



For Office Use Only

Date of Receipt & Staff Initials: _____ Referral Source: _____

Check-In Dates: _____ Notes: _____

Transitional Housing Application

****Please be sure to review the Ithaka Housing Options before filling out this application****

APPLICANT INFORMATION

Name _____ Alias(es): _____

Mailing Address: _____

Phone: () _____ Can we text you? _____ Can we leave voice mail? _____

Email: _____

Date of Birth: _____ Gender: _____ Social Security # _____ - _____ - _____

Hispanic/Latino: Yes No Race: _____ Highest Education Completed: _____

Are you a veteran? Yes No Dates of Service: _____ Branch: _____

Theater of operations: _____ Discharge Status: _____

Have you applied to Ithaka Land Trust before? Yes No

If yes, please describe: _____

Driver's License or Colorado ID (if any):

Your Driver's License Number: _____ State: _____

Vehicle Information:

Make/Model: _____ Year: _____ License Plate State: _____

RESIDENTIAL HISTORY

Current Living Situation:

<i>Homeless</i>	
<input type="checkbox"/> Vehicle, outdoors, or abandoned building	<input type="checkbox"/> Safe haven
<input type="checkbox"/> Emergency shelter or emergency shelter voucher	<input type="checkbox"/> Interim housing
<i>If yes:</i> Approximate date homelessness started: _____ How many times have you been homeless in the past 3 years? _____ How many months have you been homeless in the last 3 years? _____	
<i>Institutional Situation</i>	
<input type="checkbox"/> Foster home or foster care group home	<input type="checkbox"/> Long-term care facility or nursing home
<input type="checkbox"/> Hospital or medical facility	<input type="checkbox"/> Psychiatric facility
<input type="checkbox"/> Detention facility	<input type="checkbox"/> Substance abuse treatment/detox facility
If your stay was less than 90 days: Where did you stay before this situation? _____	
<i>Transitional & Permanent Housing Situation</i>	
Owned by client <input type="checkbox"/> without subsidy <input type="checkbox"/> with subsidy	Rental through <input type="checkbox"/> no subsidy <input type="checkbox"/> housing subsidy <input type="checkbox"/> GPD TIP subsidy <input type="checkbox"/> VASH subsidy
<input type="checkbox"/> Transitional housing for homeless persons	<input type="checkbox"/> Residential program with no homeless criteria
<input type="checkbox"/> Permanent housing for formerly homeless persons	<input type="checkbox"/> Motel paid for without emergency shelter voucher
<input type="checkbox"/> Family member's residence	<input type="checkbox"/> Friends' residence
If your stay was less than 7 days: Where did you stay before this situation? _____	

Length of stay in prior living situation (Where you stayed last night): _____

Please describe your current living situation in as much detail as possible:

Last Known Permanent Address (where you last lived for 90 days or more):

HISTORY

Reasons or Contributing Factors to Homelessness (choose all that apply)

<input type="checkbox"/> Abuse or Violence in My Home	<input type="checkbox"/> Lost a Job; Could not Find Work
<input type="checkbox"/> Alcohol/Substance Abuse Problems	<input type="checkbox"/> Medical Expenses
<input type="checkbox"/> Asked to Leave	<input type="checkbox"/> Mental Illness/Discharge from psychiatric facility
<input type="checkbox"/> Bad Credit	<input type="checkbox"/> Moved to Find Work
<input type="checkbox"/> Could Not Pay Utilities	<input type="checkbox"/> Problems with Public Benefits
<input type="checkbox"/> Discharge from Foster Care	<input type="checkbox"/> Reasons Related to My Sexual Orientation
<input type="checkbox"/> Discharged from Jail	<input type="checkbox"/> Relationship Problems or Family Break-up
<input type="checkbox"/> Discharged from Prison	<input type="checkbox"/> Unable to Pay Rent/Mortgage
<input type="checkbox"/> Family Member or Personal Illness	<input type="checkbox"/> Eviction
<input type="checkbox"/> Legal Problems	<input type="checkbox"/> Other: _____

Did you relocate to Colorado/Colorado Springs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<i>Reason for relocation: (select all that apply)</i>			
<input type="checkbox"/> Care of sick relative	<input type="checkbox"/> Climate	<input type="checkbox"/> Natural Disaster	<input type="checkbox"/> Domestic Violence
<input type="checkbox"/> Driver's Licenses/ID for immigrants	<input type="checkbox"/> Employment	<input type="checkbox"/> Family Support	<input type="checkbox"/> Medical Needs
<input type="checkbox"/> Colorado marijuana laws	<input type="checkbox"/> Needed services	<input type="checkbox"/> Refugee	

Describe chronic substance abuse history & treatment:

Drug(s) of Choice: _____ Longest time of sobriety: _____

Have you ever been charged with a misdemeanor or felony? Yes No

If yes, please explain:

If currently incarcerated, estimated release date: _____

Are you currently involved in any court/legal proceedings? Yes No

If yes, please explain:

Do you have a mental health diagnosis? Yes No

If yes, please state diagnoses, treatments, and medications:

Have you survived domestic violence? Yes No

When did this occur? _____

Are you disabled? Physical Developmental None

If yes, please describe: _____

Have you been diagnosed with AIDS or tested positive for HIV? Yes No

If yes, does/will this affect your ability to live independently? Yes No

Do you have a chronic health condition? Yes No

If yes, does/will this affect your ability to live independently? Yes No

SOURCES OF INCOME

Are you willing and able to work? Yes No

Current Employment Status: Full Time Part Time Student Unemployed

Employer: _____ Employer Phone: () _____

Dates employed: _____ Salary: \$ _____ per _____

Hours per week: _____

If you marked 'No' or 'Unemployed', please explain the barriers to employment:

Income Sources *(complete all that apply)*

Employment	\$ _____ /month
	Source: _____
Unemployment Insurance	\$ _____ /month
Supplemental Security Income (SSI)	\$ _____ /month
Social Security Disability Income (SSDI)	\$ _____ /month
VA Service-Connected Disability Compensation	\$ _____ /month
VA Non-Service-Connected Disability Pension	\$ _____ /month
Private Disability Insurance	\$ _____ /month
Worker's Compensation	\$ _____ /month
Temporary Assistance for Needy Families (TANF)	\$ _____ /month
General Assistance (GA)	\$ _____ /month
Retirement Income from Social Security	\$ _____ /month
Pension or Retirement Income from a former job	\$ _____ /month
Child Support	\$ _____ /month
Alimony or other spousal support	\$ _____ /month
Other source	\$ _____ /month
Specify source	_____
Total Monthly Income	\$ _____

Non-Cash benefits

<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) \$ _____	<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
<input type="checkbox"/> TANF Child Care services	<input type="checkbox"/> Other TANF-funded services

TANF transportation services

Other _____

Health Insurance (All clients)

Medicaid _____

Medicare _____

VA Medical Services

State Children's

Employer-Provided

State Health Insurance for Adults

Private Pay

COBRA

Indian health service program

Other _____

None

REFERENCES

Personal Reference or Emergency Contact:

Name _____ Address _____

Phone _____ Relationship _____

Email Address _____

Professional Reference

Name _____ Address _____

Phone _____ Relationship _____

Email Address _____

Parole/Probation Officer or Case Manager:

Name: _____ Organization: _____

Phone: _____ Ext: _____ Title: _____

Email Address _____

Mental Health Counselor:

Name: _____ Organization: _____

Phone: _____

Email Address _____

I understand that this is a preliminary application and the information provided does not guarantee housing. I certify that all information contained herein is true and correct to the best of my knowledge.

I understand that in order to stay on the wait list for Ithaka Land Trust, I must call in every 30 days to indicate my continued need for housing. If I miss a phone call check-in, my application will drop off the wait list and I will have to re-apply for housing with Ithaka.

It is the policy of Ithaka to accept applications and place applicants into housing units based on need and date of application. In compliance with local, state, and federal laws, we provide housing regardless to applicants regardless of race, color, national origin, sexual orientation, age, gender identity, disability, or veteran status. In addition, policies that affect current residents will be carried out without regard for these irrelevant factors.

I authorize an investigation of my credit, tenant history, criminal history and employment for the purposes of renting a house, apartment or room from Ithaka Land Trust. Applicant hereby authorizes Ithaka Land Trust, its employees and agents to verify said information and make independent investigations in person, by mail, telephone, fax, or otherwise, to determine Applicant's rental, credit, financial, criminal and character standing. Applicant hereby releases Ithaka Land Trust, its employees and agents, First American Registry, Inc., its employees and agents and any and all other firms or persons investigating or supplying information, for any liability whatsoever concerning the release and/or use of said information and further, will defend and hold them all harmless from any suit or reprisal whatsoever. A copy, fax or other reproduction of this Authorization shall be as effective as the original.

Name (please print)

Date

X _____

**AUTHORIZATION FOR USE/DISCLOSURE/Obtainment
OF HEALTH/SERVICES INFORMATION**

Authorization for Use/Disclosure/Obtainment of Information: I voluntarily consent to authorize Ithaka Land Trust to use, disclose, or obtain records or knowledge of me or my treatment during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my care information to be released to and/or obtained from the following recipient(s):

Name: _____

Role: _____

Phone: _____

Purpose: I authorize the release/obtainment of my care information for the specific purpose of care coordination.

Information to be disclosed: I authorize the release/obtainment of the following care information: (check the applicable box below)

- All of my care information that the provider has in his or her possession, including information relating to any medical or mental health history, mental or physical condition, substance use progress, behavior, program adherence, and any treatment received by me.¹
- Only the following records or types of health information:
_____.

Term: I understand that this Authorization will remain in effect until I end my residency in the Ithaka Land Trust's transitional program.

Redisclosure: I understand that my Ithaka Land Trust cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
