Client Name	Date of Birth

Koinonia Inn Women & Children
Transitional Housing Application

PLEASE READ CAREFULLY OUR APPLICATION PROCESS HAS CHANGED

1. Complete the application
- Provide us with as much detail as possible, make sure to read and answer all questions.
- Ask your Counselor, Advocate or Case Manager for help.
- All Applications must include:
    - A recent (within 30 days) copy of your criminal history
    - A completed Verification of Homelessness filled out by your Counselor, Advocate, Case Manager, Shelter Provider, or other authorized party
    - (make sure there is a release of information for any person / agency that you would like Agape to communicate with for this move in)
2. Return the application
    - Mail: Agape Unlimited; 4841 Auto Center Way, Suite 101; Bremerton, WA 98312
    - Fax: 360-373-4051 Attn: KI Housing
    - Email: omccourry@agapekitsap.org and smarez-fields@agapekitsap.org
3. Check in EVERY Thursday before 5PM
    - Phone: 360-373-1529 ext.: 217- leave a detailed message if there is no answer

Note that failure to check in weekly will result in the loss of your position on the wait list.

Key Reminders

- Submitting an application does not guarantee housing
- All required documentation must be included for processing
- Weekly check-ins are mandatory to maintain your position on the waitlist
- Incomplete applications will not be processed until all materials are received (Agape must have a way to contact you if this requires us to contact a 3rd party to reach you like a treatment agency we must have a release of information to do so)

Attention Counselors, Advocates, Case Managers and Navigators: Third party verification of homelessness is required for approval. Please review and complete the Agency Verification of Homelessness Document included in this packet. Only **one** option should be selected on Agency Verification of Homelessness Document.

4841 Auto Center Way Ste 101
Bremerton, WA 98312
(360) 373-1529

Client Name	Date of Birth

Application Date : _____

PERSONAL INFORMATION

Name: _____ _____ _____
First Middle Last

Marital Status: _____ Requested Move in Date: _____

Current Address (prior to treatment): _____

Mailing Address (if different than above): _____

Phone #: (_____) _____ Can we leave a message at this number? [ ] Yes [ ] No

FAMILY INFORMATION

Are you pregnant? [ ] Yes [ ] No If Yes, Estimated Delivery Date: ____/___/____ Trimester: _____

Postpartum? [ ] Yes [ ] No If Yes, Date of Delivery: _____

Parenting? [ ] Yes [ ] No ***This includes any children under the age of 18 in your custody or attempting to regain custody***

Any Children Moving in with Resident? [ ] Yes [ ] No If Yes, List Age(s) and Gender(s): _____

_____

Any Children **NOT** Moving in with Resident? [ ] Yes [ ] No If Yes, List Age(s) and Gender(s), who they live with and visitation schedule: _____

Do any of your children have any medical, developmental or behavior problems? [ ] Yes [ ] No

If Yes, Please describe: _____

Do you have CPS involvement? [ ] Yes [ ] No If Yes, County: _____

Case Worker: _____ Phone #: (_____)_____

FINANCIAL INFORMATION

Are you currently on Public Assistance? [ ] Yes [ ] If YES, Circle Type: TANF SSI SSDI

County: _____ ID#: _____ Monthly $ Amount: _____

Do you currently have Apple Health? [ ] Yes [ ] NO

Employed? [ ] Yes [ ] No If Yes, List Employer: _____ Monthly $ Amount: _____

Work Schedule: _____ Child Support? [ ] Yes [ ] No If Yes, Monthly $ Amount:_____

MEDICAL INFORMATION

4841 Auto Center Way Ste 101
Bremerton, WA 98312

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Client Name	Date of Birth

Do you have any medical conditions/issues that may interfere with you attending treatment?
[ ] Yes [ ] No

If YES, please explain: _____

Are you currently under a physician's care: [ ] Yes [ ] No Physician Name: _____

Are you currently on any medications? [ ] Yes [ ] If YES, please list below:
1._____ for:_____ 3._____ for:_____

2._____ for:_____ 4._____ for:_____

TREATMENT INFORMATION *SUBTANCE ABUSE/MENTAL HEALTH*

Are you currently in treatment? [ ] Yes [ ] No Agency: _____

Admission Date: __/__ /__ Scheduled Discharge: __ /__/__ Release Signed: [ ] Yes [ ] No

Counselor Name: _____ Phone Number: (_____)_____

When was the last time you used: _____/_____ County: _____

Are you currently in Drug Court: [ ] Yes [ ] No What was your drug of choice? (Check all that apply)

[ ] Alcohol [ ] Marijuana [ ] Methamphetamine [ ] Fentanyl [ ] Prescription Drugs [ ] Nicotine
[ ] Other(s)_____

Treatment History Agency & Location	Date(s) of Treatment	Completed Treatment? Circle YES or NO	Length of Abstinence *How Long Did You Remain Clean*
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	

PAST Mental Health Client? [ ] Yes [ ] No Diagnosis: _____

Receiving CURRENT Mental Health Services? [ ] Yes [ ] No

If Yes, Agency: _____ Counselor: _____

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Client Name	Date of Birth

LEGAL INFORMATION

Do you have any current or pending legal obligations? [ ] Yes [ ] No

List Charges: _____ Court: _____

Do you have a Probation/Parole Office? [ ] Yes [ ] No If Yes, Name: _____

Do you have any current warrants? [ ] Yes [ ] No If Yes, please list: _____

Are you currently or have recently been in a violent or potentially dangerous situation? [ ] Yes [ ] No

If yes, with who: _____ Current Restraining Order: [ ] Yes [ ] No

OTHER INFORMATION

Do you have a valid driver's license? [ ] Yes [ ] No Vehicle? [ ] Yes [ ] No Car Insurance? [ ] Yes [ ] No

If Yes, List Insurance Agency: _____ Have you lived on our own before? [ ] Yes [ ] No

If Yes, how long: _____ When: _____ Are you attending school? [ ] Yes [ ] No

If Yes, Where: _____ Schedule: _____

Do you feel you can live in a group home setting? [ ] Yes [ ] No What are your special needs, if any: _____

_____

What is your objective in living here? _____

_____

Are you a former patient of Agape Unlimited? [ ] Yes [ ] No If yes, when: _____

Are you a former resident of Koinonia Inn? [ ] Yes [ ] No If yes, when: _____

Tell us about yourself: _____

_____

_____

_____

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Client Name	Date of Birth

Mental Health Screening

1.	Are you currently taking any prescription or over the counter medication?	[ ]Yes [ ]No
2.	How long have you been taking this medication? _____	
3.	Was the medication prescribed by a licensed clinician?	[ ]Yes [ ]No
	Need release (if applicable) from: _____	ROI __/__/___
4.	Have you ever spent time in an inpatient mental health facility?	[ ]Yes [ ]No
	If yes, where: _____ Reason: _____	
5.	Have you ever had a psychiatric evaluation?	[ ]Yes [ ]No
	If yes, where: _____ Reason: _____	
6.	Have you had any prior mental health counseling?	[ ]Yes [ ]No
	If yes, where: Reason:	
7.	What is the longest period of abstinence you have obtained? _____	
8.	During this clean time did you struggle with depression?	[ ]Yes [ ]No
9.	Did you ever hear or see things that were not there while you were sober?	[ ]Yes [ ]No
10.	Has anyone ever told you that they were worried about your mental health?	[ ]Yes [ ]No
11.	Have you ever felt concerned about your own mental health?	[ ]Yes [ ]No
12.	Has anyone in your family suffered from mental health issues such as chronic depression, bi-polar disorder, schizophrenia, other): Please List: _____	[ ]Yes [ ]No
13.	Has anyone in your biological family ever been on medications for mental health illness?	[ ]Yes [ ]No
14.	Have you ever been diagnosed with a mental health condition? If yes, what was the diagnosis? _____	[ ]Yes [ ]No

Suicide/Self Harm Risk Assessment: Have you ever tried to commit suicide? [ ] Yes [ ] No

If yes, when? _____ What were the circumstances? _____

Are you currently having any thoughts about committing suicide? [ ] Yes [ ] No

If yes, do you have a plan? [ ] Yes [ ] No If yes, has safety plan been initiated? [ ] Yes [ ]No

Do you have a history of self-harm (i.e. cutting, risky behavior)? [ ] Yes [ ] No

Do you have any plans to harm yourself or anyone else? [ ]Yes [ ]No

Are you currently homeless? [ ] Yes [ ] No Describe your situation of homelessness_____

_____

_____

4841 Auto Center Way Ste 101
Bremerton, WA 98312

(360) 373-1529

Client Name	Date of Birth

Duration of Homelessness: [ ] 1day [ ] 2-30 days [ ] 31-180 days [ ] 181-365 days [ ] 366-730 days

Verification of Homelessness Document included? [ ] Yes [ ] No
Are you chronically homeless as defined in the definition above? [ ] Yes [ ] No

If you have marked **YES** to the above question and have your third-party verification of homelessness, please continue to fill out your application and submit it to the Koinonia Inn Housing Coordinator. If you have marked **NO** or are awaiting your third-party documentation, please contact Koinonia Inn Housing Coordinator:

Attn: Koinonia Housing Coordinator
4841 Auto Center Way
Bremerton WA. 98312
360-373-1529 Fax:360-373-4051

Verification that applicant is eligible

I VERIFY THAT TO THE BEST OF MY ABILITY THIS IS TRUE AND CORRECT.

_____/_____/ _____
Print Name Signature Date

As Housing Coordinator, I have reviewed this applicant's documentation and do believe her to meet the definition of chronic homelessness.

Housing Coordinator: _____/_____
Housing Coordinator Signature Print Name

YOU **MUST** ATTACH A SIGNED RELEASE OF CONFIDENTIAL INFORMATION FOR AGENCY AND COUNSELOR WHERE YOU ARE CURRENTLY ATTENDING SUBTANCE ABUSE AND/OR MENTAL HEALTH TREATMENT SERVICES AS WELL AS CPS WORKER.

4841 Auto Center Way Ste 101
Bremerton, WA 98312
(360) 373-1529

Client Name	Date of Birth

Agency Verification of Homelessness

MUST BE COMPLETED WITH HOUSING APPLICATION

FROM:		**TO:**
Agency:		*Agape Unlimited Koinonia Inn Housing Coordinator*
Address:		4841 *Auto Center Way, STE 101*
City:		*Bremerton, WA 98312*
St:	Zip:	*P 360-373-1529 F 360-373-4051*
Phone:	Fax:	

RE: Verification of Homelessness for Prospective Resident of the Koinonia Inn Transitional Housing Program

Name of Homeless Individual: _____

As defined by HUD, a person is considered homeless ONLY when he/she meets **one** of the categories of homeless as described below. Choose a category that best describes the Homeless Individual's situation. You're certifying with a working knowledge of the above named individual and can verify that they are homeless by meeting one of the following homeless categories.

1. [ ] The above-named individual lacks a fixed, regular, and adequate nighttime residence, meaning they are currently staying: **(Check only ONE box that best describes the current living situation)**
   - [ ] In a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or campground; **OR**
   - [ ] In a supervised publicly or privately operated shelter designated to provide temporary living arrangements including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals as of this date: _____; **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. [ ] The above named individual who: **(ALL boxes below MUST be checked to qualify)**
   - [ ] Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's primary nighttime residence or has made the individual afraid to return to their primary nighttime residence; AND
   - [ ] Has no other residence; AND
   - [ ] Lacks the resources or support networks (family, friends, and faith-based or other social networks) to obtain other permanent housing

Please contact me if I may be of further assistance at: (_____) _____-_____

_____

Signature of Agency Representative Title

_____ _____

Printed Name Date

AGENCY VERIFICATION OF HOMELESSNESS FORM" MUST be filed out with each application

Client Name	Date of Birth

Self-Disclosure Verification of Homelessness

MUST BE COMPLETED WITH HOUSING APPLICATION

Date: _____ **Name:** _____

As defined by HUD, a person is considered homeless ONLY when he/she meets one of the four categories of homeless as described below. Choose **one** of the categories that best describes the Homeless Individual's situation.
I am currently homeless because:

1. [ ] I lack a fixed, regular, and adequate nighttime residence, meaning I am currently staying: **(Check only ONE box that best describes your current living situation**)
   - [ ] In a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; **OR**
   - [ ] In a supervised publicly or privately operated shelter designated to provide temporary living arrangements including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals as of this date: _____; **OR**
   - [ ] Is exiting an institution where I 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. [ ] I am currently: **(ALL boxes below MUST be checked to qualify)**
   - [ ] Fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's primary nighttime residence or has made the individual afraid to return to their primary nighttime residence; AND
   - [ ] Have no other residence; AND
   - [ ] Lack the resources or support networks (family, friends, and faith-based or other social networks) to obtain other permanent housing

I am unable to access verification of my homeless status from the above checked agency because:

_____

_____

I certify that I am homeless and in need of homeless services.

_____

Signature of Homeless Individual Date Print Name

This **"SELF-DISCLOSURE VERIFICATION OF HOMELESSNESS"** MUST be filed with **EACH** Koinonia Inn Transitional Housing Program **APPLICATION**

Client Name	Date of Birth

Referring Agency Release of Confidential Information

I,_____

First **Middle** **Last**

Authorize Agape' Unlimited to: [X] Disclose to: [X] Obtain From:

REFERRING AGENCY_____

Name, address and phone # of person or organization to which disclosure is being made

The following information (Nature of information, as limited as possible):

Personal identifying information, assessment results, treatment planning, progress notes, UA results, attendance and participation, discharge summary and recommendations, medications.

The purpose if the disclosure authorized herein is to (Be specific as possible):

Coordination of Services

I understand that my substance use disorder records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any references to diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted diseases, mental health services, substance use disorder services. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment. Unauthorized redisclosure by recipient is prohibited, but may be a potential risk. I understand that I do not have to sign this authorization in order to receive health care benefits except for health are services necessary to create any assessment or report for disclosure to the recipient identified in this authorization. In any event this authorization expires automatically as follows:

2 years from date signed

Specification of the date, event or condition upon which this consent expires

The information may be released in the following forms:

[X] Written [X] Verbal [X] Audio [X] Electronically (email/fax) [ ] Other_____

_____ _____

Client Name	Date of Birth

Patient Signature Date Witness Signature Date

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I,_____

First **Middle** **Last**

Authorize Agape' Unlimited to: [X] Disclose to: [X] Obtain From:

Housing Solutions Center 1201 Park Avenue Bremerton, WA 98337 Phone: (360) 473-2035 Fax: (360) 792-8708

Name, address and phone # of person or organization to which disclosure is being made

The following information (Nature of information, as limited as possible):

Personal identifying information, housing status and compliance, rental amount and payments, treatment status, and diagnosis.

The purpose if the disclosure authorized herein is to (Be specific as possible):

Collaboration for rental assistance. _____

I understand that my substance use disorder records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any references to diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted diseases, mental health services, substance use disorder services. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment. Unauthorized redisclosure by recipient is prohibited, but may be a potential risk. I understand that I do not have to sign this authorization in order to receive health care benefits except for health are services necessary to create any assessment or report for disclosure to the recipient identified in this authorization. In any event this authorization expires automatically as follows:

2 years from date signed_____

Specification of the date, event or condition upon which this consent expires

The information may be released in the following forms:

[X] Written [X] Verbal [X] Audio [X] Electronically (email/fax) [ ] Other_____

_____ _____

Patient Signature Date Witness Signature Date

Client Name	Date of Birth

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I,_____

First **Middle** **Last**

Authorize Agape' Unlimited to: [X] Disclose to: [X] Obtain From:

Emergency contact name, contact number, relationship:

_____

Name, address and phone # of person or organization to which disclosure is being made

The following information (Nature of information, as limited as possible):

Personal identifying information, nature of emergency, To pick up my belongings if I am unable to

The purpose if the disclosure authorized herein is to (Be specific as possible):

*To collaborate information in the event of an emergency*_____

I understand that my substance use disorder records are protected under the federal regulations governing

Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any references to diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted diseases, mental health services, substance use disorder services. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment. Unauthorized redisclosure by recipient is prohibited, but may be potential risk. I understand that I do not have to sign this authorization to receive health care benefits except for health are services necessary to create any assessment or report for disclosure to the recipient identified in this authorization. In any event this authorization expires automatically as follows:

2 years from date signed_____

Specification of the date, event or condition upon which this consent expires

The information may be released in the following forms:

[X] Written [X] Verbal [X] Audio [X] Electronically (email/fax) [ ] Other_____

_____ _____

Client Name	Date of Birth

Patient Signature Date Witness Signature Date

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____

First Middle Last

Authorize Agape' Unlimited to: [ ] Disclose to: [ ] Obtain From:

_____

Name, address and phone # of person or organization to which disclosure is being made

The following information (Nature of information):

Personal identifying information: _____

The purpose of the disclosure authorized herein is to (Be specific as possible):

Collaboration of services _____

I understand that my substance use disorder records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any references to diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted diseases, mental health services, substance use disorder services. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment. Unauthorized redisclosure by recipient is prohibited, but may be a potential risk. I understand that I do not have to sign this authorization in order to receive health care benefits except for health are services necessary to create any assessment or report for disclosure to the recipient identified in this authorization.

In any event this authorization expires automatically as follows:

_____ 2 Years after Signing _____

Specification of the date, event or condition upon which this consent expires

The information may be released in the following forms:

[ ] Written [ ] Verbal [ ] Audio [ ] Electronically (email/fax) [ ] Other_____

_____ _____

Patient Signature Date Witness Signature Date