



DOOR OF HOPE

Door of Hope Housing Application

Application process may take about 3 days after all information requested is received by the Director.

The following items are also needed to complete the application/eligibility process.

- 1) A picture ID (driver license, bus card or city ID)
- 2) Proof of Income (social security award letter, pension, employment, etc.)
- 3) Proof of Homelessness (verification letter from a shelter, or an approved agency)

Door of Hope Housing Application

Housing

Type of housing offered: (Please Circle) Pilgrims Rest (747 Court) Group Home Door of Hope (669 Madison) Single Room Occupancy Permanent Supportive Housing(on-site) COC referred (245 N. Bellevue)

APPLICANT INFORMATION

Name:

Date of birth: _____ SSN: _____ Phone: _____
 Current address/Location: _____ Income: (Please Circle) Yes or No Amount: \$ _____
 City: _____ State: _____ Zip Code: _____
 Marital Status: (Please Circle) Single, Married, Divorced Gender: (Please Circle) Female Male Transgender How Long? _____
 Do you have any misdemeanors or Felonies? (Please Circle) Yes or No Age: _____
 Have you ever served in the U.S. Military? (Please Circle) Yes or No Education Level: _____ Race: _____

Emergency Contact

Name of Contact: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Relationship: _____ Can we contact them: (Please Circle) Yes or No

Mental Health Provider

Name: _____ Phone: _____ Fax: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Diagnosis: _____ Case manager Name: _____ Phone: _____

Physical Health Provider

Name: _____ Phone: _____ Fax: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Diagnosis: _____ Case manager Name: _____ Phone: _____

Homeless Information

Name: _____ Phone: _____
 Shelter Address: _____ City: _____ State: _____ Zip Code: _____
 How Long: _____ E-mail: _____ Fax: _____

Referral Agency

Name: _____ Address: _____ Phone: _____
 Agency Rep Name: _____ Phone: _____ Email: _____ Fax: _____
 Agency Rep Signature: _____ Date: _____
 Applicant Signature: _____ Date: _____

Certification and Agreement

I certify that all the information above is complete, correct and true to the best of my knowledge. I understand that false or misleading information may result in the rejection of my application. I also understand that completion of this application in no way guarantees me that I will received housing. Furthermore, I give permission to check any information and/or references obtained. All information will be verified by the Door of Hope Director prior to an applicant interview. I authorize the verification of the information provided on this form. All applicants must meet established selection criteria and pass background check. I have received a copy of this application.

Applicant Signature _____

_____ Date

Manager/Director Approval or Denial

Deposition: Approved Denied Approved/Denied Date: _____
 Approved Date: _____ Denial Date: _____ Notified Date: _____

Door of Hope

Background Check Authorization

(Please Print)

Name: (First) _____ (Middle) _____ (Last) _____

Current Address Since: _____

(City) _____ (State) _____ (Zip) _____

Social Security Number: _____ DOB: _____

Telephone Number: _____ Driver's License Number/State: _____

The information contained in this application is correct to the best of my knowledge.

I hereby authorize Door of Hope, Inc and its designated agents or representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for visitation of clients and/or application process. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: credit reports, current and previous residences; civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions and any other public records. I further authorize any individual, company, firm, corporation, or public agency to divulge all information, verbal or written, pertaining to me, to Door of Hope, Inc or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. Door of Hope, Inc and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner to protect the visitor or applicant's personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: _____ Date: _____



MEMPHIS/SHELBY COUNTY MANAGEMENT INFORMATION SYSTEM (MSCCOC-MIS)

CLIENT CONSENT FORM

IMPORTANT: Do not enter personally identifying information into MSCCOC-MIS 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. *If this applies to you, **STOP- Do Not Sign this Form.***

This agency participates in the Memphis/Shelby County Management Information System (MSCCOC-MIS) by collecting information, over time, about the characteristics and service needs of men, women, and children experiencing homelessness or at-risk of homelessness.

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 Memphis/Shelby County. In order to make sure that clients are not counted twice if services are provided by more than one agency, we need to collect some personal information. Specifically, we need: name, birth date, social security, race, and last permanent zip code. Your information will be stored in our database for 7 years.

- The data you provide will be combined with data from other providers providing housing, shelter, and supportive services 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 in the research division who have signed confidentiality agreements will be able to see this information.
- Your decision to participate in the MSCCOC-MIS 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, shelter or housing. However, if you do choose to participate, services in the city/county may improve if we have accurate information about homeless individuals and the services they need.
- We will guard this information with strict security policies to protect your privacy. Our computer system is highly secure and uses up-to-date protection features such as data encryption, passwords, and identity checks required for each system user. If you ever suspect the data in MSCCOC-MIS has been misused, immediately contact the MSCCOC-MIS Administrator (Tanyce A. McCray0Davis) at tanyce@cafth.org or call (901) 527-1302 Ext. 306.

I consent to the inclusion of personal information in MSCCOC-MIS about me and any dependents listed below. I understand that my personal 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.

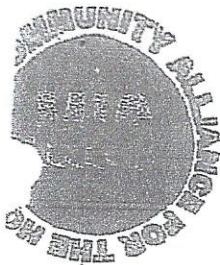
Dependent children under 18 in household, if any (Please print below):

CLIENT SIGNATURE (PARENT/GUARDIAN)

DATE

CLIENT NAME

STAFF NAME



Community Alliance, Management Information Systems Department
 Tanyce A. McCray-Davis, System Manager/HMIS Sys. Adm. II
 *(901) 527-1302 Office * (901) 527-1308 Fax * (901) 652-2678 Cell*
 tpathinc@bellsouth.net

Client Authorization to Release and Exchange Information

Name of Agency:	Program:			
Client's Last Name:	First Name:		Middle Initial:	
Date of Birth:	SSN:			

I understand that all information gathered about me is personal and private and that I do not have to participate in the MIS. I also understand that if I participate, I may make a request to this agency stating that I no longer want to participate in the MIS and from that date forward my information will no longer be shared. This release will remain in force for (determined by agency) months/years from today and will expire on _____ (MM/DD/YYYY).

This release authorizes the following data to be exchanged among MIS user agencies:

<u>Date and Time of Intake into the HMIS</u>	<u>Permission to Release Information</u>
First Name, Middle Initial, Last Name	Household Relationships
Social Security Number	Housing Location (as of last night)
Date of Birth/Birthday	Zip Code of Last Permanent Residence
Gender	Whether you are a U.S. Military Veteran
Race	Highest Level of Education Attained
Ethnicity	Income and Sources/Non-Cash Benefits
Marital Status	Medical Insurance Status
Program Entry	Disabling Condition/Disabilities/Illness, including physical/mental health, and/or substance abuse
Emergency Contact: Person, Phone Number, & Relationship	Whether you are a victim of domestic violence
Whether you are homeless?	Exit Date
Whether you are chronically homeless	Destination once you leave the Program
Housing Status	

The above basic identifying, confidential, and non-confidential information will be shared with other MIS user agencies who will assist you.

I authorize that a copy of this original form will serve as an original for the purposes stated above.

 Client's Authorizing Signature

 Date (MM/DD/YYYY)

 Agency Representative's Signature

 Date (MM/DD/YYYY)

✓ Description for Informed Decision: Verbal Explanation _____ Interpreter _____ Written _____