Referral Application for Pathways To Stability

"P2S"

Office: (907) 677-8490 Fax: (907) 677-8453

2515 A Street, Anchorage, Alaska, 99503

	Program Applicant	***All Household members (Use a separate sheet if more than one other household***	***Information***
Last Name:			***Case Manager***
First Name:			
Middle Name:			***CM Contact Number***
Soc. Sec. Number:			
Birth Date:			***Emergency Contact***
Mailing Address:			
			Emergency Contact #
Residence Address:			
			Family Status
Phone:			☐ **Single**
Relationship to HOH:			☐ **Married**
Ethnicity/Race:			☐ **Partner**
Gender:			☐ ***# Children***
Veteran:			**HMIS#**

A. American Indian/Alaska Native
B. Asian
C. Black/African American
D. Native Hawaiian/Pacific Islander
E. White

NHL. Non-Hispanic/ Latino
HL. Hispanic/ Latino

HOUSEHOLD COMPOSITION AND CHARACTERISTICS - **LIST THE HEAD OF HOUSEHOLD AND ALL OTHER PERSONS WHO WILL BE LIVING IN THE UNIT. INDICATE THE RELATIONSHIP OF EACH FAMILY MEMBER TO THE HEAD OF HOUSEHOLD.**					
MEMBER'S FULL NAME	**RELATIONSHIP**	**BIRTH DATE**	**AGE**	**SEX**	**SOCIAL SECURITY NO.**

Program Duration

Households served through this program are eligible for up to 5 months of total assistance. The assistance period will begin on the date the household begins to receive Rent Relief services and end September 30, 2025.

Eligibility for Program

Persons served through this program must satisfy both Housing Status and Income eligibility criteria:

1. Housing Status: Households must lack a safe place of their own to sleep at night. Please identify which of each criteria your household fits into.

   ☐Persons sleeping outside

   ☐Persons sleeping in a car

   ☐Persons sleeping in a place not fit for habitation

   ☐Persons who are living in an emergency shelter

   ☐Persons fleeing human trafficking, domestic violence, or abusive households

   ☐Persons with minor children facing long term housing instability

   ☐Persons with co-occurring mental health and substance use disorders

2. Income: Households must be at or below 80% of the Area Median Income

☐50-80% AMI = $77,840.00

☐30-49% AMI = $48,650.00

☐00-29% AMI = $29,190.00

NWAK Certifying Case Manager _____

INCOME INFORMATION

List all the income you and each person in your household receive on the following chart.

SOURCE ,	***NAME***	***NAME***	***AMOUNT PER***
Supplemental Security Income (SSI)			
Social Security Disability Income (SSDI)			
Social Security (Retirement, Death			
General Public Assistance			
Interim Public Assistance			
ATAP - Alaska Temporary Assistance			
Child Support			
Veterans Benefits			
Veterans' Health Care			
Employment Income			
Unemployment Benefits			
Alaska Permanent Fund			
Native Corporation Dividends			
Corporation Name:			
Additional Corp/Tribal:			
No Financial Resources			
Medicare			
Medicaid			
Food Stamps			
WIC			
Other (please specify)			

☐ *Guardian* ☐ *Conservator* ☐ *Payee*

*Please provide Name/ Agency/ Contact # of above:*_____

FAMILY HOUSEHOLD INFORMATION (Families with Children Only)

CHILD CARE EXPENSES

Do you receive Child Care Assistance? YES ☐ *NO* ☐

*Assistance Amount: $*_____*(hr./wk./mo./yr.)*

*Child Care Expense (Out of Pocket): Amount $*_____*(hr./wk./mo./yr.)*

Name and Address of Child Care Provider: _____

_____

Phone number of Child Care Provider: _____

CHILD IN TRANSITION

Do you have school-aged children? YES ☐ *NO* ☐

Do you receive Child In Transition Assistance? YES ☐ *NO* ☐

*Where do your children currently receive education services?*_____

CLIENT INFORMATION

Check all that applies. Information used to assist in the placement of Permanent Housing Programs:

***Disability**: What are the applicants' verified disability categories?*

a. ☐ *Mental illness*
b. ☐ *Alcohol abuse*
c. ☐ *Drug abuse*
d. ☐ *HIV/AIDS & related diseases*
e. ☐ *Developmental Disability*
f. ☐ *Physical Disability*
g. ☐ *Chronic Health Condition*

***Homeless**: What was the applicant's prior living situation the night prior to application?*

a. ☐ *Non-housing (streets, car, camp.)*
b. ☐ *Emergency shelter*
c. ☐ *Transitional housing for homeless*
d. ☐ *Psychiatric facility**
e. ☐ *Substance abuse TX facility**
f. ☐ *Hospital**
g. ☐ *Jail/prison **

**** Is exiting an institution where they have resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.***

Approximate Date Homelessness Started: _____

***Duration of Homelessness**:*

☐ *<1 day* ☐ *1-30 days* ☐ *31-180 days* ☐ *181-365 days*
☐ *366-730 days* ☐ *>730 day*

***Chronic Homelessness**: To be considered "chronically homeless," a person must have been living in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 12 months OR on at least four separate occasions in the last three years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least seven consecutive nights of not living as described above. Stays in institutional care facilities for FEWER than 90 days will not constitute a break in homelessness. Still, instead, such stays are included in the 12-month total if the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility.*

***Has the applicant been**:*

☐ *Homeless for 12 or more consecutive months*
☐ *Homeless four or more times in the past three years, totaling a combined 12 months and meets all the criteria set forth by HUD.*

***The total number of months Homeless**:*_____

Please see additional homeless verification requirements if the person is considered chronically homeless and will be applying for PSH programs as well.

***Reason for referral to the "CHANGE" Program and source of referral*:**_____

_____

_____

_____

_____

List previous residences for the past two years.

Landlord: _____

Address: _____

From: _____ *To:* _____

Landlord: _____

Address: _____

From: _____ *To:* _____

Please list any other agencies providing services to the applicant such as Assets, The ARC, ABH, Choices, PRC, etc. Please include a contact name and phone number.

_____

_____

I hereby give my permission to NeighborWorks Alaska to verify any information they may need to determine my eligibility for housing and continued occupancy in any NWAK rental assistance programs. I fully understand this waiver covers future and current verification from State and Federal Agencies. NeighborWorks Alaska is hereby given my permission to request information from all other available sources.

The above information is accurate and correct. I hereby authorize NeighborWorks Alaska to check references and verify the information contained in this application.

_____

Applicant Name

_____

Applicant Signature *Date*

_____

Co-Applicant Name

_____

Co-Applicant Signature *Date*

_____

Referring Agency Representative Name/Title

_____

Referring Agency Representative Signature *Date*

Date application submitted _____

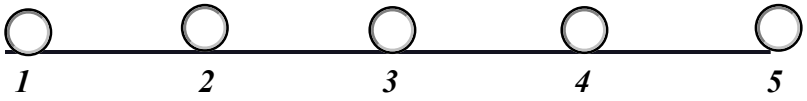
+

SUPPORTIVE HOUSING PROGRAMS -- APPLICANT PROFILE

Please provide a brief narrative describing the applicant's strengths and areas where support may be beneficial, focusing on the following topics. This information helps us better understand how to offer services and maintain stable housing. We recognize that challenges in these areas can sometimes impact housing, and our goal is to partner with tenants to promote long-term success. Please feel free to use additional pages if needed.

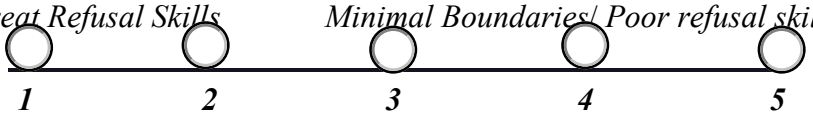
1. *Please describe the applicant's relationships to persons who may cause problems or victimize them (i.e., drug dealers, domestic violence, etc.) and evaluate the potential for victimization on a scale of 1 to 5, with 5 being the most significant risk.*

Least risk for Victimization *Greatest risk for Victimization*



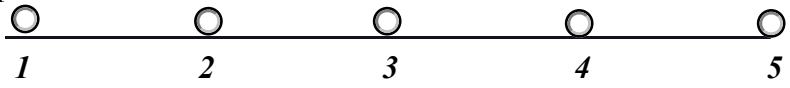
2. *Please describe the ability of the applicant to set boundaries, apply appropriate refusal skills, and set limits for themselves and others regarding allowing other people free access to their apartment. Evaluate the applicant's ability in this regard on a scale of 1 to 5, with 1 being the highest ability to set boundaries, etc.*

Excellent Boundaries/ Great Refusal Skills *Minimal Boundaries/ Poor refusal skills*



3. *Please describe the applicant's level of treatment compliance and engagement. Evaluate the applicant's ability in this regard on a scale of 1 to 5, with 1 being the highest quality of compliance and 5 being the lowest quality of compliance.*

High level of Compliance *Non-Compliant*



Please fill out the following form and describe the applicant's history regarding substance use and legal history on the back of this page, specifically if the applicant is currently using substances or on probation/parole.

Treatment History:

Mental Health	***Alcohol & Drug Treatment***	***Legal History***
___ *No Treatment History*	___ *No Treatment History*	___ *Past Probation/Parole*
___ *Outpatient Only*	___ *Outpatient Only*	___ *Present Probation/Parole*
___ *<3 Psychiatric Hospitalizations*	___ *<3 In-Patient Admits*	___ *# Jail Sentences*
___ *>3 Psychiatric Hospitalizations*	___ *>3 In-Patient Admits*	___ *Felony History*

NeighborWorks Alaska

"P2S" PROGRAM

Applicant Checklist

The following information must be provided for the application to be processed.

☐ ***Completed and signed application***

☐ ***Verification of income (within 30 days) to include Social Security/APA printout, child support statements, bank statements, paycheck stub, etc. (ALL household members)***

☐ ***All applicable ROIs***

☐ ***Copies of Identification, Social Security Cards, Birth Certificates (for children if applicable), ECT. (ALL household members)***

RELEASE OF INFORMATION (ROI)

Client Authorization for the Release/Exchange of Confidential Information

Client Name: _____

Date of Birth: _____ / _____ / _____

Phone Number: _____

PURPOSE:

I, the undersigned, authorize the release and/or exchange of confidential information for the purposes of service coordination, housing assistance, case management, care planning, benefit eligibility, program referrals, and continuity of care.

PARTIES TO WHOM INFORMATION MAY BE RELEASED OR OBTAINED:

I authorize the **release of and/or obtainment of information** between the following organizations:

- Henning Inc.
- NeighborWorks Alaska
- Anchorage Coalition to End Homelessness
- RurAL CAP
- United Way of Alaska
- New Life Development
- Covenant House Alaska
- Choosing Our Roots
- Anchorage Health Department
- Alaska Housing Finance Corporation (AHFC)

INFORMATION TO BE SHARED (check all that apply):

☐ Identification and Contact Information
☐ Housing History and Homeless Status
☐ Case Management/Supportive Services Notes
☐ Mental Health and/or Substance Use Information
☐ Financial/Income/Benefit Verification
☐ Criminal History
☐ Medical Information (if applicable and protected by HIPAA)
☐ Program Enrollment and Participation Details
☐ Other (specify): _____

RELEASE OF INFORMATION (ROI)

METHOD OF SHARING:

☐ Verbal Communication
☐ Written Reports/Documents
☐ Electronic Communication (e.g., email, secure portal)

DURATION OF AUTHORIZATION:

This authorization shall remain in effect for: ☐ 12 months from the date signed
☐ Until (specify date): ____ / ____ / _____
☐ Until services are no longer being provided by NeighborWorks Alaska
☐ Other (specify): _____

RIGHTS AND CONDITIONS:

- I understand that I have the right to revoke this authorization at any time in writing. Revocation does not apply to information already disclosed under this authorization.
- I understand that services provided by NeighborWorks Alaska or other listed organizations will not be denied if I refuse to sign this authorization, except when services require disclosure of information to determine eligibility or program coordination.
- I understand that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected under federal confidentiality laws.
- I understand that I have a right to request a copy of this signed authorization.

CLIENT CONSENT:

Client Signature: _____

Date: ____ / ____ / _____

Parent/Guardian or Legal Representative (if applicable):

Name: _____

Signature: _____

Relationship: _____

Date: ____ / ____ / _____

Witness (Print Name): _____

Signature: _____

Date: ____ / ____ / _____