GPD-BH Referral Checklist

This checklist needs submitted with the GPD-BH referral packet. Please provide copies of supporting documentation for the items listed below if Veteran has them available. If the Veteran does not have the documents on hand, please provide information on what steps are being taken in order to obtain these items. Veterans need to be in the process of being document ready to be considered for the GPD-BH program. These steps will help streamline the housing process once Veterans are enrolled in programming. Please reach out to Jenna Lenhardt, LCSW, GPD Liaison if you have questions (307-920-1172).

Identification

- State ID
  - ☐ Yes
  - ☐ No - Please describe steps taken to obtain this documentation:

    _____
- VA ID
  - ☐ Yes
  - ☐ No - Please describe steps taken to obtain this documentation:

    _____

Social Security Card

- ☐ Yes
- ☐ No - Please describe steps taken to obtain this documentation:

  _____

Income Verification

- Please list all forms of income: _____
  - ☐ Yes
  - ☐ No - Please describe steps taken to obtain this documentation:

    _____

Bank Statements (if Veteran has a checking or savings account)

- ☐ Yes
- ☐ No - Please describe steps taken to obtain this documentation:

  _____

SELF SUFFICIENCY OF LARAMIE COUNTY

EQUAL HOUSING OPPORTUNITY

Community Action of Laramie County, Inc.
1920 Evans Avenue
Cheyenne, Wyoming 82001
(307) 635-9291

Application

Check what program(s) are you applying for?

Date: _____

☐Housing ☐Project Hope ☐COVID Relief ☐Veteran GPD Program

☐Guardianship ☐Adult Glasses ☐Children's Glasses

Applicant Information*:

Name		**SSN**	
Birth Date		**Gender**	
Phone		**Disabled**	☐Yes ☐No
Email		**Veteran**	☐Yes ☐No ☐Active
Education	☐0-8 ☐12+ Some Post-Secondary ☐College Grad ☐9-12 Non Graduate ☐GED ☐High School Grad ☐Graduate of other Post-Secondary	**Race**	☐American Indian or Alaskan Native ☐Asian ☐Biracial/Multi-Racial ☐Black or African American ☐Native Hawaiian or other Pacific Islander ☐White ☐Other
Work Status	☐Full Time ☐Part Time ☐Seasonal ☐Retired ☐Not in Labor Force ☐Unemployed Less than 6 months ☐Unemployed More than 6 months	**Ethnicity**	☐Hispanic or Latino ☐Not Hispanic or Latino
Health Ins.	☐None ☐Direct Purchase ☐Military ☐Medicare ☐Medicaid ☐State Children ☐State Adult ☐Employment Based ☐Other	**Marital Status**	☐Married ☐Single ☐Divorced ☐Domestic Partner ☐Separated ☐Widowed

**For households with more than one person, please request additional household member forms.*

Total number of people in the household:_____

Residency History:

Are you currently Homeless? ☐Yes ☐No

Current Address:_____ City. State, Zip:_____

☐Rent ☐Own ☐Other:_____ From (date):_____ To:_____

Landlord's Name:_____ Landlord's Phone:_____ Rent: $_____

Previous Address:_____ City. State, Zip:_____

☐Rent ☐Own ☐Other:_____ From (date):_____ To:_____

Landlord's Name:_____ Landlord's Phone:_____ Rent: $_____

Income Sources:

Source		Gross Amount	Household Member(s) Receiving Income
Employment:	☐Yes ☐No	$_____	_____
SSDI/SSI:	☐Yes ☐No	$_____	_____
Retirement/Pension:	☐Yes ☐No	$_____	_____
Unemployment:	☐Yes ☐No	$_____	_____
Child Support:	☐Yes ☐No	$_____	_____
TANF:	☐Yes ☐No	$_____	_____
Worker's Compensation:	☐Yes ☐No	$_____	_____
Recurring Contribution:	☐Yes ☐No	$_____	_____
Alimony:	☐Yes ☐No	$_____	_____
VA Disability:	☐Yes ☐No	$_____	_____
VA Retirement:	☐Yes ☐No	$_____	_____
Active Duty Pay:	☐Yes ☐No	$_____	_____
Other:	☐Yes ☐No	$_____	_____

Does any household member have any assets (this includes checking or savings account, IRAs, CDs, Bonds, Real Estate, etc)? ☐Yes ☐No

Type of Asset	Balance/Value	Institution	Asset Owner
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone in your household disposed of any asset(s) in the past twenty-four (24) months? ☐Yes ☐No

If yes, explain:_____

Briefly describe your situation and how Community Action can assist you:

_____

_____

_____

_____

_____

Program Specific Information:

The following information is only needed if you are applying for Transitional Housing or Project Hope:

Does anyone in your household have a criminal history? ☐Yes ☐No

If yes, list name(s) and crime(s) w/date:_____

_____

Do you have pets? ☐Yes ☐No If yes, how many? _____

Are any of these pets Service Animals/Emotional Support Animals? ☐Yes ☐No

Is there documentation? ☐Yes ☐No

Is the household composition expected to change in the next year (absent spouse, absent child, roommate, etc)?

☐Yes ☐No If yes, explain: _____

Are there any students in the household? ☐Yes ☐No

Is any household member's student status expected to change in the next year? ☐Yes ☐No

List students in household:_____

The following information is only needed if applying for the Veteran Housing Services

Branch of Service:_____ VI-SPDAT Score:_____

Discharge Status:_____

Have you previously stayed in a GPD Program? ☐Yes ☐No If yes, how many times before? _____

HUD-VASH Case Manager Name:_____ VOANR Case Manager Name:_____

If there is a waitlist for a program, your name will not be added to the waitlist until all documentation is turned in.

Under penalty of perjury, I certify that the information presented in the application is true and accurate to the best of my knowledge. The undersigned further understand(s) that providing false information herein constitutes an act of fraud. False, misleading or incomplete information will result in denial of my application for services.

Head of household's Signature:_____ Date:_____

Other adult's Signature:_____ Date:_____

To be filled out by Community Action staff:
Date all documentation is received: Staff Initials:

Please turn in the required documentation when you submit your application

- ☐ Picture ID for each adult (18+)
- ☐ Social Security Card or Birth Certificate for each household member
- ☐ Income for the past 2 months (Paystubs, SSDI/SSI Award Letter, TANF, Child Support, Unemployment, SNAP, Workers Compensation, VASC, Retirement, etc)
- ☐ Two months of Checking Account, Savings Account, pay card, benefit card, etc.
- ☐ Lease, mortgage, letter of residency from friend or shelter, hotel receipts
- ☐ Verification of current monthly expenses (Black Hills Energy, Board of Public Utilities, WiFi, phone bill, car payment, car insurance, medical bills, credit cards, etc)
- ☐ Eviction Notice if applicable

Required documents for specific programs

- ☐ If applying for COVID assistance: proof of how you were financially impacted by COVID (Ex. quarantined without pay or lost your job due to COVID)
- ☐ If applying for Transitional Housing, we need SIX (6) months of bank statements (checking and savings) and proof of all assets.
- ☐ If applying for housing or Project Hope, each adult (18+) needs to complete the background check authorization

The application process will not be completed until all required documentation is turned in. If you have questions about specific documents, please call Community Action of Laramie County as there may be a form we can use in place of a required document.

Community Action of Laramie County, Inc.
1920 Evans Avenue
Cheyenne, WY 82001
307-635-9291

SELF SUFFICIENCY
OF LARAMIE COUNTY

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* and *Project Hope*. 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.

*Name (Last, First, M.I.): **Please Print Clearly**

_____

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

_____

*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 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

**Community Action Staff*

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 information needed 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 the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 24VA10A7 "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 NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

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 requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☒ OTHER *(Please specify)* Care Coordination

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)*: Verbal and encrypted email sharing of information re: housing/care needs

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

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

I request and authorize 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 and that 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 disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

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 *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*

LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY: