Love Makes A Difference
Agapé

Welcome to the Agape Sisyphus II Housing Project

PLEASE READ CAREFULLY - OUR APPLICATION PROCESS HAS CHANGED

Our housing programs provide independent, permanent living environments for homeless individuals and families affected by Substance Use Disorder and other disabilities. These programs house up to 58 individuals and their families.

This cover sheet is designed to guide you through the application process. Please note that submission of this application does guarantee housing or secure a bed. The review and scheduling process typically takes 7 to 10 business days from the date of submission to final review/approval by the housing department.

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

2. Return the application
- Mail: Agape Unlimited; 4841 Auto Center Way, Suite 101; Bremerton, WA 98312
- Fax: 360-373-4051 Attn: Housing
- In person: Deliver directly to the Housing Case Manager at Agape Unlimited

3. Check in ***EVERY Thursday before 5PM*****

Applicants are required to check in every Thursday before 5:00pm to remain active on the waitlist.

Check in by:
- Phone: 360-373-1529 ext: 108 – leave a detailed message if there is no answer
- Email: ctunison@agapekitsap.org
- In-Person

****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*

Attention Counselors, Advocates, Case Managers and Navigators: Third party verification of homelessness and verification of disability 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 these forms.

HOUSING APPLICATION TRACKING FORM

Applicant Information

Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

Application Processing Steps

Step	Description	Date	Notes/Staff Initials
1	Application Received	_____	_____
2	Correction Request Sent	_____	_____
3	Application is Complete	_____	_____
4	Added to Waitlist	_____	_____
5	Approved for Move-in	_____	_____
6	Deposit Secured	_____	Funder: _____
7	Treatment Intake Scheduled	_____	Time: _____
8	Housing Intake Scheduled	_____	Time: _____

Corrections/Follow-Up Needed

Describe any missing documents, signature issues or corrections needed to complete the application

_____

_____

_____

Weekly Check-Ins

Date: _____ Date: _____ Date: _____

Date: _____ Date: _____ Date: _____

Date: _____ Date: _____ Date: _____

Staff Name: _____

Date Archived: _____

Client Name	Date of Birth	Date

Sisyphus II Housing Project
Continuum of Care
Participation Requirement

Sisyphus II Housing program is for chronically homeless individuals. If you are not homeless or chronically homeless you will not be eligible at this time. We would be happy to provide you with referrals.

Homelessness Definition:

Chronically homeless. (1) An individual who: (i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and (iii) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability; (2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Homeless means:

(1) An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) An individual or family with a primary nighttime residence that is 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; (ii) An individual or family living 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); or (iii) An individual who 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) An individual or family who will imminently lose their primary nighttime residence, provided that: (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing; (To be eligible under this section the applicant must provide an eviction notice for the entire household)

(3) Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who: (i) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);

(4) Any individual or family who: (i) 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 or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; (ii) Has no other residence; and (iii) Lacks the resources or support networks, e.g., family, friends, and faith- based or other social networks, to obtain other permanent housing.

Client Name	Date of Birth	Date

Are you currently homeless? [ ] Yes [ ] No Describe what your homelessness looks like (IE: where are you sleeping, bathing, eating, etc.):_____

_____

_____

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 Sisyphus II Housing. If you have marked **NO** or are awaiting your third party documentation, please contact Sisyphus II Housing manager:

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

Agape Housing Staff Only

Verification that applicant is eligible

3rd Party Verification submitted: [ ] Yes [ ] No

Does applicant meet the definition of chronic homelessness: [ ] Yes [ ] No

I have reviewed this applicant's documentation and do believe him/her to meet the definition homelessness.

Housing Manager: _____/_____
Housing Case Manager Signature / Print Name

Client Name	Date of Birth	Date

Sisyphus II Housing Project
Participant Eligibility Screening

Name:_____ Todays Date:_____
First Middle Last

DOB: _____/_____/_____ Age: _____ Social Security Number: _____-_____-_____

Do you have a mailing Address:

_____

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

If you are unable to receive messages, who do you designate as a contact person?

Name:_____ Phone #: (____)_____ Release signed? [ ] Yes [ ] No

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

Are you a former resident of Sisyphus II Housing Project? [ ] Yes [ ] No If yes, when: _____

Race: [ ] Caucasian [ ] African American [ ] Asian/Pacific Islander [ ] Native American

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widow [ ] Separated

Veteran: [ ] Yes [ ] No Gender: [ ] Male [ ] Female Ethnicity: [ ] Hispanic [ ] Non-Hispanic

For Sponsor Applicants:

Name of Child	DOB/Age	Relation	Child will be resident	Pending Reunification	Child will not live in unit

Are you pregnant at this time? [ ] Yes [ ] No If yes, estimated Delivery Date: _____/_____/_____

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

Case Worker: _____ Phone #: (_____)_____

Do you have scheduled visits with a non-custodial parent: [ ] Yes [ ] No

Joint custody? [ ] Yes [ ] No If yes, please explain: _____

_____

Do you have a Parenting Plan on file with the court? [ ] Yes [ ] No

Client Name	Date of Birth	Date

Do any of your children have any physical, emotional, developmental or behavioral problems?

[ ] Yes [ ] No If yes, explain: _____

_____

_____

Disability Definition: Alcohol/drug abuse or other disability that is expected to be of long-continued and indefinite addiction, and impeded his/her ability to live independently; and alcohol/drug abuse that is such a nature that the disability could be improved in more suitable housing conditions.

Do you have a disability? [ ] Yes [ ] No

Type of Disability:
[ ] Chemically Dependent [ ] Mental Health
[ ] Dual Diagnosis (Mental Health & Chemical Dependency)
[ ] Other Disability: _____

Are you currently on any medications?
1._____ for:_____ 3._____ for:_____

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

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

Physician Name: _____ [ ] PCH [ ]Other:_____ Date of last Physical: ___/___/_____

Do you have any medical conditions/issues that would prevent you from attending supportive services outside of the home 3 to 5 times a week? [ ] Yes [ ] No If yes, explain: _____

_____

Release needed? [ ] Yes [ ] No

Have you ever had any of the following? Seizures: [ ] Yes [ ] No Heart Disease: [ ] Yes [ ] No
Diabetes: [ ] Yes [ ] No Vision Problems: [ ] Yes [ ] No Respiratory Problems: [ ] Yes [ ] No
Hepatitis: [ ] Yes [ ] No Hearing Problems: [ ] Yes [ ] No High Blood Pressure: [ ] Yes [ ] No
Back Injury: [ ] Yes [ ] No Tuberculosis: [ ] Yes [ ] No

Have you been diagnosed with a Traumatic Brain Injury? [ ] Yes [ ] No If yes, when:_____

Have you been diagnosed with Fetal Alcohol Syndrome? [ ]Yes [ ] No

Dyslexia/Learning Disability? [ ]Yes [ ] No

Low Income Definition: Are you low income? [ ] Yes [ ] No
A person is determined to be low income if their income meets the following criteria:
[ ] 1 person annual income less than $28,650
[ ] 2 person annual income less than $32,750
[ ] 3 person annual income less than $40,950
[ ] 5 person annual income less than $44,250

Client Name	Date of Birth	Date

Are you currently receiving income or benefits from the following?
Cash Benefits: [ ] SSI [ ] ABD [ ] TANF [ ] Pell Grant
Non Cash: [ ] Basic Food [ ] WIC [ ] PCAP [ ] Lifeline

Other _____ Child Support $_____

Occupation: _____ Date of last Employment: ____/____/_____

Total Monthly Income $_____ Current through (Date): ____/____/_____

Education: Highest grade level completed: _____ Diploma or GED? _____

List colleges or vocational schools attended and degrees obtained: _____

Treatment History:

Agency and Location	Dates of Service	Completed Y or N	Length of Abstinence

Who referred you to services?
[ ] Self [ ] Street Outreach Worker [ ] Emergency Shelter [ ] Psychiatric Hospital, Medical Clinic
[ ] Mental Health Outpatient [ ] Alcohol & other Drug Programs [ ] Other Social Service [ ] Police
[ ] PHA (public housing authority) [ ] Other:_____

Are you currently in treatment? [ ] Yes [ ] No If yes: [ ] Inpatient [ ] Outpatient

Agency:_____

Admission Date: ____/____/_____ Scheduled Discharge Date: ____/____/_____

Counselor Name: _____ Phone Number: (_____)_____

Release Signed: [ ] Yes [ ] No

When was the last time you used: _____/_____/_____ Did you participate in Detox? [ ] Yes [ ] No

Was your treatment court ordered? [ ] Yes [ ] No County: _____
Are you currently in Drug Court: [ ] Yes [ ] No What was your drug of choice? (Check all that apply)
[ ] Alcohol [ ] Marijuana [ ] Methamphetamine [ ] Heroin [ ] Prescription Drugs [ ] Nicotine
[ ] Other(s)_____

What has been your longest period of sobriety? _____

On a scale of 1-10, (where 1 is not all confident and 10 is very confident) how confident are you that you can abstain from substances in your current program of recovery? _____

Tell us how you feel about your recovery (please continue on the back of this page if needed):

_____

_____

_____

Client Name	Date of Birth	Date

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

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

Do you have any current warrants? [ ] Yes [ ] No If yes, where_____

Presently on Probation or Parole? [ ] Yes [ ] No Less than 3 jail sentences: [ ] Yes [ ] No

More than 3 Jail sentences: [ ] Yes [ ] No Sexual Assault: [ ] Yes [ ] No

Domestic Violence: [ ] Yes [ ] No Restraining/Protection orders: [ ] Yes [ ] No

Probation Officer: Name: _____ Phone:_____

Release of Information signed? [ ] Yes [ ] No

Arrests:

[ ] Crime unknown [ ] Criminal Trespass [ ] Domestic Violence [ ] Driving under the influence [ ] Fraud

[ ] Drug possession [ ] Drug Trafficking or Manufacturing [ ] Violent Crime [ ] Embezzlement [ ] Theft

[ ] Property Crime [ ] Malicious Mischief/Disorderly Conduct [ ] ID Theft [ ] Forgery

How many times in the last 90 days have you been arrested? _____

Client Name	Date of Birth	Date

How many times have you ever been charged with the following: Arson: _____ Burglary: _____
Reckless burning: _____ Contempt of Court: _____ Drug related Violence: _____ Forgery: _____
Homicide: _____ Kidnapping: _____ Prostitution: _____ Sexual Offence: _____ Robbery: _____
Shoplifting: _____ Weapons Offense: _____

Do you have a history of violent behavior? [ ] Yes [ ] No If Yes, explain:_____

_____

Current legal involvement: (Check all that apply) [ ] Awaiting Charges [ ] Awaiting Trial
[ ] Child Custody issues [ ] Convicted awaiting sentence [ ] CPS Court involvement [ ] On Probation

Substance Abuse Questionnaire:

1) At the time of your active addiction, which of the following areas of your life did you neglect or have limitations (mark "Yes" for areas of your life which you were NOT able to maintain during your active addiction):
   a. Self-Care (hygiene): [ ] Yes [ ] No
   b. Ability to shop: [ ] Yes [ ] No
   c. Manage or budget money: [ ] Yes [ ] No
   d. Walking or standing (mobility): [ ] Yes [ ] No
   e. Maintain a home (household chores): [ ] Yes [ ] No
   f. Drive a vehicle: [ ] Yes [ ] No
2) At the time of your active addiction, have you lost any jobs or employment which affected your ability to pay for housing, food or bills? [ ] Yes [ ] No

   If yes, number of jobs lost: _____

   Why (check all that apply): [ ] Quit [ ] Fired [ ] Used on the job [ ] Absenteeism
3) Do you have any physical limitations which prevent you from being able to adequately perform your acts of daily living? [ ] Yes [ ] No
   a. If yes, please explain: _____

   _____
4) Would housing services substantially increase your ability to maintain abstinence and/or improve your ability to live independently? [ ] Yes [ ] No

We strive to maintain a clean, safe and allergen-reduced environment for all residents. As such, this program has a **no pets policy**.

Service and Support Animals

We recognize and comply with all federal, state, and local laws regarding individuals with disabilities.

Client Name	Date of Birth	Date

Agency Verification of Homelessness

MUST BE COMPLETED WITH HOUSING APPLICATION

FROM:
Agency:
Address:
City:
St: Zip:
Phone: Fax:

TO:
Agape Unlimited Sisyphus II Housing Program
4841 Auto Center Way, STE 101
Bremerton, WA 98312
P 360-373-1529 F 360-373-4051

RE: Verification of Homelessness for Prospective Resident of the Sisyphus II 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.

To avoid delays in application processing: Select only ONE numbered item below, then mark a single "X" in the applicable box that accurately describes the person listed above.*

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 individuals 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

This **"AGENCY VERIFICATION OF HOMELESSNESS FORM" MUST** be filed with **EACH** Sisyphus II Housing Program **APPLICATION** and be available for review by the U.S. Department of Housing, Urban Development and Agape Unlimited.

Client Name	Date of Birth	Date

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 categories of homeless as described below. Choose **one** of the categories that best describes the Homeless Individual's situation.
I am currently homeless because:

To avoid delays in application processing: Select only ONE numbered item below, then mark a single "X" in the applicable box that accurately describes the person listed above.*

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

Please describe what your homelessness looks like (IE: Where did you sleep last night, or the night prior to admission to the residential facility where you are now?):

_____

_____

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** Sisyphus II Housing Program **APPLICATION** and be available for review by the U.S. Department of Housing, Urban Development and Agape Unlimited.

CONSENT FOR RELEASE OF
CONFIDENTIAL INFORMATION

Love Makes A Difference

Agapé

I,_____
First Middle Last

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

Emergency Contact: _____

_____
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, pick up personal belongings in the event I am unable to pack and collect my things due to abort, abandonment, disappearance, incarceration, termination or eviction from program, and I do not schedule to pick up the belongings.

The purpose of the disclosure authorized herein is to (Be specific as possible):
Emergency situations and removal of belongings from Housing.

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:

two 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

4841 Auto Center Way, Suite #101, Bremerton, WA 98312 – (360) 373-1529 – Fax (360) 373-4051

Love Makes A Difference
Agapé

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I,_____, _____, _____
First Name Middle Name Last Name

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: (keep 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 federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR, 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 of 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 care 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:

_____
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