemination of any information obtained for the purposes of this background check. Furthermore, I understand that client records are treated as confidential information and cannot be released and/or discussed in the absence of a signed release form; however, in the case of a court subpoena it is a requirement by law to release the requested records and information to the party listed on the written subpoena once served.

SIGNATURES DATE
______/______/_______

_______________________ ____________________ _____________ ___________________
Applicant (signature) (print name) (date of birth) (social security #)

If Applicant is a minor, a parent or legal guardian must also sign below.

_______________________ ____________________ _____________ ___________________
Parent / guardian (signature) (print name) (date of birth) (social security #)

RELEASE OF INFORMATION

I, _________________________, give permission for Erin Kimball Memorial Foundation

staff and ____
(name of agency/agencies)

to discuss any pertinent information regarding my case with either agency (or agencies).

____________________________________ _________________________
(printed name of client) (date)

____
(client's signature)

Housing Agreement

I acknowledge that my transitional housing at Fountain Heights, Desert Rose Apartments or other apartment locations is conditional upon my adherence to my Empowerment Agreement with the Erin Kimball Memorial Foundation and my lease with said apartment complex.

Upon the condition that I choose not to live in harmony with my agreement, I will be asked to leave the program and I will forfeit my transitional housing.

Dated this __________day of _____________, 20__.

_______________________________ _______________________________

Program Participant Erin Kimball Foundation Director/Staff