Hope Harbor, Inc.

610 West Division
Grand Island, NE 68801
308-385-5190

Application for Assistance

DATE: ___/___/___ REFERRED BY: ______________________

LAST NAME	FIRST NAME	BIRTHDATE	SEX	HISPANIC/ NON-HISPANIC
		/ /	M F	H NH

EACH ADDITIONAL HOUSEHOLD MEMBER WILL COMPLETE THE PAGE TITLED "APPLICATION FOR FAMILY MEMBERS" – ONE PAGE FOR EACH MEMBER

ETHNIC ORIGIN: *Please circle*

1. WHITE
2. BLACK/AFRICAN AMERICAN
3. ASIAN
4. AMERICAN INDIAN /ALASKAN NATIVE
5. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER
6. ASIAN & WHITE
7. AMERICAN INDIAN /ALASKAN NATIVE & WHITE
8. BLACK/AFRICAN AMERICAN & WHITE
9. OTHER: Please Indicate
10. AMERICAN INDIAN / ALASKAN NATIVE & BLACK

GENERAL INFORMATION

(This information is for the confidential use of Hope Harbor. Please check __ALL__ that apply to you.)

Applicant Social Security Number. #: _______-_______-_______

Marital Status: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED If applicable, do you have proof of marriage? ☐ YES ☐ NO

Where do you currently live? If you are homeless, please list where you stayed last night:

Address:______________________ City:______________ ST:______ ZIP: _______ County:______________

Is this address… ☐ YOUR RENTAL ☐ YOU OWN IT ☐ A FRIEND'S HOUSE ☐ A FAMILY MEMBER ☐ TREATMENT ☐ JAIL ☐ STREETS ☐ OTHER ______________

How long have you been at this address? ______________________

Phone # ______________ Alternate Phone # ______________ Email Address: ______________________

Applicant History:

Highest level of education completed: (Please Circle)

Grade 1 2 3 4 5 6 7 8 9 10 11 12 GED - Some College - College Graduate - Advanced Degree(s)

Were you as a child in foster care? ☐ YES ☐ NO

Have you ever been a ward of the state? ☐ YES ☐ NO

Are you a Veteran? ☐ YES ☐ NO If yes, are you receiving Veteran's Services? ☐ YES ☐ NO

Medical History:

Have you ever experienced any of the following?(Check box for all that apply)

☐ Domestic Abuse Currently fleeing yes___ no ____ How long ago ______

☐ Chronic mental illness (Diagnosis)______________________

☐ Developmental Disability ☐ HIV/AIDS ☐ Alcohol Dependency ☐ Drug Dependency

☐ Physical Disability ☐ Chronic Health Condition (Diagnosis)______________

Are you pregnant? ☐ YES ☐ NO If yes, what is your due date? ______________

Health Insurance Company: ______________________________________

Income

Are you now employed: ☐ YES ☐ NO Employer: ______________________

What was your Income, from all sources, for the past 30 days: $____________

Do you receive Income for any of the following? (Check all that apply)

☐ SSI ☐ SSDI ☐ TANF ☐ Child Support ☐ Job ☐ Unemployment

Do you receive: ☐ WIC ☐ SNAP If so, how much? ____________

Number of times you have lived on the streets or in a shelter in past 3 years?_______________
How many months have you been living on the street or in an emergency shelter in the past 3 years? __________

WHY ARE YOU SEEKING ASSISTANCE?

___ Could not locate affordable housing
___ Loss of job
___ Chemical dependency problems
___ Low income
___ Leaving other facility: Name of facility_________________________________
___ Stranded in area, please list destination________________________________
___ Other ____
___ Eviction (Eviction Date :_________)
___ Fleeing domestic abuse
___ Mental health problems

Backgrounds (including Central Registry, and Sex Offender Registry) are checked before entrance to the shelter and those with convictions which are aggravated, aggressive, or sexual in nature may not be approved to be sheltered in our facility

I (we) have truthfully answered the questions in this application and give permission for this information to be verified. I furthermore understand that assistance is offered as it is available, and that Hope Harbor, Inc. reserves the right to refuse assistance.

Signed: ____ Date:___/___/___
(Applicant's Signature)

Rules for acceptance and participation in the program are the same for everyone without regard to race, color, national origin, age, sex, or disability. Any person who believes he or she has been discriminated against in this program should write to Administrator, Food and Consumer Service, 3101 Park Center Drive, Alexandria, VA 22302.

RELEASE OF INFORMATION

I, as an applicant for assistance from Hope Harbor, Inc., understand that information may need to be exchanged between Hope Harbor, law enforcement, other agencies and churches in order to further assist me and agree to such.
IMPORTANT: HOPE HARBOR is required to clear with the Grand Island Police Dept., Adult Protective Services and Child Protective Services, and any police department of former residence locations, criminal history of any person seeking shelter or help from this office. Law enforcement agencies may review our records upon their request.

By signing this release form I give my permission for Hope Harbor, Inc. to request information and share information with other agencies, law enforcement, and churches, which includes but is not limited to the agencies listed below. The purpose of sharing of information is to determine by eligibility for services and to assist me by make other referrals appropriate to my situation. This RELEASE OF INFORMATION FORM is valid for **12** months, beginning with the date of execution and will expire on ______ day of ______________________, 20____.

The following listed agencies are the most frequent contacts by Hope Harbor, Inc., however the release is not limited to these agencies:

Grand Island Police Department
Mid-Plains Center
Community Action of Nebraska
Hall County Housing Authority
Nebraska Department of Corrections
St. Francis Hospital/Third City Clinic
Grand Island Public Schools
Region3 Behavioral Services
Mary Lanning
Church's
Applicants Employer
V.A. Hospitals
Doctor's Office/Physicians
Central Nebraska Goodwill Industries
Vocational Rehabilitation
Independence Rising
Dept. of Health and Human Services
Hall County Corrections
Futures Family Services
United Way
Salvation Army
Landlords
Crisis Center
Crossroads Mission
Friendship House
HH Therapists
Drug Court
Families Care
Richard Young Hospital
State Parole/Probation

Executed this _______ day of ___________________________, 20____

_______________________________ _______________________________
Applicant (Print Full Name) Applicant Signature

_______________________________ Witness Signature

Standard NMIS User Agency Client Authorization to Release Basic Information

Name of NMIS User Agency:					
Client's Last Name:		**First Name:**		**Middle Initial:**	
Date of Birth:		**SSN: (partial acceptable)**			

I authorize Hope Harbor (the Agency), as a Nebraska Management Information System (NMIS) user agency and its contracted agents, to disclose my basic identifying information to NMIS and to all of the NMIS user agencies. The disclosure will be made by entering the information into the NMIS database. Once the disclosure has been made in reliance upon this authorization, the information cannot be retrieved, and all current and future NMIS user agencies will be able to access, use, and disclose the information. The NMIS user agencies are health and human service providers who are permitted by the NMIS to access and enter data into the NMIS database, which allows them to collect, share, and use basic identifying information about service recipients.

I understand that the Agency cannot condition decisions about my treatment, payment, enrollment or eligibility for benefits or services on whether or not I sign this authorization. A copy of this authorization shall be as valid as the original. I understand that the information disclosed is subject to re-disclosure by the recipient and may no longer be protected by the federal privacy regulations, 45 CFR § 164 Subpart E.

Basic identifying information authorized to be disclosed to the NMIS and made accessible to other NMIS user agencies:

Date and Time of Intake into the NMIS	Permission to Release Information
First Name, Last Name	Social Security Number and Qualifier
Medical Insurance Status	Date of Birth/Birthday
Gender	Primary Race
Ethnicity	Primary Language
Type of Living Situation	Highest Level of Education Attained
Are you Homeless? (yes or no)	Household Relationships
Zip Code of last Permanent Residence	Are you a U.S. Military Veteran? (yes or no)

I understand that I do not have to participate in the NMIS. I understand that I may revoke this authorization at any time, by doing so in writing to the NMIS user agency named above. A revocation of this authorization will be effective except to the extent the entity disclosing the information has taken action relying on this authorization. This authorization will expire in 180 days from the date I sign it. I understand that revocation or expiration of this authorization will not affect information that has already been entered into the NMIS database in reliance on this authorization.

______________________________ ______________

Client's Authorizing Signature **Date (mm/dd/yy)**

I also authorize the Agency to disclose basic identifying information about my dependent(s) to the NMIS. Name(s) of Dependent(s) that the Legal Guardian Authorizes to Participate in the NMIS:

______________________________ ______________________________

Name SS# DOB Name SS# DOB

______________________________ ______________________________

Name SS# DOB Name SS# DOB

______________________________ ______________

Parent or Legal Guardian's Authorizing Signature **Date (mm/dd/yy)**

____

Printed Name and Relationship to Dependent

______________________________ ______________

Agency Representative's Signature Date (mm/dd/yy)

____

Agency Representative's Printed Name

✓ Description for Informed Decision: Verbal Explanation ___ Interpreter___ Written___

Application for Family Members

Please complete this additional page: 1 for each family member who is not head of household.

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LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	SEX	HISPANIC/ NON-HISPANIC
			/ /	M F	H NH

ETHNIC ORIGIN: Circle

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6. AMERICAN INDIAN /ALASKAN NATIVE & WHITE
7. ASIAN & WHITE
8. BLACK/AFRICAN AMERICAN & WHITE
9. AMERICAN INDIAN / ALASKAN NATIVE & BLACK
10. OTHER: Please Indicate

Relationship to Head of Household: ______________________________

Type of residence if different from head of household: ________________________ **How long:** __________
Address:________________________ City:______________ ST:______ ZIP: ________ County:_________

GENERAL INFORMATION

(This information is for the confidential use of Hope Harbor. Please check **ALL** that apply to you.)

Health Insurance Company: ____

Applicant History:
Highest level of education completed: (Please Circle)
Grade 1 2 3 4 5 6 7 8 9 10 11 12 GED - Some College - College Graduate - Advanced Degree(s)
Were you as a child in foster care? ☐ YES ☐ NO
Have you ever been a ward of the state? ☐ YES ☐ NO
Are you a Veteran? ☐ YES ☐ NO If yes, are you receiving Veteran's Services? ☐ YES ☐ NO
Additional ADULT only: Number of times in past 3 years you have been on the streets or in a shelter _______
Total number of months on the street or in a shelter in the past 3 years ___________

Medical History:
Have you ever experienced any of the following?(Check box for all that apply)
☐ Domestic Abuse: Currently fleeing yes___ no____ How long ago (months) _________
☐ Chronic mental illness (Diagnosis)____________________
☐ Developmental Disability ☐ HIV/AIDS ☐ Alcohol Dependency ☐ Drug Dependency
☐ Physical Disability ☐ Chronic Health Condition (Diagnosis)______________
Are you pregnant? ☐ YES ☐ NO If yes, what is your due date? ______________

Income
Are you now employed: ☐ YES ☐ NO Employer: ____________________________

What was your Income, from all sources, for the past 30 days: $___________

Do you receive Income for any of the following? (Check all that apply)

☐ SSI ☐ SSDI ☐ TANF ☐ Child Support ☐ Job ☐ Unemployment

Do you receive: ☐ WIC ☐ SNAP If so, how much? ____________