



915 SW 3rd Ave.
Ontario, OR 97914
PH. (541) 889-9555
Fx. (541) 889-0768

Housing Intake Application

YOU ARE REQUIRED TO COMPLETE EVERY PAGE OF THE APPLICATION AT THE TIME OF APPOINTMENT OR WHEN SUBMITTING YOUR APPLICATION.

Inability to submit the following documents with your Application may result in a delay of services

1. **PROOF OF IDENTIFICATION** -for all adults 18 and older
2. **SOCIAL SECURITY CARDS(S)**-for all members in the home
3. **PROOF OF INCOME:** If you receive income, please look through the following examples of what to submit (BEFORE deductions) for all household members for the last 30 days
 - A. **Social Security:**
 - Copy of the Benefit/Award Verification letter for the current year.
 - If you are unable to locate your Benefit Verification letter, you may obtain a copy from the Social Security Office by calling **1-866-403-8016** or logging into www.socialsecurity.gov. **You must provide your 2022 Benefit letter if applying in 2022.**
 - B. **Unemployment Benefits:**
 - Printout, with your name on it, from the Oregon/Idaho Employment Department.
 - C. **Wages:**
 - Pay stubs for the most recent 30 days. This must list GROSS wage amounts (BEFORE TAXES)
 - D. **Retirement, Pension, Veteran's, and/or Other Benefits:**
 - Recent/Current award letter covering the last 30 days.
 - E. **Child Support and/or Alimony:**
 - Current/Recent letter from the state office in Pendleton or into www.justice.oregon.gov
 - F. **Food Stamp and/or TANF Verification Award Letter**
4. **Lease Agreement** – if you have one, including the eviction notice if you have received one.

PART TWO: Your Housing Status and Housing Goals

Your household is best described as —

- | | | |
|---|--|--|
| <input type="checkbox"/> Single Parent - Female | <input type="checkbox"/> Single Parent – Male | <input type="checkbox"/> Single - Female |
| <input type="checkbox"/> Two Adults / Children | <input type="checkbox"/> Single - Male | <input type="checkbox"/> Unaccompanied Youth |
| <input type="checkbox"/> Two Adults / No Children | <input type="checkbox"/> Extended Family-(living with relatives) | <input type="checkbox"/> Grandparents and children |

Do you currently receive rental assistance subsidies? _____

Household Size – Including yourself, how many total people live in your household? (Check **one box)**

- 1
 2
 3
 4
 5
 6
 7
 8+

List all additional members of your household (NOT including yourself), using legal name for each member as it appears on his/her Social Security Card or INS documents.

Name & Gender <i>Last, First</i>	Relationship to Head of Household	Personal Information	Race* (Select as many as apply)	Ethnicity*	Disability	Disability Type* (if applicable)	Receiving Disability Treatment	Social Security Number
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Gender		DOB: _____ Age: _____ School Attending: _____ Last grade attended: __	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Yes <input type="checkbox"/> No Diagnosed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Drug Abuse <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Illness <input type="checkbox"/> Physical/Medical <input type="checkbox"/> Physical/Mobility <input type="checkbox"/> Other disability not listed <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No Provider: _____	- - -or- <input type="checkbox"/> I don't know or don't have one <input type="checkbox"/> I choose not to provide the SSN.
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Gender		DOB: _____ Age: _____ School Attending: _____ Last grade attended: __	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Yes <input type="checkbox"/> No Diagnosed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Drug Abuse <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Illness <input type="checkbox"/> Physical/Medical <input type="checkbox"/> Physical/Mobility <input type="checkbox"/> Other disability not listed <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No Provider: _____	- - -or- <input type="checkbox"/> I don't know or don't have one <input type="checkbox"/> I choose not to provide the SSN.
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Gender		DOB: _____ Age: _____ School Attending: _____ Last grade attended: __	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Yes <input type="checkbox"/> No Diagnosed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Drug Abuse <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Illness <input type="checkbox"/> Physical/Medical <input type="checkbox"/> Physical/Mobility <input type="checkbox"/> Other disability not listed <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No Provider: _____	- - -or- <input type="checkbox"/> I don't know or don't have one <input type="checkbox"/> I choose not to provide the SSN.
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PART THREE: Income and Cash Benefits

<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Gender	DOB: _____ Age: _____ School Attending: _____ Last grade attended: ____	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Yes <input type="checkbox"/> No Diagnosed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Drug Abuse <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Illness <input type="checkbox"/> Physical/Medical <input type="checkbox"/> Physical/Mobility <input type="checkbox"/> Other disability not listed <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No Provider: _____	- or - <input type="checkbox"/> I don't know or don't have one <input type="checkbox"/> I choose not to provide the SSN.
--	--	--	--	--	--	--	--

Has any member of the household received any **income or cash benefits** in the last 30 days? Yes No

If yes, please indicate the monthly amount from each of the following sources:

Income Type	Gross Monthly Amount	Who?	Approx. Date Income Began	Income Type	Gross Monthly Amount	Who?	Approx. Date Income Began
Child Support	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Social Security Retirement	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
Earned Income Employer: _____ _____	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		SSDI	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
Pension	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		SSI	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
Self-Employment	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		TANF	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
List Asset (checking, savings, 401K, stocks/bonds, vehicle make and model, etc.):	Value \$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Unemployment	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
	Value \$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Veteran's Benefits	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
	Value \$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Worker's Compensation	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
				Other (financial aid, insurance settlement, etc.)	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	

If no income was received, where do you get \$ to pay your bills? _____

B. Non-Cash Benefits

Has any member of the household received any **non-cash benefits** in the last 30 days? Yes No

If yes, please indicate the monthly amount from each of the following sources:

Benefit Type	Monthly Amount, if known	Who?	Approx. Date Benefit Began	Benefit Type	Monthly Amount, if known	Who?	Approx. Date Benefit Began
Food Stamps (aka "SNAP")	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Other TANF-Funded Services	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
Medicaid	N/A	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Rental Subsidy (Section 8, HUD)	\$ _____	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
Medicare	N/A	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____					

SCHIP	N/A	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____					
Spec. Supp. Nutrition, aka WIC	N/A	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____					
VA Medical Services	N/A	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____					

Income Level — (Please circle the number closest to your annual gross income by the # in household)

1	2	3	4	5	6	7	8	AMI
\$17,000	\$20,440	\$25,820	\$31,200	\$36,580	\$41,960	\$47,340	\$52,720	30%
\$28,350	\$32,400	\$36,450	\$40,450	\$43,700	\$46,950	\$50,200	\$53,400	50%
\$45,300	\$51,800	\$58,250	\$64,700	\$69,900	\$75,100	\$80,250	\$85,450	80%

Employment Status of head of household (APPLICANT)

- Employed Full-Time
- Unemployed, receiving benefits
- Disabled, receiving benefits
- Employed Part-Time
- Unemployed, not receiving benefits
- Retired
- Employed Seasonally
- Self-Employed
- Other (Specify) _____

Most Recent Employer: _____ Dates of Employment: _____ to _____

Address: _____ Work Phone: _____
 Address City/State Zip

Previous Employer: _____ Dates of Employment: _____ to _____

Address: _____ Work Phone: _____
 Address City/State Zip

Employment Status of other adult in home:

- Employed Full-Time
- Unemployed, receiving benefits
- Disabled, receiving benefits
- Employed Part-Time
- Unemployed, not receiving benefits
- Retired
- Employed Seasonally
- Self-Employed
- Other (Specify) _____

Most Recent Employer: _____ Dates of Employment: _____ to _____

Address: _____ Work Phone: _____
 Address City/State Zip

Previous Employer: _____ Dates of Employment: _____ to _____

Address: _____ Work Phone: _____
 Address City/State Zip

PART FOUR: Participation Agreement

Participation Agreement: *Actively participate in activities *Maintain confidentiality about discussions that occur in counseling sessions *Attend one-on-one appointments on time * Work to meet goals set during counseling sessions

Printed Name _____ Signature _____ Date _____

Printed Name (co-applicant) _____ Signature _____ Date _____

Intake Specialist Name _____ Signature _____ Date _____

_____ (please initial) I certify that I have received the following HUD required documents:

- *LED-Based paint information *10 questions to ask an inspector *For your protection, get a home inspection
- *Fair housing/fair lending

PART FIVE: Your Rental and Mortgage Information

If you are currently renting, how long have you been renting? _____ Years _____ Months

Please check all that apply:

<input type="checkbox"/> I pay market rent	<input type="checkbox"/> I receive a rent subsidy and/or public housing resident	<input type="checkbox"/> I am a Section 8 recipient
<input type="checkbox"/> I am facing eviction	<input type="checkbox"/> I am delinquent with my rent and need assistance	<input type="checkbox"/> I am delinquent with utilities and need assistance
<input type="checkbox"/> I am interested in filing a fair housing claim. Specify reason(s):		

If you own your property, do you have a mortgage? YES NO IF YES, please answer the questions below.

My mortgage data		
	First Mortgage	Second Mortgage
Is this loan current or delinquent?	<input type="checkbox"/> Current <input type="checkbox"/> Delinquent	<input type="checkbox"/> Current <input type="checkbox"/> Delinquent
Mortgage server name		
Loan Number	# _____ <input type="checkbox"/> I don't know	# _____ <input type="checkbox"/> I don't know
Loan Balance	\$ _____ <input type="checkbox"/> I don't know	\$ _____ <input type="checkbox"/> I don't know
Interest Rate	_____ % <input type="checkbox"/> I don't know	_____ % <input type="checkbox"/> I don't know
Monthly Principal and Interest Payment (excluding taxes and insurance)		
Fixed or Adjusting Interest Rate?	<input type="checkbox"/> Fixed <input type="checkbox"/> Adjusting <input type="checkbox"/> I don't know	<input type="checkbox"/> Fixed <input type="checkbox"/> Adjusting <input type="checkbox"/> I don't know
Date you made your last payment:	____ / ____ / ____	____ / ____ / ____
Private Mortgage Insurance (PMI) payment	\$ _____	\$ _____
Past Due Amount:	\$ _____	\$ _____
Have you previously applied for a loan modification or forbearance? If yes, please provide details on the outcome of your previous foreclosure prevention effort here:→	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Reason for Default:		
<input type="checkbox"/> Divorce <input type="checkbox"/> Disability <input type="checkbox"/> Marital Separation <input type="checkbox"/> Decrease in income <input type="checkbox"/> Increase in expenses <input type="checkbox"/> Medical Hardship		

Other (specify) _____

Please provide additional remarks about your hardship here:

Has your hardship ended? YES NO

Do you have the ability and willingness to resume mortgage payments? YES NO

If NO, are you seeking an alternative outcome, Explain:

Questions related to your credit history:

1. Are there any outstanding judgements against you? YES NO

2. Have you declared bankruptcy within the past seven years? YES NO I am currently in a bankruptcy plan.

3. Within the past seven years, have you had a property foreclosed or surrendered through a deed-in-lieu? YES NO

PART SIX: Your Income, Debt, and Average Monthly Expenses

Monthly Spending Plan for Month of _____ 20__

Monthly Income		
Item	Gross	Net
Earned Income 1		
Earned Income 2		
SSI/SSDI		
Unemployment Ins.		
Child Support		
Food Stamps		
Other		
Subtotal		

Children Expense	
Item	Monthly Pmt
Child Care	
Toys/Games	
Other	
Subtotal	

Insurance	
Item	Monthly Pmt
Vehicle Insurance	
Homeowner/Renter	
Health	
Life	
Subtotal	

Housing		
Item	Arrearages	Monthly Pmt
Mortgage/Rent		
Taxes		
Water/Sewer		
Electric		
Gas		
Garbage		
Cable		
Internet		
Phone		
Other		
Subtotal		

Food	
Item	Monthly Amount
Groceries	
Eating Out	
Other	
Subtotal	

Miscellaneous	
Item	Monthly Amount
Entertainment	
Clothing	
Household	
Personal Care	
Medical	
Pet Care	
Other	
Subtotal	

Transportation		
Item	Arrearages/Total	Monthly Pmt
Vehicle Payment 1		
Vehicle Payment 2		
Fuel		
Maintenance		
Other		
Subtotal		

Assets	
Item	Current
Savings	
Checking	
Other	
Other	
Total	

Loans		
Item	Total Balance	Monthly Pmt
Credit Card 1		
Credit Card 2		
Credit Card 3		
Payday Loan		
Student Loan		
Title loan		
Collections Accts.		
Other		
Subtotal		

Monthly Budget	Amount
Total Income	
Total Expenses	
Monthly Difference	+/-

Circle Budget Type: (Standard) (Crisis)

Landlord/Lease Information Form

Property Manager/Landlord Name: _____

Landlord Phone Number: _____

Landlord Email Address: _____

Do you have a lease/rental agreement: Yes No

Lease Start Date: _____

Lease End Date: _____



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 www.communityinaction.info

CONSENT TO EXCHANGE INFORMATION

I, _____, understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing Community in Action and any other agencies, including but not limited to those listed below, to exchange certain information for the purpose of working together effectively to provide or coordinate services or benefits, determine eligibility, and as needed for verification purposes for myself and any children for whom I am parent and/or legal guardian.

Names of Agencies and/or Entities

Cascade Natural Gas
 Cities of Ontario, Nyssa, and Vale
 Housing Stability Counseling Program (HSCP)
 Department of Human Services (DHS)
 Employers (Previous and Current)
 Community Action Partnerships of Oregon
 Head Start
 Housing Authority of Malheur County
 HUD
 Idaho Power
 Landlord (Previous and Current)
 Lifeway's
 Malheur County Departments
 Community in Action Network

Ontario Police Dept./Law Enforcement
 Oregon Housing and Community Services
 Oregon Human Development Center (OHDC)
 Physicians and Other Medical Institutions
 Project Dove
 School District Staff
 Senior and Disabled Services Division
 Social Security Administration
 State Employment Agencies
 State Oregon Health and Human Services
 Training and Employment Consortium (TEC)
 TFP Therapeutic Services
 Other: _____

Any and all providers of services of any kind (Including educators) for my minor children: _____

I understand that my records are protected under the Privacy Act and/or other State and Federal laws and regulations, and they cannot be disclosed without written consent unless otherwise provided for in the regulations. I also understand that I may withdraw this consent at any time, except to the extent that any actions have been taken in reliance on it. This consent expires two years after the closure of my case.

I consent to allow Housing Stability Counseling Program (HSCP) to submit client-level information to the ORS, to allow HSCP to open files to be reviewed for program monitoring and compliance purposes, and to allow HSCP to conduct follow-up with the client related to program evaluation.

PRINT: _____ SIGNATURE: _____ DATE: _____

LAST FOUR OF SOCIAL: _____



This Agency Uses **SERVICEpoint™**

Cloverleaf®

Notice to Clients of Uses & Disclosures Privacy Notice

- Our agency enters personal and demographic information about you into a computerized record-keeping system.
- The information is used to plan delivery of services & to provide statistical information for setting goals.
- Information you provide will be used for administrative and operational purposes to improve, provide & coordinate services that can be offered you.
- Information you provide will be used for functions related to payment or reimbursement for services, monitor program effectiveness, and to prepare reports and statistical information without personal identifying information.
- If you have safety concerns, you may not want personal information entered into the system, you should discuss this with a staff member.
- Personally, identifying information may be seen by staff members who provide you with services, select community service providers when appropriate, and a small number of people (ie: system administrators or program funders) who maintain the computerized record-keeping system, except as required by law.
- You will not be denied services, if you refuse to consent to share data.
- You have the right to see your record and to ask that it be corrected.
- You have the right to file a grievance if you feel you have been harmed in some way by the use of the computerized data system.

I acknowledge that I have read and signed this release of information for the agency to use as needed.

Signature _____ Date _____

Other Adult Signature _____ Date _____

© THIS IS NOT A COMPLETE STATEMENT OF YOUR INFORMATION RIGHTS. For a complete statement of your information rights, please ask a staff person for a copy of our Privacy Policy. If you have any questions about our computerized record-keeping system and how it might affect you, feel free to talk about your concerns with a staff member. NW SOCIAL SERVICE CONNECTIONS HMIS Privacy Notice to Clients Legal Review Oct /2011 Released 10/13/2011

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Burns, OR 97720
(541) 573-6024 ex:27
Fax (541) 573-6025
www.CommunityinAction.info



Conflict of Interest Disclosure

Community in Action serving Malheur and Harney Counties is a HUD Approved Housing Counseling Agency. Our office is located at 915 SW 3rd Ave., Ontario OR. We are open Monday through Thursday 9 am – 4 pm and Friday 9am – 12pm.

Community in Action provides the following services:

- Information and Referrals
- Rental Assistance Programs
- Homeless Prevention and Rapid Rehousing
- Energy Assistance Programs and Education
- Weatherization Programs
- Homeownership and Foreclosure Prevention

Community in Action provides a wide-range of Housing Counseling Services in Malheur County that include:

- Counseling in the areas of Rental Topics, Pre-Purchase, Post-Purchase, Down Payment Assistance, Individual Development Accounts/VIDA, Financial Literacy
- Down Payment Assistance
- Individual Development Accounts/VIDA
- Financial Literacy/Budgeting

Group Education Classes and Workshops

- Ready to Rent: 6-hour education course
- Realizing the American Dream: 8-hour pre-purchase education class
- Post-Purchase
- Homeless Prevention
- Financial Literacy
- Pre-purchase homeownership orientation workshop including 15 steps to homeownership topics

Online Homebuyer Education Programs/IDA Education Programs

- Money Smart
- eHome America: Online Pre-Purchase Education Course
- eHome America Post-Purchase Homeowner Education Course

Community in Action receives State and Federal funding from the following sources:

- Housing and Urban Development (HUD)
- Rural and Community Assistance Corporation (RCAC)
- Oregon Housing and Community Services (OHCS)
- Community and Shelter Assistance Corporation (CASA)
- Rural Oregon Continuum of Care (ROCC)
- United States Department of Agriculture (USDA)

Community in Action Partnering Organizations, Agencies, and Businesses:

~Community Action Partnerships of Oregon ~Housing Authority of Malheur County ~Oregon Housing and Community Services ~Oregon Human Development Center ~Cities of Ontario, Nyssa, and Vale ~Credco ~Oregon Department of Human Services ~Cascade Natural Gas ~HUD ~Idaho Power ~Lifeway’s ~Malheur County Departments ~Ontario Police Department ~Malheur County Sheriff’s Department ~ Malheur County Veteran Service Officer ~Physician’s and Medical Institutions ~Project Dove ~Department of Human Services (DHS) ~Ontario School District Staff ~Senior and Disabled Services ~Social Security Administration ~State Employment Agencies ~State of Oregon Health and Human Services ~Training and Employment Consortium ~TFP Therapeutic Services ~Community in Action Network ~Treasure Valley Community College ~Area Real Estate Agencies ~Area Landlords ~Head Start of Malheur County ~Malheur County Financial Institutions ~ Worksource Oregon ~Fair Housing Council of Oregon ~Oregon Law Center ~Boys and Girls Club of Ontario ~Oregon Food Bank ~Four Rivers Health Care DBA Community Building Supply

Other:

Any and all providers of services of any kind (including educators) for my/our minor children:

I/We acknowledge that I/we have received a copy of the Community In Action Privacy Policy, and that I/we are not obligated or required to utilize any program or assistance which is available from Community in Action or its partners. Participation in any one program does not obligate me/us to participate in another, although I am/we are welcome to do so. I/We further understand that participation in Community in Action counseling activities does not in any way obligate me/us to use Community in Action’s referred lenders, realtors, or business partners.

I/We understand that records are protected under the Privacy Act and/or other State and Federal laws and regulations, and they cannot be disclosed without written consent unless otherwise provided for in the regulations. I/We also understand that I/we may withdraw this consent t any time, except to the extent that any actions have been taken in reliance on it.

SIGNATURE: _____ SIGNATURE: _____

Print Name: _____ Print Name: _____

Date: _____ Date: _____

PRIVACY POLICY

Community in Action is committed to assuring the privacy of individuals and/or families who have contacted us for assistance. We realize that the concerns you bring to us are highly personal in nature. We assure you that all the information shared both orally and in writing will be managed within legal and ethical considerations. Your "nonpublic personal information," such as your total debt information, income, living expenses and personal information concerning your financial circumstances, will be provided to creditors, program monitors, and others only with your authorization and signature. We may also use anonymous aggregated case file information for the purpose of evaluating our services, gathering valuable research information and designing future programs.

Community in Action has a grievance [policy](#) and you can request a copy of it at any time from our agency or you can download it from our website.

TYPES OF INFORMATION THAT WE GATHER ABOUT YOU

1. Information we receive from you orally, on application or other forms, such as your name, address, social security number, assets, and income.
2. Information about your transactions with us, your creditors, or others, such as your account balance, payment history, parties to transactions and credit card usage; and
3. Information we receive from a credit reporting agency, such as your credit history.

YOU MAY OPT-OUT OF CERTAIN DISCLOSURES

1. You have the opportunity to "opt-out" of disclosures of your nonpublic personal information to third parties (such as your creditors), that direct us not to make those disclosures.
2. If you choose to "opt-out", we will not be able to answer questions from your creditors. If at any time, you wish to change your decision [with regard to](#) your "opt-out", you may call us at 541-889-9555 ext. 103 and do so.

RELEASE OF YOUR INFORMATION TO THIRD PARTIES

1. So long as you have not opted out, we may disclose some or [all of](#) the information that we collect, as described above, to your creditors or third parties where we have determined that it would be helpful to you, would aid us in counseling you, or is a requirement of grant awards which make our services possible.
2. We may also disclose any nonpublic personal information about you or former customers to anyone as permitted by law (e.g., if we are compelled by legal process)
3. Within the organization, we restrict access to nonpublic personal information about you to those employees who need to know that information to provide services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

I acknowledge that I received a copy of Community in Action's Privacy Policy.

1. I may be referred to other housing services of the organization or another agency or agencies as appropriate that may be able to assist with [particular concerns](#) that have been identified. I understand that I am not obligated to use any of the services offered to me.
2. A counselor may answer questions and provide information, but not give legal advice. If I want legal advice, I will be referred for appropriate assistance.
3. I understand that Community in Action provides counseling and education on loss mitigation, credit/budget management, individual development accounts, loan products, homebuyer education/counseling, post-purchase and financial fitness classes. Community in Action currently does not have any financial relationships with industry partners. I further understand that the housing counseling I received from Community in Action in no way obligates me to choose any of these [particular housing programs](#).

I authorize Community in Action Housing Center to:

Obtain a copy of the FINAL HUD-1 Settlement Statement, Appraisal, and Real Estate Note(s) when I purchase a home, from the lender who made me/us a loan or the title company that closes the loan.

I/We understand that any intentional or negligent representation(s) of the information contained on this form may result in civil liability and/or criminal liability under the provision of Title 18, United States Code, Section 1001.

Applicant

Date

Co-applicant

Date



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HOMELESSNESS CERTIFICATION

This is to certify that the individual or household meets the eligibility for the following category of homelessness.

Please check below the box that most closely describes your current situation:

1. **Literally Homeless**-An individual or family who lacks a fixed, regular and adequate nighttime residence, meaning:
 - Has a primary nighttime residence that is a public or private place not meant for human habitation; or
 - Is living in a publicly or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels/motels paid for by charitable organizations or by federal, state, and local government programs); or
 - Is exiting an institution where he or she resided for 90 days or less AND who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

2. **Imminent Risk of Homelessness**-An individual or family who will imminently lose their primary nighttime residence, provided that:
 - Residence will be lost within 14 days of the date of the application for homeless assistance;
 - No subsequent residence has been identified; and
 - Lacks the resources or support networks needed to obtain other permanent housing.

3. **Homeless under other Federal Statutes**-Unaccompanied youth (under 25) or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
 - Are defined as homeless under another federal statute;
 - Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
 - Have experienced persistent instability as measured by two moves or more during the preceding 60 days; and
 - Can be expected to continue in such status for an extended period of time due to special needs or barriers.

4. **Fleeing/Attempting to Flee Domestic Violence**-Any individual or family who:
 - Is fleeing, or is attempting to flee, domestic violence;
 - Has no other residence; and

- Lacks the resources or support networks needed to obtain other permanent housing

5. At Risk of Homelessness (EHA/HTBA only)

- At risk of Homelessness** – Any individual or family who:

Category 1 – Individuals and Families

- a. Has an annual income below 30% of median family income for the area; AND
- b. Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the “homeless” definition; AND
- c. Meets one of the following conditions (**circle one**):
 - i. Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR
 - ii. Is living in the home of another because of economic hardship; OR
 - iii. Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR
 - iv. Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; OR
 - v. Lives in an SRO or efficiency apartment unit in which there resides more than 2 persons or lives in a larger housing unit in which there resides more than half persons per room; OR
 - vi. Is exiting a publicly funded institution or system of care; OR
 - vii. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient’s approved Con Plan

Category 2 – Unaccompanied Children and Youth

- a. A child or youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under another Federal statute

Category 3 – Families with Children and Youth

- a. An unaccompanied youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under section 725(2) of the McKinney-Vento Homeless Assistance Act, and the parent(s) or guardian(s) of the child or youth are living with him or her.

TO APPLY FOR HOUSING ASSISTANCE, please complete the following:

A. Where have you been living or staying up until today? Please check one:

- | | | |
|--|---|---|
| <input type="checkbox"/> Emergency Shelter (including hotel/motel voucher) | <input type="checkbox"/> Owned by me
<input type="checkbox"/> With Subsidy or <input type="checkbox"/> Without Subsidy | <input type="checkbox"/> Staying with Family |
| <input type="checkbox"/> Foster Care Home or Group Home | <input type="checkbox"/> Permanent Housing for Formerly Homeless Persons | <input type="checkbox"/> Staying with Friends |
| <input type="checkbox"/> Hospital (Non-Psychiatric) | <input type="checkbox"/> Psychiatric Hospital or Facility | <input type="checkbox"/> Substance Abuse Treatment Facility |
| <input type="checkbox"/> Hotel or Motel Paid Without Emergency Shelter Voucher | <input type="checkbox"/> Rental by me | <input type="checkbox"/> Transitional Housing |
| <input type="checkbox"/> Jail, Prison, or Juvenile Facility | <input type="checkbox"/> Subsidized | <input type="checkbox"/> Car |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Not Subsidized | <input type="checkbox"/> Prefer not to answer |
| | | <input type="checkbox"/> Other: _____ |

B. How long have you been staying in the situation above?

- | | | |
|--|---|---|
| <input type="checkbox"/> One week or less | <input type="checkbox"/> One to three months | <input type="checkbox"/> One year or longer |
| <input type="checkbox"/> More than one week, but less than one month | <input type="checkbox"/> More than three months, but less than one year | |

C. Why can you not continue to live there?

- | | | |
|--|--|--|
| <input type="checkbox"/> Violates Rental Agreement | <input type="checkbox"/> Hotel: can't pay | <input type="checkbox"/> 72-hour notice |
| <input type="checkbox"/> Asked to leave | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Court summons or eviction |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Violates: _____ | |

When are you required to be out?

- | | | |
|---|---|-------------------------------|
| <input type="checkbox"/> One week (within 7 days) | <input type="checkbox"/> Two weeks (within 14 days) | <input type="checkbox"/> ASAP |
|---|---|-------------------------------|

D. Where did you sleep last night?

- | | | |
|--|---|---|
| <input type="checkbox"/> On the street | <input type="checkbox"/> Hotel or Motel | <input type="checkbox"/> Staying with Family |
| <input type="checkbox"/> Emergency Shelter | Who paid for it?
_____ | <input type="checkbox"/> Staying with Friends |
| <input type="checkbox"/> Foster Care Home or Group Home | <input type="checkbox"/> Owned by me
<input type="checkbox"/> With Subsidy or <input type="checkbox"/> Without Subsidy | <input type="checkbox"/> Substance Abuse Treatment Facility |
| <input type="checkbox"/> Hospital (Non-Psychiatric) | <input type="checkbox"/> Permanent Housing for Formerly Homeless Persons | <input type="checkbox"/> Transitional Housing |
| <input type="checkbox"/> Jail, Prison, or Juvenile Facility | <input type="checkbox"/> Psychiatric Hospital or Facility | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Rental by me
<input type="checkbox"/> Subsidized <input type="checkbox"/> Not Subsidized | | <input type="checkbox"/> Car/Camp Trailer |

Number of bedrooms in Rental _____ Rent amount \$ _____

Utilities costs circle all that are paid by you (water, gas, power, garbage) \$ _____ estimate of all utilities

What is/was the zip code of your last permanent address? _____ Don't know Prefer not to answer

Are you/your household currently homeless? _____ Yes No

If yes, enter approximate date current homelessness started: _____ (mm/dd/yyyy)

How many times have you been homeless in the past three years? _____ Total # of months _____

Are you a survivor of domestic violence? Yes No Prefer not to answer

If yes: How long ago was the last incident?

- | | | |
|---|--|---|
| <input type="checkbox"/> Currently fleeing | <input type="checkbox"/> From six to twelve months ago | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Within the past three months | <input type="checkbox"/> More than one year ago | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Three to six months ago | | |

Have you, or a member of your household, served in the US Military? Yes No Prefer not to answer

Has any individual listed on Page 1 been charged or convicted of a crime?..... Yes No

If yes: List individual and most recent conviction date: _____

Has any individual been charged or convicted of a sex offense or illegal drug charge? Yes No

If yes: List individual and most recent conviction date: _____

Does any individual listed on Page 1 have a medical marijuana card? Yes No

Notice of Use.

Community in Action provides services through a variety of funding sources such as; Oregon Housing and Community Services, Rural Community Assistance Corporation, HUD, Department of Human Services, and private foundations. **Community in Action** is required to collect and report on certain information to account for how these funds are used. In addition, this information may aid the effort to end homelessness by demonstrating how many individuals and families in the area need services.

For this reason, you have been asked to provide the information on this form. The information you have provided will be entered into a Homeless Management Information System (HMIS) and used to provide statistical information about services provided to homeless persons (or persons at risk of homelessness) in **Malheur** County.

Your identifying information will be kept as confidential as possible: it will only be seen by persons employed by or volunteering with **Community in Action**, and persons administering or auditing the HMIS.

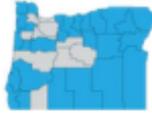
Statement of accuracy

Under penalty of perjury, I/we certify, through my/our signature below, that all information provided herein by me/us is true and accurate. I/we understand that providing false representations constitutes an act of fraud. False, misleading or incomplete information may result in termination of any assistance provided to me/us and may violate state and/or federal law resulting in criminal charges.

Completion of this document does not guarantee assistance. Consent to release information must be completed by all person's age 18+.

Signature of the Head of the Household

Date



**Rural Oregon
Continuum
Of Care**

**Homeless Management Information System (HMIS)
Informed Consent & Release of Information Authorization**

I, (print participant's name) _____, understand that (Service Provider) _____ collects information about me and/or my dependents listed below to enter it into a database system called Homeless Management Information System (HMIS). This database helps us to better understand homelessness, to improve service delivery to the homeless, and to evaluate the effectiveness of services provided to the homeless. Participation in data collection and release, although optional, is a critical component of our community's ability to provide the most effective services and housing possible. The information that is collected in the HMIS database is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with the standards set forth by federal, state, and local regulations governing confidentiality of client records. Every person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information.

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

The information gathered and prepared by this agency will be included in a HMIS database of the Rural Oregon Continuum of Care (ROCC)'s participating agencies (list available), and only to the participating agencies who have entered into an HMIS Agency Participation Agreement and shall be used to:

- a. Produce a client profile at intake that will be shared by collaborating agencies
- b. Produce anonymous, aggregate-level reports regarding use of services
- c. Track individual program-level outcomes
- d. Identify unfilled service needs and plan for the provision of new services
- e. Allocate resources among agencies engaged in the provision of services

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

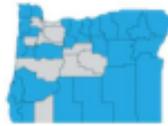
I authorize the participating agencies and their representatives to share basic information regarding my family members listed below and/or me. I understand that this information is for the purpose of assessing my/our needs for housing, utility assistance, housing counseling and/or other services.

THE INFORMATION MAY CONSIST OF THE FOLLOWING PPI (PROTECTED PERSONAL INFORMATION):

• Name	• Homeless History
• Date of Birth	• Family Composition
• Social Security Number	• Employment Status
• Gender	• Veteran Status
• Ethnicity and Race	• Disabling Condition
• Income and Non-Cash Benefits information	• Domestic Violence
• Housing information	

I UNDERSTAND THAT:

- Information I give concerning physical or mental health problems will not be shared with other participating agencies that have not completed an HMIS Agency Participation Agreement.
- The participating agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the client confidentiality policies used by the HMIS participating agencies.
- Staff members of the participating agencies who will see my information have signed agreements to maintain confidentiality regarding my information.
- I understand that participation in data collection is optional, and I may choose to not participate without it disqualifying me from receiving assistance.



Rural Oregon
Continuum
Of Care

Homeless Management Information System (HMIS) Informed Consent & Release of Information Authorization

- The release of my information does not guarantee that I will receive assistance, and my refusal to authorize the use of my informational again does not disqualify me from receiving assistance.
- I understand that I may withdraw my consent at any time.
- This authorization will remain in effect until I withdraw my consent in writing, and I may revoke authorization by signing a "Limited Visibility Request", but that cancellation will not be retroactive.
- If I revoke my authorization, all information about me already in the database will remain but will become invisible to all the participating agencies.
- My records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- Auditors or funders who have legal rights to review the work of this agency, including the U.S. Department of Housing and Urban Development may see my information.
- I understand that my personal information will not be made public and will only be used with strict confidentiality.
- This release is valid for seven (7) years from the date of my signature below.

Participating agencies: A list of the participating agencies within the Rural Oregon Continuum of Care (ROCC) System may be viewed prior to signing this form. Information about the ROCC can be found at the website: oregonbos.org

List all Dependent children under 18 in household, if any (first and last names):

1.	2.
3.	4.
5.	6.

Please initial one of the following levels of consent:

_____ I understand that Protected Personal Information and other relevant information will be entered into the HMIS and shared between participating agencies.

_____ I understand that I can choose to limit Protected Personal Information to only the service provider agency listed on this document.

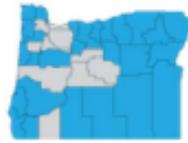
Participant Signature

Date

Agency Personnel Name (print)

Agency Personnel Signature

Date



Notice to Clients of Uses & Disclosures
Privacy Notice to Clients

This notice tells you about how we use and share your private personal information. It tells you about your rights and our responsibilities to protect the privacy of your private personal information. It also tells you how to let us know if you believe that we have violated any of your rights or any of our responsibilities.

We are required by law to keep the privacy of your private personal information and we must adhere to the terms of this notice.

We reserve the right to change this Notice at any time. This Notice is not a legal contract. If this notice is changed, a copy of the revised notice will be available upon request or posted on our website.

You may request a copy of our notice at any time. For more information about our privacy practices, or for more copies of this notice, please request this from the agency assisting you.

We will enter the information given our agency into a computerized record-keeping system called ServicePoint. Participating agencies use ServicePoint to better organize and deliver services to homeless or near homeless individuals and families. Agencies and staff have sign confidentiality agreements to keep information in ServicePoint protected.

Certain basic client information is shared only to participating agencies to avoid creating duplicate records. Authorized HMIS persons at participating community agencies will be able to see the following data elements of all client records:

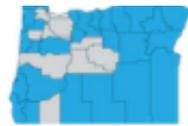
- First Name and Last Name
 - Social Security Number (needed for specific services)
 - Veteran Status
-

Our goal is to improve efforts to better understand what we can do to prevent and end homelessness. Information you share will play an important role, including:

- Help us prioritize, plan, and provide meaningful services to you and your family.
 - Help our agency to improve its work with families and individuals that are homeless or at-risk of homelessness.
 - Allow local agencies to work better together to prevent and/or end homelessness.
 - Provide statistics for local, state, and national policy makers to set effective goals.
-

Information you share is used to:

- Enter program and services in ServicePoint.
 - Improve and coordinate services that can be offered you.
 - Receive reimbursement for services provided.
 - Monitor program effectiveness.
 - Prepare aggregate reports and statistical information without personal identifying information.
-



Any other Personal identifying information will not be shown to any third-party, unless authorized by you or required by law. Authorization not needed for certain disclosures to government agencies or legal processes:

- Uses and disclosures required by law
- Public health, health oversight and regulatory agency activities
- Cases of neglect, abuse or domestic violence
- Judicial and administrative proceedings
- Law enforcement investigations
- Deceased individuals and organ donors
- Serious threats to health or safety
- Disclosure of "de-identified" health information

How will my information be kept secure?

- ServicePoint has the highest degree of security protection available.
- ServicePoint is governed by federal, state, county, and local privacy policies. System-wide access to personally identifying information contained in ServicePoint is limited to individuals employed and screened by a participating agency with documented agreements in place.
- Persons with access to ServicePoint data will not issue reports having personal identifying information.
- Personal identifying information in addition to those listed above may be viewed by the agency assisting you and other participating agencies that may provide you additional assistance.
- Personal identifying information will be removed before reports are issued to local, state, or national agencies.
- ServicePoint users receive training in privacy protection and have received copies of this privacy policy and have signed a confidentiality agreement pledging to adhere to its requirements.

Know your information rights!

As a client receiving assistance from a Participating agency, you are entitled to a copy of this notice. In addition, you can:

1. Decide the level of disclosure of your information; allow or refuse to share your information with ROCC participating agencies.
2. Revoke visibility of your information by providing this service provider written notice. This includes restricting data visibility to only the agency assisting you.
3. Request reasonable accommodation. The agency you are seeking services from must make reasonable accommodations to ensure that you understand your information rights.
4. Access your record. You have the right to review your ServicePoint record, obtain a printed copy of your data, and have information that you do not understand explained to you.
5. Correct your record. You have the right to have your record corrected so that information is up-to-date, correct, and to ensure fairness in its use. Disagreements over the accuracy of information shall be subject to the agency grievance process and any uncorrected disagreement shall be noted in your ServicePoint record.
6. Refuse to allow access and not be denied assistance. You will not be denied services for which you are otherwise eligible if you refuse to consent to the sharing with other provider agencies of data that has been entered into ServicePoint. If you have safety concerns, please discuss this with a staff member.



-
7. File a grievance. You have the right to be heard if you feel that you have been unjustly served, put at personal risk, or harmed. Employees or agencies that misuse information are subject to reprimands, warnings, and dismissal from using ServicePoint. The agency must make their written grievance policy available to you.
-

Additionally:

- **Data Archival:** All personally identifying data will be archived from ServicePoint no later than seven years after being entered or after last being modified.
- **Amendments:** The terms of this privacy notice may be amended at any time and all amendments will be effective with respect to previously obtained information.
- **Privacy Policy Questions & Complaints:** All questions or complaints about this agency's privacy and data security practices may be pursued through the agency grievance process.
- **Agencies with access to shared information can be found on the Rural Oregon Continuum of Care website:** <https://caporegon.org/what-we-do/the-rocc/> . Your intake worker can print a list of participating agencies at your request.



Limited Visibility Request

Client Name _____ Date of Birth _____
Head of Household

Project/Provider _____ Client ID # _____

Date of Enrollment Intake _____ Agency Name _____

I do not want my information that I provided to this agency to be shared with other agencies using the computer database system called WellSky Community Services (formerly called ServicePoint).

I understand that this request may reduce my access to some services available by partnering agencies, yet I cannot be refused assistance at this agency if I limit my information.

I understand that Veterans eligible for Supportive Services for Veteran Families (SSVF) projects are required to share Personally Identifying and Program Enrollment Information.

I understand that I can change my decision to share my information at any time. Information already shared cannot be taken back or revoked.

I do not want this **Program Enrollment Information** to be shared:

- To a specific Agency (List agency): _____
- To any Participating Agencies

List all dependents in the household that are included in this request.

Name	Age	Name	Age

Signatures

Client (Head of Household) Signature _____ Date _____

Printed Name of Intake Worker/Agency Staff _____ Privacy Script read/provided?
 To all other Agencies; or
 To a specific Agency:

Signature of Intake Worker/Agency Staff _____ Date _____