232-0124

Hours: 9 to 11am and 1 to 3pm

Monday thru Wednesday

AND 9 to 11am on Thursday ONLY

Family Development Program Application Instructions

MUST BE A RESIDENT OF NATRONA COUNTY

ALL REQUIREMENTS LISTED BELOW MUST BE IN THAT ORDER

Family Development is a program that will assist applicants, who meet the criteria, in removing barriers during an emergency situation.

- Step 1 Complete the Application Packet.
- Step 2 Bring the following information with you when you drop off the application:

☐ Proof of income for the **last thirty days** (30 Days) for total household members

☐ Proof of residency in **NATRONA COUNTY** (Photo ID, Lease and/or month to month Agreement, utility bills, car registration, Letter confirming receipt of services from local social services or medical services, etc.)

☐ If disabled, provide documented **proof of disability from Social Security or medical doctor**

☐ Provide current award letter, if receiving housing assistance from Casper Housing Authority

We cannot proceed with your eligibility review until we receive all required documentation

What Happens Next?

Step 3 Your application will be assessed for income eligibility, and program qualifications. If you do not meet criteria for emergency assistance, you will receive a letter in the mail.

Step 4 If you meet all the eligibility requirements to be considered for emergency assistance, you will be seen by a Client Advocate at that time, and then they will instruct you to come to the next available Program Orientation.

Step 5 At this initial meeting, you and the Client Advocate will determine if you qualify for emergency assistance or family development services.

Step 6 If you are unemployed, you will be required to attend the Empowerment Opportunities to Success Program.

Step 7 After meeting with your Client Advocate, he or she will take your case to a weekly scheduled Staffing Meeting to discuss your case. If you are approved for emergency assistance or family development services, your Client Advocate will call you to discuss your case and available services with you.

Step 8 The Client Advocate will process a voucher to complete the payment transaction. You will receive a letter from your Client Advocate stating the payment has been completed and a copy of the payment documentation.

Emergency Assistance Application

Community Action Partnership of Natrona County

Orientation Date _______________ Application Date __________________

(For Office use Only) Appointment Date ____________________

NAME: ____SSN: ______________________

Any other last names you have gone by? ____

Physical Address: ____

City: ________________________County: ________________ State: _______ Zip __________

Mailing Address IF DIFFERENT____

City: ________________________County: ________________ State: _______ Zip __________

Home Phone (____) ____________________ Cell Phone (____) ________________

Msg. Phone (____) ____________________ Other Phone (____) ________________

What is your immediate need: ____

Referred by: ____

Household Information

Family Type:	Living Situation	
2 Parent Family	Homeless	# of People in Household _________
Female Single Parent	Other	
Male Single Parent	Own Home	# of People under 18 _____________
Other	Rent	
Single Person	Share	
Two Adults (0 Children)	Shelter	

HOUSEHOLD INFORMATION

All questions need to be answered for each household member

Person completing the application:

Name ______________________________________ SSN ________________________

Birth Date ______________________ Age _____ Relationship to Applicant SELF

Gender: ☐M ☐F ☐Transgender-Male to Female ☐Transgender-Female to Male
☐Gender Non-Conforming (not exclusively male or female) ☐Refused

Race: ☐Asian ☐Black ☐Native American ☐White ☐Other
Ethnicity: ☐Non-Hispanic/Latino ☐Hispanic/Latino

Marital Status: ☐Married ☐Divorced ☐Separated ☐Single ☐Widowed ☐Domestic Relationship

Highest Grade Completed: ☐0-8 ☐9-12 (non Grad) ☐High School Grad ☐G.E.D ☐College/Tech

Do you have a Disabling Condition? : ☐ Yes ☐ No Veteran: ☐ Yes ☐ No

Health Issues: ☐Yes ☐No If Yes, explain: ____

Health Insurance? ☐Medicaid ☐Medicare ☐State Health/Children ☐State Health Adults
☐Military Health Care ☐ Direct Purchase ☐ Employment Based ☐ None

Employed: ☐Yes ☐ No *If Yes are you*: ☐Full Time ☐ Part Time ☐Self Employed
☐ Not Working **How long Unemployed:**_______________________________________

Person 2
Name ____ SSN ________________________

Birth Date ______________________ Age ____ Relationship to Applicant ____________________

Gender: ☐M ☐F ☐Transgender- Male to Female ☐Transgender-Female to Male
☐ Gender Non-Conforming (not exclusively male or female) ☐ Refused

Race: ☐Asian ☐ Black ☐ Native American ☐ White ☐Other
Ethnicity: ☐Non-Hispanic/Latino ☐Hispanic/Latino

Marital Status: ☐ Married ☐Divorced ☐Separated ☐ Single ☐ Widowed ☐ Domestic Relationship

Highest Grade Completed: ☐0-8 ☐9-12 (non Grad) ☐ High School Grad ☐ G.E.D. ☐ College/Tech

Do you have a Disabling Condition?: ☐Yes ☐No Veteran: ☐Yes ☐No

Health Issues: Yes No If Yes, explain:_______________________________________

Health Insurance? ☐Medicaid ☐Medicare ☐State Health/Children ☐State Health Adults
☐Military Health Care ☐Direct Purchase ☐ Employment Based ☐ None

Employed: ☐Yes☐ No If Yes are you: ☐ Full Time ☐Part Time ☐ Self Employed ☐Not Working
How long unemployed: _______________________________________

Person 3
Name ____ SSN _________________________

Birth Date _______________________ Age ____ Relationship to Applicant _____________________

Gender: ☐M ☐F ☐Transgender- Male to Female ☐Transgender-Female to Male
☐ Gender Non-Conforming (not exclusively male or female) ☐ Refused

Race: ☐Asian ☐ Black ☐ Native American ☐White ☐ Other
Ethnicity: ☐Non-Hispanic/Latino ☐Hispanic/Latino

Marital Status: ☐ Married ☐ Divorced ☐Separated ☐ Single ☐ Widowed ☐ Domestic Relationship

Highest Grade Completed: ☐0-8 ☐9-12 (non Grad) ☐ High School Grad ☐ G.E.D. ☐ College/Tech

Do you have a Disabling Condition?: ☐**Yes** ☐**No** **Veteran:** ☐**Yes** ☐**No**

Health Issues: Yes No If Yes, explain:____

Health Insurance? ☐Medicaid ☐Medicare ☐State Health/Children ☐State Health Adults
☐Military Health Care ☐Direct Purchase ☐ Employment Based ☐ None

Employed: ☐Yes ☐No If Yes are you: ☐Full Time ☐Part Time ☐ Self Employed ☐Not Working

How long unemployed:____

Person 4
Name ____ SSN _________________________

Birth Date _______________________ Age ____ Relationship to Applicant _____________________

Gender: ☐M ☐F ☐Transgender- Male to Female ☐Transgender-Female to Male
☐ Gender Non-Conforming (not exclusively male or female) ☐ Refused

Race: ☐Asian ☐ Black ☐ Native American ☐ White ☐ Other
Ethnicity: ☐Non-Hispanic/Latino ☐Hispanic/Latino

Marital Status: ☐ Married ☐ Divorced ☐Separated ☐ Single ☐ Widowed ☐ Domestic Relationship

Highest Grade Completed: ☐0-8 ☐9-12 (non Grad) ☐ High School Grad ☐ G.E.D. ☐ College/Tech

Do you have a Disabling Condition?: ☐**Yes** ☐**No** **Veteran:** ☐**Yes** ☐**No**

Health Issues: Yes No If Yes, explain:____

Health Insurance? ☐Medicaid ☐Medicare ☐State Health/Children ☐State Health Adults
☐Military Health Care ☐Direct Purchase ☐ Employment Based ☐ None

Employed: ☐Yes ☐ No If Yes are you: ☐ Full Time ☐Part Time ☐ Self Employed ☐Not Working

How long unemployed:____

Person 5
Name ____ SSN _________________________

Birth Date _______________________ Age ____ Relationship to Applicant _____________________

Gender: ☐M ☐F ☐Transgender- Male to Female ☐Transgender-Female to Male
☐ Gender Non-Conforming (not exclusively male or female) ☐ Refused

Race: ☐Asian ☐ Black ☐ Native American ☐ White ☐ Other
Ethnicity: ☐Non-Hispanic/Latino ☐Hispanic/Latino

Marital Status: ☐ Married ☐ Divorced ☐Separated ☐ Single ☐ Widowed ☐ Domestic Relationship

Highest Grade Completed: ☐0-8 ☐9-12 (non Grad) ☐ High School Grad ☐ G.E.D. ☐ College/Tech

Do you have a Disabling Condition?: ☐**Yes** ☐**No** **Veteran:** ☐**Yes** ☐**No**

Health Issues: Yes No If Yes, explain:____

Health Insurance? ☐Medicaid ☐Medicare ☐State Health/Children ☐State Health Adults
☐Military Health Care ☐Direct Purchase ☐ Employment Based ☐ None

Employed: ☐Yes☐ No If Yes are you: ☐ Full Time ☐Part Time ☐ Self Employed ☐Not Working

How long unemployed: ____

Person 6
Name ____ SSN _________________________

Birth Date _______________________ Age ____ Relationship to Applicant _____________________

Gender: ☐M ☐F ☐Transgender- Male to Female ☐Transgender-Female to Male
☐ Gender Non-Conforming (not exclusively male or female) ☐ Refused

Race: ☐Asian ☐ Black ☐ Native American ☐White ☐ Other
Ethnicity: ☐Non-Hispanic/Latino ☐Hispanic/Latino

Marital Status: ☐ Married ☐ Divorced ☐Separated ☐ Single ☐ Widowed ☐ Domestic Relationship

Highest Grade Completed: ☐0-8 ☐9-12 (non Grad) ☐ High School Grad ☐ G.E.D. ☐ College/Tech

Do you have a Disabling Condition?: ☐**Yes** ☐**No** **Veteran:** ☐**Yes** ☐**No**

Health Issues: Yes No If Yes, explain:____

Health Insurance? ☐Medicaid ☐Medicare ☐State Health/Children ☐State Health Adults
☐Military Health Care ☐Direct Purchase ☐ Employment Based ☐ None

Employed: ☐Yes☐ No If Yes are you: ☐ Full Time ☐Part Time ☐ Self Employed ☐Not Working

How long unemployed: ____

Person 7
Name ____ SSN ________________________

Birth Date ______________________ Age ____ Relationship to Applicant ____________________

Gender: ☐M ☐F ☐Transgender- Male to Female ☐Transgender-Female to Male
☐ Gender Non-Conforming (not exclusively male or female) ☐ Refused

Race: ☐Asian ☐ Black ☐ Native American ☐White ☐ Other
Ethnicity: ☐Non-Hispanic/Latino ☐Hispanic/Latino

Marital Status: ☐ Married ☐ Divorced ☐Separated ☐ Single ☐ Widowed ☐ Domestic Relationship

Highest Grade Completed: ☐0-8 ☐9-12 (non Grad) ☐ High School Grad ☐ G.E.D. ☐ College/Tech

Do you have a Disabling Condition?: ☐**Yes** ☐**No** **Veteran:** ☐**Yes** ☐**No**

Health Issues: Yes No If Yes, explain:_______________________________________

Health Insurance? ☐Medicaid ☐Medicare ☐State Health/Children ☐State Health Adults
☐Military Health Care ☐Direct Purchase ☐ Employment Based ☐ None

Employed: ☐Yes ☐ No If Yes are you: ☐ Full Time ☐Part Time ☐ Self Employed ☐Not Working

How long unemployed:____

Person 8
Name ____ SSN ________________________

Birth Date ______________________ Age ____ Relationship to Applicant ____________________

Gender: ☐M ☐F ☐Transgender- Male to Female ☐Transgender-Female to Male
☐ Gender Non-Conforming (not exclusively male or female) ☐ Refused

Race: ☐Asian ☐ Black ☐Native American ☐ White ☐Other
Ethnicity: ☐Non-Hispanic/Latino ☐Hispanic/Latino

Marital Status: ☐ Married ☐ Divorced ☐Separated ☐ Single ☐ Widowed ☐ Domestic Relationship

Highest Grade Completed: ☐0-8 ☐9-12 (non Grad) ☐ High School Grad ☐ G.E.D. ☐ College/Tech

Do you have a Disabling Condition?: ☐**Yes** ☐**No** **Veteran:** ☐**Yes** ☐**No**

Health Issues: Yes No If Yes, explain:_______________________________________

Health Insurance? ☐Medicaid ☐Medicare ☐State Health/Children ☐State Health Adults
☐Military Health Care ☐Direct Purchase ☐ Employment Based None

Employed: ☐Yes ☐ No If Yes are you: ☐ Full Time ☐Part Time ☐ Self Employed ☐Not Working

How long unemployed:_______________________________________

Income Questions

In the Last thirty (30) days have you or anyone in the household received:

You must check yes or no for each question

Wages in the Household from Employment?	☐ Yes	☐ No
Unemployment insurance?	☐ Yes	☐ No
Worker's Compensation?	☐ Yes	☐ No
Social Security?	☐ Yes	☐ No
SSDI?	☐ Yes	☐ No
SSI?	☐ Yes	☐ No
P.O.W.E.R.?	☐ Yes	☐ No
Child Support?	☐ Yes	☐ No

201 N. David, 5th floor (Hall of Justice), Casper, WY

307-235-9229 or 800-292-3219

Alimony or Spousal Support?	☐ Yes	☐ No
Per Cap Payments from a Tribe?	☐ Yes	☐ No
Student Loans?	☐ Yes	☐ No
Pensions?	☐ Yes	☐ No
Rail Road Retirement?	☐ Yes	☐ No
Other? Please Explain__________________	☐ Yes	☐ No
Other? Please Explain__________________	☐ Yes	☐ No

THIS PAGE TO BE COMPLETED BY CAPNC STAFF ONLY

<u>This Section to be completed by the Intake Worker</u>

Monthly Total $ ____________
Annual $ ____________

Percent of Poverty Guidelines: ______________%

Poverty Level for this family: $______________

Meets the CSBG Income Guidelines Yes ______ No _______

Meets the TANF Income Guidelines Yes ______ No________

Registered with the TANF Program if eligible Yes ______ No________

Disconnected – Not Working and Not in School (for 14-24 age group) Yes______ No_______

Memo: ____
____
____
____

Please continue on the next page!

FAMILY INCOME

Please list monthly Income for each family member.

Source of Income	Current Month	Last Month	Prior Month
Wages earned by: Employer:	$	$	$
Wages earned by: Employer:	$	$	$
Wages earned by: Employer:	$	$	$
Wages earned by: Employer:	$	$	$
Power	$	$	$
SSDI Name:	$	$	$
SSDI Name:	$	$	$
SSDI Name:	$	$	$
SSI Name:	$	$	$
SSI Name:	$	$	$
SSI Name:	$	$	$
Social Security Name:	$	$	$
Social Security Name:	$	$	$
Social Security Name:	$	$	$
Child Support	$	$	$
Alimony	$	$	$
Unemployment Compensation	$	$	$
Worker's Compensation	$	$	$
Per Cap Payments for Tribe	$	$	$
Student Loans	$	$	$
Pensions	$	$	$
Other:	$	$	$
Other:	$	$	$
Total			

Assistance you or your household is receiving

Assistance Source	Yes / No/ Applied	Amount	Household Member
SNAP (Food Stamps)	Yes or No or Applied		
Child Support	Yes or No or Applied		
Subsidized Housing	Yes or No or Applied		
School Lunches	Yes or No or Applied		
Veterans Administration	Yes or No or Applied		
Welfare to Work	Yes or No or Applied		
Equality Care (Medicaid and Kid Care)	Yes or No or Applied		
Private Insurance	Yes or No or Applied		
WIC	Yes or No or Applied		
TANF/POWER	Yes or No or Applied		
Ex TANF/POWER	Yes or No or Applied		
LIHEAP	Yes or No or Applied		
Weatherization	Yes or No or Applied		
Transitional House Waiting List	Yes or No or Applied		

Household Monthly Bills

Rent		Renter's Insurance		Personal Property Tax	
Mortgage		Health Insurance		Personal Toiletries	
Lot Rent		Medical/Dental Payments		Household Cleaning Supplies	
Lot Payment		Child Care		Church	
Electricity		Food		Charity	
Gas/Heating		School Lunches		Newspaper	
Water/Sewage		Eating Out		Magazine	
Telephone		Regular Savings		Club Dues	
Cell Phone		Emergency Savings		Union Dues	
Cable TV		Life Insurance		Tuition	
Car Payment		Clothing		Books	
Gasoline/Oil		Laundry		Vacation	
Auto Maintenance		Dry Cleaning		Entertainment	
Bus Fare		Loans		Hobbies/Crafts	
Car Insurance		Credit Cards		Alcohol	
Home Owner's Insurance		Other:		Tobacco	
Other:		Other:		Other:	
Other:		Other:		Other:	
Other:		Other:		Other:	
Other:		Other:		Other:	

This is an honest estimate by you, and if there is something you do not have or pay for then zero is an acceptable answer.

Do you rent? ☐ **Yes** ☐ **No**

Landlord's Name: ____

Landlord's Address: ____

Landlord's Telephone #: ____

Do you have a formal lease or do you rent month-to-month? ____________________

Are you behind on your rent? ☐ **Yes** ☐ **No**

How much are you behind? _______________________________________

Do you own your home? ☐ **Yes** ☐ **No**

Mortgage Lender's Name: ____

Mortgage Lender's Address: ______________________________________

____

Mortgage Lender's Telephone #: ___________________________________

Account #: ____________________________________

Are you behind on your mortgage? ☐ **Yes** ☐ **No**

How much are you behind? _______________________________________

If approved for assistance this month, how will you make ends meet next month?

____

____

____

____

I certify that the information contained on the Community Action Partnership of Natrona County application is complete and accurate to the best of my knowledge and that I have been notified of my appeal rights.

I understand that I am signing this application under penalty of criminal prosecution if I knowingly give false information, which results in assistance for which I am not eligible.

Authorization to furnish and obtain information:
I hereby authorize, consent to, and instruct the appropriate agents and employees of the Community Action Partnership of Natrona County to obtain and/or exchange any and all information in y file to any other entity or individual in determining whether I am eligible for assistance or continued assistance.

Any information requested or released under this waiver shall be used solely by Community Action Partnership of Natrona County for the purpose of determining appropriate and effective case management.

Also, Community Action Partnership of Natrona County may forward, upon request, any information to the above agencies for the sole purpose of determining appropriate and effective case management.

______________________________________ ____________________
Applicant Signature Date

The Above Verified by:

______________________________________ ____________________
Intake Worker Date

Authorization for Release of Confidential Information

Name: ____________________________DOB:__________________

I, AUTHORIZE, Community Action Partnership of Natrona County and its Representatives, to Release to and/or Obtain from:

______ Landlord: ____
______ Black Hills Energy
______ Rocky Mountain Power
______ City of Casper
______ DFS: ____
______ Employer: ____
______ Other: ____

(Name of person, title, agency, address, and telephone number to whom the information is to be released and/or obtained).

The following information:

______ Status of Application Process/Classes
______ Other: ____
____

(Extent and nature of information to be released and/or obtained)

For the following purpose(s):
______ Receipt of Financial Assistance
______ Other: ____
____

Without expressed revocation, this consent expires on: _______________

I also understand that I may revoke this authorization (in writing) at any time unless action has already been taken based upon this authorization but, in any event, this consent expires after the date cited above or One (1) year from the date signed, whichever comes first.

I understand that only with my written consent, the agency will be able to release or obtain specific information concerning my records.

In signing this authorization, the undersigned acknowledges that the records disclosed here and under might be subject to re-disclosure by/to persons not covered by HIPAA.

___________ ____________________________

Date Signature of Client

_______________________ ____________________________

Signature of Witness Signature of Parent or Legal Guardian

Community Action Partnership of Natrona County
Family Development and Self-Sufficiency Program

Pre-Assessment Tool to Determine Need for Case Management

Income

Do you have income from a job?	☐ yes	☐ no
Do you have income from a disability, retirement or per cap (tribal)	☐ yes	☐ no

Employment

Do you have a job?	☐ yes	☐ no
If you have a job, is it a part-time job?	☐ yes	☐ no

Housing

Are you homeless or in a shelter?	☐ yes	☐ no
Are you doubled up with another household?	☐ yes	☐ no
Is your housing unaffordable or unsafe?	☐ yes	☐ no

Food

Are you able to afford well-balanced nutritional meals?	☐ yes	☐ no
Do you rely on food programs or food pantries for basic nutritional needs?	☐ yes	☐ no

Education

Are you able to read or write?	☐ yes	☐ no
Do you have a high school diploma or GED?	☐ yes	☐ no

Transportation

Can public transportation take you where you want to go?	☐ yes	☐ no
Is your care reliable and can it take you where you want to go?	☐ yes	☐ no

Childcare

Do you need childcare but cannot afford it?	☐ yes	☐ no
Do you need childcare but none is available in your area?	☐ yes	☐ no

Health Care Coverage

Do you have health insurance?	☐ yes	☐ no
Do you have reliable and affordable health care?	☐ yes	☐ no

Community Action Partnership of Natrona County

Grievance Policy

This grievance policy applies to clients or applicants for services provided at Community Action Partnership of Natrona County. Any client with a complaint about being denied services or the way their case is handled is encouraged to discuss the matter with the supervisor or team. Case Managers/Outreach Workers will provide the client with a copy of the Community Action Partnership of Natrona County Grievance Policy.

Participant or applicant may submit, in writing, his or her complaint to the Supervisor or Team Leader. If the Supervisor or Team Leader does not resolve the complaint, the participant may ask for a review by the Community Action Partnership of Natrona County Executive Director. The process to have a complaint reviewed by the Director is as follows:

1. The complaint must be filed, in writing, within fifteen (15) days of the decision or action being reviewed. The Community Action Partnership of Natrona County will locate an impartial person to assist any client who needs help to put their complaint in writing.

2. The Director will review the case and issue a written determination within five (5) working days of receipt of the complaint.

Any client may appeal the Director's determination to a committee of the Community Action Partnership of Natrona County board. The appeal process is as follows:

1. The client must request the appeal within ten (10) days of the date of the Director's determination.

2. The committee will set a date for the meeting between the client/applicant and the CAPNC Committee, which will be within ten (10) working days of the date of receipt of the request.

3. The committee will issue a written determination within five (5) working days following the hearing.

The Community Action Partnership of Natrona County will respond to all complaints and appeals as expediently as possible and always within the time frame described in this policy.

Copies of the grievance procedure are available upon request.

____________________________________ ________________________

Signature of Client Date

Policy Approved 01/22/02

Certification of Zero Income

Name: ______________________________________ SSN: ______________________

Address: ____________________________________

____

I hereby certify that I **do not** individually, nor do any of my family members, living in my household, receive income from the following sources:

A. Wages from employment
B. Unemployment Compensation
C. Worker's Compensation
D. Non-farm self-employment
E. Unincorporated business, personal enterprise, or partnership
F. Farm self-employment
G. Social Security Payments
H. Retirement
I. Supplemental Security Income (SSI) or Supplemental Security Disability Income (SSDI)
J. Government Employee Pensions (Includes Military Retirement pay)
K. Veteran's Benefits
L. Military Family Allotments
M. Training Stipends
N. Alimony
O. Child Support
P. Emergency Assistance Relief Payments
Q. Public Assistance or TANF (Temporary Assistance for Needy Families)
R. Other Support from Absent Family Members
S. Private Pensions
T. Regular Insurance or Annuity Payments
U. Dividends, Interest, Net Rental Income
V. Net Royalties
W. Periodic receipts from estates or trusts
X. Net Gambling or Lottery winnings
Y. Strike Benefits from Union Funds

I will be using the following sources of funds to pay for rent and other necessities:

____

I understand that I am signing this verification under the penalty of criminal prosecution if I knowingly give false information, which results in assistance for which I am not eligible.

____________________________	__________________________	__________________
Signature of Applicant	Signature of Case Manager	Date

Wyoming Homeless Collaborative (WHC)

WHC COORDINATED ENTRY RELEASE OF INFORMATION. COMPLETE FOR ALL ADULT(S) AND FAMILY MEMBERS PARTICIPATING IN HMIS AND/OR COORDINATED ENTRY AND RETAIN FOR PROVIDER RECORDS

What is WHC Coordinated Entry? How will my information be used? WHC Coordinated Entry is a collaboration through which participating agencies collectively measure and plan for the needs of individuals and families experiencing homelessness in Wyoming. With your permission, you will be assessed by a staff person or volunteer for an agency that participates in WHC Coordinated Entry. The results of your assessment will be entered into a database called the Homeless Management Information System (HMIS). You have the right to decline to participate. If you opt to participate, your assessment results will be provided to the Coordinated Entry Team—a multidisciplinary team that facilitates referrals to several housing projects. If a project opening is identified for which you are potentially eligible to be prioritized, attempts will be made to reach you at the contact information you provide so that you can undergo project-level assessment.

Homeless Prevention Services: Assessment for homeless prevention services may or may not be assessed through the coordinated entry process.

What agencies currently participate in some aspect of WHC Coordinated Entry? Campbell County YES Transition in Place (TLP) COMEA Shelter Community Action of Laramie County Community Action Partnership of Natrona County Council of Community Services Seton House Fremont Good Samaritan Rescue Mission Recover Wyoming Laramie Good Samaritan Sweetwater Family Resource Center Teton County Good Samaritan Rescue Mission United Way 211 Volunteers of America – Northern Rockies Veterans Administration – Cheyenne Wyoming Rescue Mission

How do I opt to release (or not release) my information for purposes of WHC Coordinated Entry? Please complete the following.

Check the box that applies: Yes, I release my information to participate in WHC Coordinated Entry as it has been described to me. No, I do not release my information to participate in WHC Coordinated Entry as it has been described to me.

Print your full name: Print your date of birth:

Print your full name: Print your date of birth:

Sign to certify the designation you have made: Print today's date:

Sign to certify the designation you have made: Print today's date:

Agency staff, complete the following.

Sign to indicate you witnessed review of this information and completion of the preceding section:

Wyoming Homeless Collaborative (WHC)

Consumers Informed Consent &   Sharing of Information Authorization

I __________________________________ and ____________________________________understand information about me and/or my dependents listed below is entered into a database system called ServicePoint. This system helps to better understand homelessness, to improve service delivery and to evaluate the effectiveness of services provided. Participation in data collection is a critical component of our community's ability to provide the most effective services and housing possible. The information that is collected is protected by limiting access to the database and limiting what information may be shared. Access to the data and sharing of the data is in compliance with the standards set by the federal, state and local regulations governing confidentially of client records. Every person and agency that is authorized to read or enter information into the system has signed an agreement to maintain the security and confidentiality of the information.
List all Dependent Children under 18 in the household, if any:

First and Last Name Date of Birth First and Last Name Date of Birth

____

By signing this form, I authorize the following: The information collected by this agency will be included in ServicePoint and only partner agencies, which have entered into an HMIS Agency Participation Agreement at which I have obtained or sought out services, may use my information to:

• Produce a client profile at intake that will be shared with collaborating agencies • Produce aggregate level reports regarding use of services • Track individual program-level outcomes • Identify unfilled service needs and plan for enhancements • Allocate resources among agencies engaged in services

By signing this form, I authorize the following: I authorize the partner agencies and their representatives to share basic information regarding my family members listed below and/or me. I understand that this information is for assessing my/our needs for housing and other services.

______I give permission for the following Personal Protected information (PPI) to be shared in HMIS for any service Project. • Name • Ethnicity and Race • Date of Birth • Client Location • Social Security Number • Veteran Status • Gender • Photo (if applicable)

Wyoming Homeless Collaborative (WHC)

Consumers Informed Consent & Sharing of Information Authorization

______I do not give permission for the following Personal Protected information (PPI) to be shared in HMIS for any service Project.

______I give permission for the following information to be shared in HMIS for any service Project.

• Homeless History • Disabling Condition • Family Composition • Housing information • Income/Non-cash • Health Insurance Status • Domestic Violence • Entry/Exit Information • Measurement Score (VI-SPDAT)

______I do not give permission for the following information to be shared in HMIS for any service Project.

I Understand That:
The partner agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the client confidentiality polices used by the HMIS partner agencies.

✓ Staff members of the partner agencies who will see my information have signed agreements to maintain confidentiality regarding my information. ✓ The release of my information does not guarantee that I will receive assistance; my refusal to authorize the use of my information does not disqualify me from receiving assistance. ✓ My records are protected by federal, state, and local regulations governing confidentially of client records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. ✓ This authorization will remain in effect until I revoke it in writing, and I may revoke authorization at any time, if I revoke my authorization, all information about me already in the database will remain. ✓ This release will remain in effect for 1 year from date this ROI is signed. ✓ Auditors or funders who have legal rights to review the work of this agency may see my information in HMIS related to the services I received and funded by their Department/s.

____ __________________________

Client Signature Date

____ ________________________

Client Signature Date

____ ________________________

Agency Staff Name (print) Date

____

Agency Staff Signature

We Do Business in Accordance With the Federal Fair Housing Law

(TheFairHousingAmendements Act of 1988)

It is illegal to Discriminate Against Any Person Because of Race, Color, Religion, Sex, Handicap, Familial Status, or National Origin

- In the sale or rental of housing or residential lots
- In advertising the sale or rental of housing
- In the financing of housing
- In the provision of real estate brokerage services
- In the appraisal of housing
- Blockbusting is also illegal

Anyone who feels he or she has been discriminated against may file a complaint of housing discrimination:
1-800-669-9777 (Toll Free)
1-800-927-9275 (TTY)
www.hud.gov/fairhousing

U.S. Department of Housing and Urban Development
Assistant Secretary for Fair Housing and Equal Opportunity
Washington, D.C. 20410

I hereby acknowledge that Community Action Partnership of Natrona County informed me of the Fair Housing Act

____ ______________

Signature of Client ***Date***