Application for Pathways' Security Deposit Assistance Program

Name: _____Date:_____
Phone Number_____
Social Security Number: _____
Date of Birth:_____
CIRCLE ONE: **Hispanic** or **Non-Hispanic**
Race: _____
Current address & rent
amount:_____Landlord:_____

List all household members and <u>health insurance or veteran status:</u>

Name	SSN	DOB	Race	Relationship to HoH	Veteran	Health Insurance	Disability

List additional members on the back of this page with all information requested.

Please List one person to contact in case of emergency
Name:_____
Relationship:_____
Address:_____ Phone:_____

Apartment intended for Security Deposit Assistance
Address:_____ Date Available:_____
Property Manager name and phone number:_____
Please list all sources of income and an estimated monthly
amount:_____

Applicant affirms that all information provided is true and that assistance is only guaranteed for a security deposit that is a once in a lifetime benefit.
Signature: _____ Date:_____

<u>ALL INFORMATION PROVIDED ON THIS PAGE IS CONFIDENTIAL</u>
Pathways rules for program acceptance and participation are the same for everyone without regards to race, ethnicity, national origin, age, sex, or handicap.

OFFICE USE ONLY:
DATE RECEIVED: _____ Benificiary ID: _____
DATE OF HOUSEHOLD APPROVAL/DENIAL_____
Service Justification_____
REASON FOR DENIAL:_____
APPROVED/DENIED BY:_____

Where is your current nighttime residence?

_____

Length of stay

___ One night or less

___ Two to Six nights

___ One week or more but less than a month

___ Don't Know

___1 month or more but less than 90 days

___90 days or more but less than a year

___ A year or more

___Refused

Number of times the client has been homeless in the past three years:

___ AT-Risk of Homelessness

___ 1 (1st time homeless) ___ 2 ___ 3 ___ 4 or more

How many calendar month's homeless in the past 3 years? (If a client is homeless for only 1 night of a month, that is considered 1 month of experiencing homelessness)

1 2 3 4 5 6 7 8 9 10 11 12 or more

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Release of Information:

During my enrollment with Pathways, it may become necessary for staff to call appropriate referral sources for me to share goals, needs, verify my information or collaborate on services. *I _____ give permission for the Pathways staff to give information to and request from these agencies:*

- **Contact Center**
- **Yankton Housing**
- **Low income housing Properties**
- **Law enforcement**
- **SD Department of Social Services**
- **LCBHS**
- **Yankton School District**
- **DLR/ Voc Rehab**
- **Employer**
- **State Dept. of Health**

Client Signature:_____
Date:_____

Pregnancy in Household? Y / N

Due Date: _____

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Barriers

Head of Household

Alcohol Abuse: YES / NO

Developmental Disability : YES / NO

Chronic Health Condition (liver, kidneys, heart, lungs): YES / NO

Drug Abuse: YES / NO

HIV/AIDS:: YES / NO

Mental Illness: YES / NO

Physical Disability-: YES / NO

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Co-Head of Household

Alcohol Abuse: YES / NO

Developmental Disability : YES / NO

Chronic Health Condition (liver, kidneys, heart, lungs): YES / NO

Drug Abuse: YES / NO

HIV/AIDS:: YES / NO

Mental Illness: YES / NO

Physical Disability-: YES / NO

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Domestic Violence Present? ___ Yes___ No

___ Client Doesn't Know ___ Client Refused

If Yes, when did the experience occur:

___ Within the past 3months ___ 3-6 months ago

___ From six to twelve months ago ___ More than a year ago

___Client Doesn't Know _____Client Refused

Is Client fleeing? ___Y ___N

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Vocational Training? Y / N In school? Y N

Highest Grade Completed:_____

Pathways HMIS Client Informed Consent Form

South Dakota Homeless Management Information System

Informed Consent and Release of Information Authorization

This agency participates in the South Dakota Homeless Management Information System (*SDHMIS*). *SDHMIS* is administered by the South Dakota Housing Development Authority on behalf of the South Dakota Housing for the Homeless Consortium. Because this system is made up of many service providers across South Dakota that are administering the ESG grant, your information will be shared with other service providers from which you might be seeking services. This will reduce the time spent answering basic questions regarding your situation, and allow that agency to focus on meeting your service needs. *SDHMIS* has industry standard security protocols, and is updated regularly to meet these security standards. The information you provide will only be shared with this agency and any other ESG agency in the system and limited staff of *SDHMIS*. Information collected is housed in a secure server. Limited staff persons have access to this server and the data housed there for system support and maintenance purposes only. Data collected for the system will be maintained for seven years from the date of entry and then any inactive record will be permanently deleted from the network.

The Items listed below will be shared with other agencies as well as SDHMIS Staff.

Identifying information (Name, birth date, social security number)

Demographic information (gender, race, residential information, family composition)

Financial information (income verification, public assistance payments, food stamps)

The items listed below are optional items that you may wish to share with other agencies. Please mark Yes or No to the below items.

____ Medical records, Psychological records & evaluations, vocational assessment, care coordinators recommendations and direct observations, employments status, etc.

____ HIV/AIDS diagnosis

____ Substance abuse diagnoses, treatment plan, progress in treatment, discharge

I understand that I have the right to inspect, copy, and request all HMIS records maintained by the Agency relating to the provision of services to me and to receive a paper copy of this form.

_____

Signature of Client, Guardian or Power of Attorney Date

_____

Signature of Witness Date