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: ( ) _____VM OK?: _____ 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:

Homeless	
☐ Vehicle, outdoors, or abandoned building	☐ Safe haven
☐ Emergency shelter or emergency shelter voucher	☐ Interim housing
If yes: 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? _____	
Institutional Situation	
☐ Foster home or foster care group home	☐ Long-term care facility or nursing home
☐ Hospital or medical facility	☐ Psychiatric facility
☐ Detention facility	☐ Substance abuse treatment/detox facility
If your stay was less than 90 days: Where did you stay before this situation? _____	
Transitional & Permanent Housing Situation	
Owned by client ☐ without subsidy ☐ with subsidy	Rental through ☐ no subsidy ☐ housing subsidy ☐ GPD TIP subsidy ☐ VASH subsidy
☐ Transitional housing for homeless persons	☐ Residential program with no homeless criteria
☐ Permanent housing for formerly homeless persons	☐ Motel paid for without emergency shelter voucher
☐ Family member's residence	☐ 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)

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

Did you relocate to Colorado/Colorado Springs?	☐ No	☐ Yes	
Reason for relocation: (select all that apply)			
☐ Care of sick relative	☐ Climate	☐ Natural Disaster	☐ Domestic Violence
☐ Driver's Licenses/ID for immigrants	☐ Employment	☐ Family Support	☐ Medical Needs
☐ Colorado marijuana laws	☐ Needed services	☐ 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 Specify source	$ ___.____/month _____
Total Monthly Income	$ _____.____

Non-Cash benefits

☐ Supplemental Nutrition Assistance Program (SNAP) $_____	☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
☐ TANF Child Care services	☐ 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.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my residency at Ithaka Land Trust. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Ithaka Land Trust at the address listed below.

_____

The revocation will be effective immediately upon Ithaka Land Trust's receipt of my written notice, except that the revocation will not have any effect on any action taken by Ithaka Land Trust in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the Ithaka Land Trust for answers to my questions about the privacy of my health information at 420 Mesa Rd, Colorado Springs, CO 80905, or by telephone at (719) 578-1629.

_____	_____	_____
Signature	Date	Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Name of Guardian/ Representative	Legal Relationship	Date	Witness