SELF SUFFICIENCY
OF LARAMIE COUNTY

Jonn J. Edmunds Veteran's Housing Enrollment Application

(10.18.2018)

Applicant Information

Full Name: _____ **Date:** _____
Last, First MI

Phone Number: _____ **Birthdate:** _____ **Social Security Number** _____
xxx.xxx.xxxx mm/dd/yyyy xxx-xx-xxxx

Where did you stay last night? _____ **How Long?** _____

Who referred you to us? _____
Referring Agency and/or individual

Are you a veteran? _____ **What are your dates of service?** _____ **Discharge Status?** _____
Y/N

What Branch? _____ **Are you enrolled with the VA?** _____

Have you been in a GPD program before? _____ **If so, when and where?** _____

Have you ever been or are you currently enrolled with HUDVASH? _____ **If so, do you have a voucher?** _____

Are you currently enrolled with SSVF? _____ **If not, has an appointment been made?** _____ **When?** _____

*Please provide with application copy of a picture ID, and proof of veteran status. (Driver's License, State ID, VA Card, DD214, VA Benefits Award Letter).

Income

Are you currently receiving any income? _____

If so, list your income sources below and your amount:

Income Source:	Amount: (weekly, bimonthly, monthly)

*We will need a copy of verification of income. (Ex: last 3 paystubs, current award letters, and bank statements if possible.)

Are you receiving Non-cash benefits or assistance? _____
(SNAP, TANF, etc....)

If so, list your sources below and amount:

Source:	Amount:

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Previous Employment/Education/Certifications

Company: _____ **Phone:** _____

Address: _____ **Supervisor:** _____

Job Title: _____ **Starting Salary:$** _____ **Ending Salary:$** _____

Responsibilities: _____

From: _____ **To:** _____ **Reason for Leaving:** _____

_____

_____

Company: _____ **Phone:** _____

Address: _____ **Supervisor:** _____

Job Title: _____ **Starting Salary:$** _____ **Ending Salary:$** _____

Responsibilities: _____

From: _____ **To:** _____ **Reason for Leaving:** _____

- Education Background -

Please List your Highest Level of Education and/or trainings and Certifications:

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application or interview may result in my release and/or application withdrawal.

Signature: _____ **Date:** _____

There is a $30.00 background check fee requested to process this application. If any questions, please contact Community Action of Laramie County at 1.307.635.9291 and talk to one of the case managers available.

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Community Action of Laramie County

CRIMINAL BACKGROUND CHECK AUTHORIZATION FORM

A criminal background check is required for Community Action of Laramie County Self-Sufficiency Housing Program. This check into official public records will determine the existence or non-existence of any record of criminal convictions. Federal and state law provides that certain housing programs within the State of Wyoming are unavailable to individuals who have plead guilty and/or been convicted of criminal conduct, based on the nature of the criminal violation and/or the type of position being sought. Prior criminal convictions do not automatically preclude housing. Any information received *WILL NOT* be shared with any other agency or individuals unless written permission/consent is given to this agency by the applicant.

Please Print Clearly

*Name (Last, First, M.I.): _____

List other names used, and dates of name change in the last ten (10) years:

_____

Full Name

*Date of Birth: _____ (MM/DD/YYYY)

*Social Security Number (SSN): _____

*Has this SSN been issued in the last 90 days? Yes ☐ No ☐

NONE OF THE INFORMATION PROVIDED ON THIS FORM WILL BE USED TO DISCRIMINATE AGAINST ANY APPLICANT ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, GENETIC INFORMATION, RELIGION, AGE, DISABILITY OR MILITARY STATUS.

BY SIGNING THIS FORM, YOU AUTHORIZE *DAY AND NIGHT PROCESS SERVICES, CIA Services* AND/OR ITS DESIGNATED THIRD PARTY TO CONDUCT A CRIMINAL BACKGROUND CHECK. IN ADDITION, YOU ACKNOWLEDGE THAT ANY FALSE OR MISLEADING STATEMENT, OMISSION OR FAILURE TO DISCLOSE INFORMATION MAY DISQUALIFY YOU FROM HOUSING OR, IF HOUSED, MAY RESULT IN AN EVICTION.

_____ _____

Applicant Signature Date

Please send the results to: _____ Email: _____

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and address of VA health care facility):

Cheyenne VA Medical Center
2360 East Pershing Blvd
Cheyenne, WY 82001

LAST NAME-FIRST NAME-MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

SSVF Programs, Housing Authorities, Day and Emergency Shelters, Continuum of Care, HMIS, Lead, Mental Health Agencies, and other Community Partner Organizations and agencies in Wyoming who provide outreach, resources, services, and assistance to persons experiencing homelessness.

PURPOSE(S) OR NEED: Information is to be used by the organization or individual for

☐ Treatment ☐ Benefits ☐ Legal ☐ Employment ■ Other – Please specify._____

Coordination of care related to housing assistance and/or other community services.

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ Health Summary (prior 2 years)
☐ Inpatient Discharge Summary (dates): _____
☐ Progress Notes:
  ☐ Specific clinics (name & date range): _____
  ☐ Specific providers (name & date range): _____
  ☐ Date range: _____
☐ Operative/Clinical Procedures (name &date): _____
☐ Lab results:
  ☐ Specific tests (name & date): _____
  ☐ Date range: _____
☐ Radiology Reports (name & date): _____
☐ List of Active Medications
☐ Flu Vaccination (dose, lot number, date & location)
■ Other (describe below):

Verbal sharing of information (Housing hx, financial, employment, legal, medical, mental health, family/social supports. Future information included.

LAST NAME-FIRST NAME-MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize the Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization:

☐ Drug Abuse ☐ Alcoholism or Alcohol Abuse ☐ Sickle Cell Anemia
☐ Human Immunodeficiency Virus (HIV)

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion, or because a condition of VA employment mandates the signing of this authorization. The information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any information disclosed per this authorization may no longer be protected by Federal confidentiality laws or regulations and may be subject to re-disclosure by the recipient.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire

☐ After one-time disclosure, if all needs are satisfied
■ On _____ (enter a future date other than date signed by patient)
☐ Under the following condition(s):_____

PATIENT SIGNATURE	DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable)	**DATE (mm/dd/yyyy)**

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

Type and Extent of Material Released:

Date Released:	Released by: