Housing Solutions Center
of Kitsap County

Full Name: _____ Today's Date: _____

Current Address (or Last Permanent Address if homeless)

Street Address:_____ City:_____ State:_____ Zip Code:_____

Phone #1:_____ (HOME/CELL/MESSAGE) ☐ ☐ ☐ **Phone #2:_____** (HOME/CELL/MESSAGE) ☐ ☐ ☐ **Email: _____**

List ALL household members below, starting with yourself as Head of Household.

Full Name (First, Middle, Last)	Age	Date of Birth	Social Security #	Sexual Identity	Gender Identity	Race(s) (W = White, B = Black, A = Asian, N = Native American, P = Pacific Islander)	Hispanic Y/N	Prior Military Y/N	Relationship To You
									SELF

Where did you stay last night? (Check ONE only)

☐ Non-housing (car, street, tent, etc.) ☐ Emergency Shelter ☐ Staying with Family ☐ Staying with Friends

☐ Rental (apartment, house, etc.) ☐ Home you Own ☐ Hotel or Motel ☐ Hospital ☐ Psychiatric Facility

☐ Substance Abuse Facility ☐ Jail or Prison ☐ Transitional Housing ☐ Other (please specify):_____

How long have you stayed there? _____

If less than 90 days, where did you stay the night before? _____

Monthly Rent Amount: $_____ Is your rent Subsidized? ☐ Yes ☐ No

Did you receive a pay or vacate notice? ☐ Yes ☐ No **If YES, how much do you owe? $_____**

Are you living on the streets, in an emergency shelter, or safe haven? ☐ Yes ☐ No ☐ Don't Know

If YES, what is the approximate date you started living on the streets, in shelter, or safe haven?_____/_____/_____

How many times have you lived on the streets, in shelter or safe haven in the past three (3) years? _____

How many total months have you lived on the streets, in shelter or safe haven in the past three (3) years? _____

Housing Solutions Center of Kitsap County

Does your household have any of the following disabilities or barriers to housing? (Please answer ALL)

Physical Disability ☐ Yes ☐ No ☐ Don't Know

If yes, which household member(s)? _____ Long-term physical disability? ☐ Yes ☐ No

Developmental Disability ☐ Yes ☐ No ☐ Don't Know

If yes, which household member(s)? _____ Does it limit your independence? ☐ Yes ☐ No

Chronic Health Condition ☐ Yes ☐ No ☐ Don't Know

If yes, which household member(s)? _____ Long-term Chronic Health Condition? ☐ Yes ☐ No

Mental Health Issue ☐ Yes ☐ No ☐ Don't Know

If yes, which household member(s)? _____ Long-term mental health issue? ☐ Yes ☐ No

Substance Use Issue ☐ Yes ☐ No ☐ Don't Know **Please check one** ☐ Drug ☐ Alcohol ☐ Both

If yes, which household member(s)? _____ Long-term Substance Use Issue? ☐ Yes ☐ No

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Have you been a victim of domestic or intimate partner violence? ☐ Yes ☐ No

If YES, when was the last incident? _____

Are you currently fleeing domestic violence? ☐ Yes ☐ No ☐ Don't Know

List ALL household income below. Please list each person with income, each source of income, and the monthly $ amount.
Examples: Employment, SSI, SSDI, Retirement, TANF, Unemployment, Child Support, etc.

Name	Source of Income	Monthly Amount
		$
		$
		$
		$
		$
		$
	Household Total:	**$**

Housing Solutions Center of Kitsap County

What Non-Cash Benefits are your household currently receiving? (Check ALL that apply)

☐ **NONE** ☐ SNAP (FOOD STAMPS) ☐ WIC ☐ TANF Childcare ☐ TANF Transportation

☐ Other TANF Funded Services ☐ Section 8 ☐ Temporary Rental Assistance

☐ Other (please specify):_____

Check each Health Insurance type your household is receiving, and write the name(s) of who receives it. Please account for ALL household members, even those without health insurance. If "Other", write the type of insurance in the parentheses.

☐ **NOT COVERED:**_____ ☐ Employer Provided:_____

☐ MEDICAID/Apple:_____ ☐ COBRA:_____

☐ MEDICARE:_____ ☐ Private Insurance:_____

☐ SCHIP:_____ ☐ State Health Insurance for Adults:_____

☐ VA Medical:_____ ☐ Other (_____):_____

If your last permanent residence was OUTSIDE Kitsap County, what is the main reason you came to Kitsap? (Check ONE only)

☐ Returning to the Area ☐ To Help Family/Friends ☐ To Get Help From Family/Friends ☐ Better Cost of Living

☐ Employment Opportunities ☐ Education Opportunities ☐ Military Connection ☐ Offer of Public Housing

☐ Seeking Medical/Recovery Treatment ☐ To Access Social Services ☐ Found Kitsap on Internet

☐ Fleeing Domestic Violence ☐ Assigned by D.O.C. ☐ Other (specify):_____

Were you contacted by an Outreach Specialist outside of this office? Yes / No ☐ ☐

If Yes, Where? ☐ Ferry Terminal ☐ Library ☐ Jail ☐ Drug Court ☐ KRC ☐ Olympic College ☐ Community Event ☐ Other

Do you have any pets? ☐ Yes ☐ No **If so, how many?** _____ **And what kind(s)?**_____

Is anyone in your household pregnant? ☐ Yes ☐ No **If YES, when is the due date?** _____

Has anyone in your household served in the military? ☐ Yes ☐ No

Service Years: _____ To _____ Branch: _____ Discharge Status: _____

Any theaters of operation? Please list: _____

Have you or any member of your household ever been convicted of a criminal offense? ☐ Yes ☐ No ☐ Don't Know

If you checked "Yes", please explain:

_____

_____

_____

_____

Housing Solutions Center of Kitsap County

(REQUIRED): In your own words, what brought you into the Housing Solutions Center today?

I certify that I have provided the above information, which is accurate and true. I understand that I may be subject to criminal prosecution if I have knowingly provided false information. I also give my permission for this agency to request/release necessary information that may result in my receiving benefits and for reporting purposes. I understand that my Protected Health Information will be privacy protected and not shared with third parties in accordance with HIPAA and 42 CFR Part 2 Regulations. I understand that provision of my Social Security Number is necessary to avoid duplicate assistance benefit payments to the same applicant household and may also be used for income verification. I hereby authorize Housing Solutions Center of Kitsap County staff to use my Social Security Number for those purposes only. I understand that Housing Solutions Center of Kitsap County may request a Washington State background investigation before considering my application. By signing, I grant permission for that investigation.

Applicant Signature_____ **Date**_____

*HSC Representative Signature*_____ *Date*_____

Kitsap Client Release of Information and Informed Consent Form

Washington State Homeless Management Information System (HMIS)
Kitsap HMIS Collaborative Agencies

This agency participates in the Washington State Homeless Management Information System (HMIS) by collecting information, over time, about the characteristics and service needs of people facing homelessness. **RCW 43.185C.180 and RCW 43.185C.030**

- To provide the most effective services in moving people from homelessness to permanent housing, we need an accurate count of all people experiencing homelessness in Washington State. In order to insure that clients are not counted twice, we need to collect four pieces of personal information. Specifically, we need: **name, birth date, race/ethnicity.** You may also choose to provide your social security number. However, signing this form does not require you to do so. Your information will be stored in our database for 7 years after the last date of service. If you have questions about collection of data or your rights regarding your personally identifying information, contact the HMIS System Administrator at: (360) 725-3028

- We use strict security policies designed to protect your privacy. Our computer system is highly secure and uses up-to-date protection features such as data encryption, passwords, and two-factor authentication required for each system user. There is a small risk of a security breach, and someone might obtain and use your information inappropriately. If you ever suspect the data in HMIS has been misused, immediately contact the HMIS System Administrator at: (360) 725-3028

- The data you provide may be combined with data from the Washington State Department of Social and Health Services (DSHS) and Education Research and Data Center for the purpose of further analysis. Your name and other identifying information will not be included in any reports or publications. Only a limited number of staff members, who have signed confidentiality agreements, will be able to see this information. Your information will not be used to determine eligibility for DSHS programs. Washington State HMIS system administrators have full access to all information in HMIS. This includes the Department of Commerce staff, designated HMIS system administrators, and the software vendor.

- By signing this form, you acknowledge and allow Department of Commerce staff to obtain additional records of information from other state agencies with which there is a data sharing agreement (DSA) on file between Commerce and the other agency. Our DSA guides data transfer and storage security protocols. If DSAs are in place, Commerce is authorized by you to obtain, add to HMIS, and use for evaluation purposes any other data you have provided to other Washington state agencies.

- Your decision to participate in the HMIS will not affect the quality or quantity of services you are eligible to receive from this agency, and will not be used to deny outreach, assistance, shelter or housing. However, if you do choose to participate, services in the region may improve if we have accurate information about homeless individuals and the services they need. Furthermore, some funders MAY require that you consent to provide your personally identifying information in HMIS in order for you to receive services from that funding source.

I understand the above statements and consent to the inclusion of personally identifying information in HMIS about me and any dependents listed below, and authorize information collected to be shared with partner agencies, both state agencies and organizations that participate in the Kitsap HMIS Collaborative. I understand that my personally identifying information will not be made public and will only be used with strict confidentiality. I also understand that i may withdraw my consent at any time by filing a 'Client Revocation of Consent' form with this agency. I understand that I may obtain a copy of my signed consent form from this Agency (including forms signed electronically).

IMPORTANT: Do not enter personally identifying information into HMIS for clients who are: 1) in DV agencies or; 2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault or stalking situation; 3) are being served in a program that requires disclosure of HIV/AIDS status (i.e.; HOPWA); or 4) under 13 with no parent or guardian available to consent to enter the minor's information in HMIS.
*If this applies to you, **STOP – and do not sign this form.***

Dependent(s) First & Last Name(s): _____ _____

_____ _____

Client Name: _____ Date of Birth: _____ **HMIS #** _____

Signature: _____ Date: _____

Staff Name: _____ Signature: _____ Agency: _____ ☐ NC

Revised 6/2018

Housing Solutions Center
of Kitsap County

CONSENT TO SHARE INFORMATION WITH PARTNERSHIP AGENCIES

PLEASE READ THE FOLLOWING CAREFULLY

The HOUSING SOLUTIONS CENTER (HSC), administered by KITSAP COMMUNITY RESOURCES (KCR), is requesting your permission to share your confidential information and records in order to provide you with outreach services that are provided by other programs and agency.

You are not required to give your consent to share this confidential and personal information.

If you do agree to share your confidential information and personal records, this information will be shared with partnering agencies in the community and only on a need-to-know basis.

The sole purpose of revealing this information will be to enable the HSC staff, under the administration of Kitsap Community Resources, to provide you with appropriate external and internal services.

If you do not consent to share your confidential information and records, those records will only be shared to the extent allowed by state and federal law.

Your eligibility to participate in HSC programs does not depend on your agreement to share your confidential information and personal records with outside agencies.

If you choose not to share your confidential information and personal records, including your Social Security Number, you may not be eligible for further services that require inter-agency cooperation.

The information disclosed to the HSC partnering agencies will not be further re-disclosed by those agencies without your specific authorization and further consent.

I agree that a photocopy of this authorization may be used for the purpose stated above.

_____ _____

Signature Date

KITSAP COMMUNITY Resources

Housing Solutions Center
of Kitsap County

Homeless Grant Funding Application

Head of Household ONLY:

First Name: _____ Last Name: _____ Date_____

Any family member over the age of 60?	
Any family member under the age of 5?	
Any family member pregnant?	

In the last year have you:

	YES	NO
Been released from an inpatient chemical dependency program? What Facility? When?		
Been released from an inpatient mental health facility? What Facility? When?		
Used crisis service, including crisis centers or suicide prevention hotlines?		

Are you currently?

	YES	NO
Are you currently enrolled in an outpatient chemical dependency program? What facility?		
Are you currently receiving treatment for a serious mental illness?		
Drinking or using drugs after completing a treatment program?		
Experiencing violence or fear for your safety in your household?		
Effected by a developmental or learning disability?		
Receiving treatment for a chronic medical condition? If yes, what is the condition? _____		
Having experienced any emotional, physical, psychological, sexual or other type of abuse or trauma which you have not sought help for, and/or which has caused homelessness?		
Have a permanent physical disability that limits mobility?		
IN THE PAST 2 MONTHS: Have you been tested, diagnosed, or been ordered to quarantine due to COVID-19?		

Have you:

	YES	NO
Been convicted of a felony in the past 3 years?		
Ever been homeless for a year or more or been homeless for 3 or more times?		

If you do not receive assistance today and are homeless, where will you sleep tonight? Se

Emergency shelter	
In a vehicle	
Site without water or electricity	
With someone who is abusing me or another member of my family	

Monthly Household Income_____ Significant income loss due to COVID-19 ☐ YES/NO ☐

KITSAP COMMUNITY Resources

CLIENT CONSENT FOR KCR TO SHARE INFORMATION WITH YOUR LANDLORD

PURPOSE OF THIS FORM

Welcome to KITSAP COMMUNITY RESOURCES (KCR). The purpose of this form is to obtain your consent to share your information with your landlord regarding your housing.

PLEASE READ THE FOLLOWING CAREFULLY

KITSAP COMMUNITY RESOURCES (KCR) is requesting your permission to share your housing information and records within KCR in order to provide you with outreach services that are provided by other KCR programs and your landlord.

You are not required to give your consent to share this confidential and personal information.

If you do agree to share your confidential information and personal records, this information will be shared with your landlord and KCR programs only on a need-to-know basis.

The sole purpose of revealing this information will be to enable the staff of Kitsap Community Resources to provide you with appropriate level of services.

If you do not consent to share your confidential information and records, those records will only be shared to the extent allowed by state and federal law.

I, _____, authorize Kitsap Community Resources permission to speak and/or contact the following person and/or organization regarding my housing.

Landlord Name: _____

Landlord Address: _____

Landlord Phone: _____

Landlord Email: _____

I voluntarily allow the above named parties to obtain and/or release information regarding my housing. I understand this information will not be forwarded to anyone other than the parties listed above, without my written permission. I can revoke this consent at any time. This consent form expires December 31, 2024.

_____

Signature **Date**