City of Hinesville Homeless Prevention Program

- A full application must be completed by each adult in the household.
- Each child must be listed on a separate Other Household Members-Minors form.
- Please take your time and provide responses to each section.
- Once submitted, staff will review ensure full completion as incomplete applications cannot be processed.

Please note that our programs do not provide immediate assistance. There is a process for this program which requires time to complete. *If approved, the home must pass inspection and applicants must meet with HPP staff before funds are issued. Assistance funds are paid directly to the vendor from the City of Hinesville; no payments are made to applicants.*

Prevention provides assistance to applicants that are being evicted from their residence and/or utilities are being disconnected. Applicants must reside within the City of Hinesville limits Typical application review period is two business days after all required documentation is received.

- In addition to a complete application, the following documentation must be provided:
  - Court ordered Eviction
    Eviction Notice from the landlord is not sufficient.
    - Applicant must have been served with at least a court ordered dispossessory (Pink/Yellow document).
    - The final Writ of Possession signed by the judge must be submitted before payment can be made.
      (Applicant will receive after court appearance)
  - Utility Disconnection Notice
  - Proof of Hardship
    - Loss of employment
    - Reduction of income
    - Substantial increase in utility bill
      This list is not all inclusive and will depend on the individual household's situation
  - Birth Certificates and Social Security Cards for all household members
  - Income Documentation – Most recent 30 days
    - Most recent 60 days is required if a reduction in income is the hardship.
  - Proof of any other benefits (food stamps, child support, TANF)
  - Copy of lease (ALL PAGES)

Georgia Homeless Management Information System (GA HMIS) Collaborative Client Consent to Share Information

The Georgia Homeless Management Information System ("GA HMIS") is an online database that is used to collect information (data) about clients accessing housing and homeless services throughout the State of Georgia. Organizations that receive homeless funding from the US Department of Housing and Urban Development (HUD) and other federal and state partners are required to collect and store basic information about the persons who receive their services. This organization participates in the GA HMIS and by requesting and accepting services from them you are providing consent to enter your personal information into the GA HMIS. This information is utilized to determine your needs and provide supportive services to you and your household, and information is shared with other organizations that use this database, based on your signed consent.

What type of information may be shared in the HMIS?

We collect general and Protected Personal Information about you and record it in GA HMIS. Depending on your situation, this may include, but is not limited to:

- Your basic identifying information (including name, Social Security Number, date of birth, gender, race/ ethnicity, marital and family status, household relationships, contact information, veteran status, disability status)
- Your history of homelessness and housing (including your current housing status and where and when you have accessed services)
- Your income information (sources and amounts of household income, employment information, work skills) and other resources, such as non-cash benefits
- Your legal history/information
- Your general, self-reported medical history including any mental health and substance abuse issues (however, detailed medical or treatment information will never be shared), and type of health insurance
- Your service needs and the outcomes of services provided
- Your emergency contact information

How do you benefit from sharing your information?

The information you provide to GA HMIS helps us coordinate the most effective services for you and/or your family. By sharing your information, you may be able to avoid being screened more than once, get faster and more personalized services, and minimize how many times you have to tell your 'story.' Collecting this information also gives us a better understanding of homelessness in your local area and the effectiveness of the services provided in your area.

Who can have access to your information?

The GA HMIS participating organizations can have access to your data. These organizations may include homeless service providers, other social services organizations, housing providers, and healthcare providers. System users at participating organizations who have access to your information have signed an agreement to maintain the security and confidentiality of your information.

How is your personal information protected?

Your information in the HMIS is secured by passwords and encrypted transmission technology. In addition, each participating organization and system user must sign an agreement to maintain the security and confidentiality of the information. Your information is protected by the federal HMIS Privacy Standards. In some instances, depending on the services provided by a participating organization, your information may also be protected by additional Federal and/or State regulations, which may require additional written consent prior to any disclosure.

By signing below, you understand that:

- You have the right to receive services even if you do not sign this consent form.
- Signing this consent form does not guarantee you services.
- You have the right to receive a copy of this consent form.
- Your consent allows your record to be updated by any participating organization with which you interact without you being required to sign another consent form.
- This consent is valid for seven (7) years from the date after the Protected Personal Information was created or updated.

- You may cancel your consent at any time, but your cancellation must be done either in writing or by completing the Client Revocation of Consent to Share Information form. You further understand that any cancellation of this consent will not retroactively change information that has already been disclosed or actions already taken under your previous authorization.
- The GA HMIS Privacy Policy contains more detailed information about how your information may be used and disclosed.
- Upon your request, we will provide you with:
  - A copy of the Client Revocation of Consent to Release Information;
  - A copy of the GA HMIS Privacy Policy;
  - A copy of your full HMIS records (apart from case notes) within five (5) business days of your request;
  - A current list of participating organizations that have access to your data.
- If you find inaccurate or incomplete Protected Personal Information in your records, you have the right to request a correction.
- Aggregate or statistical data that is released from HMIS will not disclose any of your Protected Personal Information.
- You have the right to file a grievance against any organization you feel has violated your confidentiality.
- If you need to be referred to another agency for services, certain information may need to be forwarded through HMIS to facilitate a referral. If you do not provide consent to share your information, it may negatively affect participating providers from addressing your service needs in a coordinated fashion.
- You are not waiving any rights protected under Federal and/or Georgia law.

SIGNATURE AND ACKNOWLEDGEMENT

Your signature below indicates that you have read (or been read) this client consent form and have received answers to your questions. Please indicate your sharing preference by choosing one of the options below:

☐ I consent to allow my information, and that of my minor children (if applicable, as listed below), to be shared via the GA HMIS as described in this consent form.

☐ I consent to allow my information, and that of my minor children (if applicable, as listed below), to be shared via the GA HMIS; however, I wish to limit that sharing as specified in the Client Consent to Share Information – Supplement form.

☐ I do not consent to allow my information to be shared via the GA HMIS. I understand that this choice may negatively affect the quality of services the GA HMIS participating providers are able to provide.

Client/ Legal Guardian Name (Please print):________________________DOB:______________Last 4 digits of SS__________

Signature____Date ________________________

Minor Children (if any):

Client Name:__________________________DOB:_______________Last 4 digits of SS__________

Client Name:__________________________DOB:_______________Last 4 digits of SS__________

Client Name:__________________________DOB:_______________Last 4 digits of SS__________

For Agency Personnel Use Only:

____ ________________________________

Print Name of Organization **Print Name of Organization Staff**

____ ________________________________

Signature of Organization Staff **Date**

City of Hinesville Homeless Prevention Program

AN APPLICATION IS NOT AUTOMATIC APPROVAL FOR SERVICES

This application is for Rental and/or Utility Assistance

Applicant Information

Date:	**Head of Household Name:**	
Social Security Number:	**Driver's License/State:**	
Date of Birth:	**Age:**	**Primary Phone Number:**
Alternate Phone Number:	**Email Address:**	

Current Address:____

Last Address:____

How long have you lived in Hinesville: ___________________________________

Emergency Contact: Name/Address/Phone

____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Widow/Widower**

Ethnicity: ☐ **Hispanic** ☐ **Non-Hispanic**

Race: ☐ **White** ☐ **Black/African American** ☐ **American Indian or Alaskan** ☐ **Asian**

☐ **Multicultural/Mixed** ☐ **Other** ______________________

Gender: ☐ **Male** ☐ **Female** ☐ **Transgender Female to Male** ☐ **Transgender Male to Female**

☐ **Client Doesn't Identify Male, Female or Transgender**

Are you pregnant: ☐ **Yes** ☐ **No**

Veteran: ☐ **Yes** ☐ **No** **Period Served:**______________________**DD Form 214 is required**

Where did you stay last night? (Please Check One):

☐ **Own House or Rental** ☐ **Shelter** ☐ **Street/Car** ☐ **Friend/Relative** ☐ **Hotel** ☐ **Jail/Prison**

Please indicate the length of stay at above: ☐ **One Week or Less** ☐ **2-4 Weeks** ☐ **1-3 Months**

☐ **4-12 Month** ☐ **1Year or More**

Health Information

General Health Status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have a disabling condition: ☐ Yes ☐ No

Is this condition permanent: ☐ Yes ☐ No

Do you currently have Health Insurance: ☐ Yes ☐ No

If yes, please indicate what type below:

☐ Private ☐ State Children's Health Insurance ☐ Private-Employer

☐ Private- Individual ☐ Military ☐ State Funded

☐ Combined Children's Health/Medicaid ☐ Medicare ☐ Medicaid

☐ Indian Health Service (IHS)

Barriers and Special Needs

Alcohol Abuse: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

Chronic Health Condition: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

Developmental Disability: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

Drug Abuse: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

HIV/AIDS: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

Mental Health: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

Physical Disability: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

Have you been a victim of Domestic Violence: ☐ Yes ☐ No
If yes, please answer the following questions below:

1. **When did the experience occur?** ☐ Within the past three months ☐ 3-6 Months ☐ 6-12 Months ☐ More than 1 year
2. **Are you currently fleeing?** ☐ Yes ☐ No

Income and Non-Cash Benefits

Income Sources:

☐ **No Income**

☐ **Employment Income**	**$ ___________**	☐ **General Assistance**	**$ ___________**
☐ **Unemployment Insurance**	**$ ___________**	☐ **Veteran's Pension**	**$ ___________**
☐ **Retirement for Social Security**	**$ ___________**	☐ **SSI**	**$ ___________**
☐ **SSDI**	**$ ___________**	☐ **Other Pension**	**$ ___________**
☐ **Veteran's Disability Pension**	**$ ___________**	☐ **Child Support**	**$ ___________**
☐ **Alimony or Spousal Support**	**$ ___________**	☐ **TANF**	**$ ___________**
☐ **Worker's Compensation**	**$ ___________**	☐ **Other: ___________**	**$ ___________**

Non-Cash Benefits:

☐ **No Non-Cash Benefits**

☐ **SNAP (Food Stamps)**	**$ ___________**	☐ **TANF Transportation Services**
☐ **WIC**		☐ **TANF Child Care Services**

***Submission of income documentation must be provided if applicant is determined eligible for prevention services.**

APPLICANT CERTIFICATION STATEMENT

I certify the information given is true and correct, and I have the authority to provide this information. I understand that providing false or misleading information may disqualify me for services and I may be subject to criminal penalties. (Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to willfully falsify a material fact or make a false statement in any matter within the jurisdiction of a federal agency).

I further certify that I have insufficient financial resources and support networks: e.g., family, friends, faith-based or other social networks, immediately available to obtain housing or to attain housing stability without emergency assistance.

Signature: ____ Date:______________________

CONSENT TO RELEASE AND OBTAIN INFORMATION

I authorize the City of Hinesville Homeless Prevention Program to release, obtain and share information regarding me, my family, health insurance, housing status, employment status, credit status/history, education, drug testing, background (criminal and otherwise) for the purpose of coordinating and providing assistance to me and my family. I understand I have the right to see this information at any time by written request. I understand I can revoke this consent in writing at any time. I understand the information shared, released and obtained can also be used to assess and plan services, determine eligibility for housing and/or social services.

By my signature below, I affirm that I have read, understand and agree to this Consent to Release and Obtain Information for the purpose of providing services to me and my family.

I____give my full consent to release, obtain and share information about me and the persons listed below:

____
Social Security Number

____
Date of Birth

And my dependent children under the age of 18 years:

Name	Date of Birth	Social Security Number

____
Signature of Applicant

____
Date

City of Hinesville – Lawful Presence Affidavit

Pursuant to O.C.G.A 50-36-1, all persons who – either on behalf of themselves or on behalf of an individual, business, corporation, partnership, or other private entity – apply for certain public benefits must (1) be eighteen years of age of older and (2) submit an affidavit that they are lawfully present in the United States. Public benefits, as defined by O.C.G.A. 50-36-1(a)(3)(A), include any grant, contract, loan, professional license, or commercial license provided by an agency of State or local government or by appropriated funds of a State or local government.

I____, swear or affirm under penalty of perjury under the laws of the State of Georgia that I am 18 years of age or older and (check one):

☐ **I am a United States citizen, or**

☐ **I am a legal Permanent Resident of the United States or,**

☐ **I am a qualified alien (other than a permanent resident) or nonimmigrant in the United States pursuant to Federal law.**

The secure and verifiable document provided with this affidavit can best be classified as:

____

I understand that this sworn statement is required by law because I have applied for a public benefit and/or a business license on my behalf as an individual or on behalf of a business, corporation, partnership, or other private entity. I understand that state law required me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit as listed above. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Georgia under O.C.G.A 16-10-20 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

____ ____________________
Signature **Date**

____ ____________________
Title **Alien Registration #**

____ ____________________
Business Name **TIN or SSN**

If this affidavit is not presented in person, applicant must submit a notarized copy of this affidavit.

Notarized this_____Day of_______________________, in the State of______, County of____________.

______________________________ ______________________________
Notary Signature **Commission Expires**

*Note: O.C.G.A. 50-36-1(c)(2) requires that aliens under the Federal Immigration and Nationality Act, Title 8 U.S.C., as amended, provide their alien registration number. Because legal permanent residents are included in the federal definition of “alien”, legal permanent residents must also provide their alien registration number. Qualified aliens that do not have an alien registration number may supply another identifying number below:

____
Another Identifying Number

City of Hinesville Informed Consent Statement

ALL APPLICANTS MUST READ AND ACKNOWLEDGE

SERVICES, LIMITS AND FEES: The City of Hinesville Homeless Prevention Program provides services to individuals who qualify in accordance with the Housing and Urban Development definition of homelessness. These services are provided based on qualifications, funding and your agreement to fulfill Project requirements. An application does not mean approval for any service, shelter, or temporary housing. Our services are delivered in accordance with needs determined during the screening, assessment and eligibility limits. We do not charge fees for services.

RECORDS: If you receive assistance through one of our programs your application for assistance becomes a permanent record in this agency. We are required to maintain your case file, in our secured location, for a minimum of five years. You have the right to access and view your case file by making a request, in writing, to this agency; however, you do not have the right to the case file.

CONFIDENTIALITY: We respect your right to receive our services without others knowing. However, certain laws or situations could cause us to break your confidentiality, such as child abuse or neglect, threats to harm yourself or someone else, court subpoenas, accessing additional services for you or certain severe mental health issues. Additionally, it is our policy that you complete the Client Authorization Form to receive services. Your case file and personal information are stored in a locked room with limited access; your electronic information is password protected.

REFUSAL OF SERVICES: You have the right to refuse service without any penalty or loss. In addition, we reserve the right to refuse services if you are ineligible, provide false/misleading information, present a threat of bodily harm or are verbally abusive to staff.

PROJECT ENROLLMENT: This means you are qualified for services and enrolled in one of our Projects. An application submitted or on file does not mean you are enrolled in a Project. In addition, Project enrollment means you have agreed to comply with policies, procedures and requirements for participation.

COMPLIANCE: Project staff will review all rules, policies and the agency's noncompliance policy in accordance with policies and procedures. Rules: Should you be enrolled as a client in the Homeless Prevention Project, your will be provided with a list of our agency rules and Noncompliance Policy. If rules are broken or there is a pattern of noncompliance, services will be terminated.

SHARING OF INFORMATION: Sometimes we will need to contact other agencies or we may need to share information, including your records, with others. We will do this only if you sign the Consent to Obtain and Release Information Form, giving us permission.

TERMINATION: If a program participant fails to follow applicable program requirements, assistance may be terminated in accordance with a formal process that recognizes rights of the participant.

GRIEVANCES: The program participant has the right to file an appeal within five (5) business days of receiving written notice. During the appeal process, the participant is given the opportunity to present written or oral objections to the Community Development Director.

You have the right to be treated with respect by our staff and we expect the same from you in return. You are encouraged to always ask questions if something is not clear. You are also encouraged to express your thoughts and to advocate for yourself as we work with you. It is our policy to work and provide services in a culturally competent manner.

I have read and understand and give my full consent. *By signing below, you acknowledge full understanding of this information.*

____ ____

Applicant Printed Name Applicant Signature

____

Date

NARRATIVE OF HOUSING STATUS

Applicant Name: ____

Number of persons in the household: _________

- ☐ **Household without dependent children**
- ☐ **Household with dependent children**

I certify that I am in imminent danger of losing my housing due to the hardship described below. I understand that I may be liable for fraud and misappropriation of federal funding, for making false or misleading statements. (Prevention Assistance)

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____ _______________________
Applicant Signature **Date**

City of Hinesville Homeless Prevention Program

Verification of Receipt of Required Documents

Name: ______________________________________ **SSN** ________________________________
Applicant's Name (print) (last four digits)

It is required that the client be provided with the information listed below. The client's signature on this document when maintained in the client file will serve as proof of delivery to the client. Check all applicable actions below. The client must initial after each checked box.

- ☐ _____ Notification of Rights to Fair Housing Information provided and reviewed
- ☐ _____ Confidentiality Agreement provided and reviewed
- ☐ _____ Grievance Policy and Appeals Process provided and reviewed
- ☐ _____ Termination Policy provided and reviewed
- ☐ _____ Program Brochure
- ☐ _____ Dangers of Lead Based Paint information provided and reviewed
- ☐ _____ VAWA Notice of Occupancy Rights (Form HUD-5380)
- ☐ _____ VAWA Certification of Domestic Violence, Dating Violence, Sexual Assault, or Stalking, and Alternative Documentation (Form HUD-5382)

********ALL ADULT HOUSEHOLD MEMBERS MUST SIGN THIS DOCUMENT********

I understand that City of Hinesville Homeless Prevention Program and/or HUD may review the information contained in order to verify my eligibility for the program or for auditing purposes.

I certify that I have received the documents noted above. I was provided the opportunity to ask questions and have those questions and have those questions answered satisfactorily.

____ _______________
Applicant Signature Date

STAFF USE ONLY

I certify that I have provided the client with the information and policies noted above. I have reviewed all documents/publications indicated and allowed the client opportunity to ask questions regarding these documents to ensure a thorough understanding of the information.

____ _______________
Signature of Homeless Prevention Program Date

CERTIFICATION OF DOMESTIC VIOLENCE, DATING VIOLENCE, SEXUAL ASSAULT, OR STALKING, AND ALTERNATE DOCUMENTATION

U.S. Department of Housing and Urban Development

OMB Approval No. 2577-0286
Exp. 06/30/2017

Purpose of Form: The Violence Against Women Act ("VAWA") protects applicants, tenants, and program participants in certain HUD programs from being evicted, denied housing assistance, or terminated from housing assistance based on acts of domestic violence, dating violence, sexual assault, or stalking against them. Despite the name of this law, VAWA protection is available to victims of domestic violence, dating violence, sexual assault, and stalking, regardless of sex, gender identity, or sexual orientation.

Use of This Optional Form: If you are seeking VAWA protections from your housing provider, your housing provider may give you a written request that asks you to submit documentation about the incident or incidents of domestic violence, dating violence, sexual assault, or stalking.

In response to this request, you or someone on your behalf may complete this optional form and submit it to your housing provider, or you may submit one of the following types of third-party documentation:

(1) A document signed by you and an employee, agent, or volunteer of a victim service provider, an attorney, or medical professional, or a mental health professional (collectively, "professional") from whom you have sought assistance relating to domestic violence, dating violence, sexual assault, or stalking, or the effects of abuse. The document must specify, under penalty of perjury, that the professional believes the incident or incidents of domestic violence, dating violence, sexual assault, or stalking occurred and meet the definition of "domestic violence," "dating violence," "sexual assault," or "stalking" in HUD's regulations at 24 CFR 5.2003.

(2) A record of a Federal, State, tribal, territorial or local law enforcement agency, court, or administrative agency; or

(3) At the discretion of the housing provider, a statement or other evidence provided by the applicant or tenant.

Submission of Documentation: The time period to submit documentation is 14 business days from the date that you receive a written request from your housing provider asking that you provide documentation of the occurrence of domestic violence, dating violence, sexual assault, or stalking. Your housing provider may, but is not required to, extend the time period to submit the documentation, if you request an extension of the time period. If the requested information is not received within 14 business days of when you received the request for the documentation, or any extension of the date provided by your housing provider, your housing provider does not need to grant you any of the VAWA protections. Distribution or issuance of this form does not serve as a written request for certification.

Confidentiality: All information provided to your housing provider concerning the incident(s) of domestic violence, dating violence, sexual assault, or stalking shall be kept confidential and such details shall not be entered into any shared database. Employees of your housing provider are not to have access to these details unless to grant or deny VAWA protections to you, and such employees may not disclose this information to any other entity or individual, except to the extent that disclosure is: (i) consented to by you in writing in a time-limited release; (ii) required for use in an eviction proceeding or hearing regarding termination of assistance; or (iii) otherwise required by applicable law.

TO BE COMPLETED BY OR ON BEHALF OF THE VICTIM OF DOMESTIC VIOLENCE, DATING VIOLENCE, SEXUAL ASSAULT, OR STALKING

1. **Date the written request is received by victim:** ____

2. **Name of victim:** ____

3. **Your name (if different from victim's):**____

4. **Name(s) of other family member(s) listed on the lease:**____

____

5. **Residence of victim:** ____

6. **Name of the accused perpetrator (if known and can be safely disclosed):**____________________

____

7. **Relationship of the accused perpetrator to the victim:**____

8. **Date(s) and times(s) of incident(s) (if known):**____
____

10. **Location of incident(s):**____

In your own words, briefly describe the incident(s):
____
____
____
____

This is to certify that the information provided on this form is true and correct to the best of my knowledge and recollection, and that the individual named above in Item 2 is or has been a victim of domestic violence, dating violence, sexual assault, or stalking. I acknowledge that submission of false information could jeopardize program eligibility and could be the basis for denial of admission, termination of assistance, or eviction.

Signature ________________________________Signed on (Date) ____________________________

Public Reporting Burden: The public reporting burden for this collection of information is estimated to average 1 hour per response. This includes the time for collecting, reviewing, and reporting the data. The information provided is to be used by the housing provider to request certification that the applicant or tenant is a victim of domestic violence, dating violence, sexual assault, or stalking. The information is subject to the confidentiality requirements of VAWA. This agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid Office of Management and Budget control number.

City of Hinesville Homeless Prevention Program

Other Household Members: Children (under age 18)

Full Name:	Social Security Number:

Date of Birth:	Age:	Relationship to Head of Household:

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ White ☐ Black/African American ☐ American Indian or Alaskan ☐ Asian

☐ Multicultural/Mixed ☐ Other ______________________________

Gender: ☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female

☐ Client Doesn't Identify Male, Female or Transgender

Are you pregnant: ☐ Yes ☐ No

General Health Status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have a disabling condition: ☐ Yes ☐ No

Is this condition permanent: ☐ Yes ☐ No

Do you currently have Health Insurance: ☐ Yes ☐ No

If yes, please indicate what type below:

☐ Private ☐ State Children's Health Insurance ☐ Private-Employer

☐ Private- Individual ☐ Military ☐ State Funded

☐ Combined Children's Health/Medicaid ☐ Medicare ☐ Medicaid

☐ Indian Health Service (IHS)

Alcohol Abuse: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

Chronic Health Condition: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

Developmental Disability: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

Drug Abuse: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

HIV/AIDS: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

Mental Health: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No

Physical Disability: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused
If yes, is the barrier expected to be long-term and substantially impair your ability to live independently:
☐ Yes ☐ No