



# Project Hope

## PROGRAM APPLICATION

(Please fill out - PRINT- one application per person even if applying as a couple). If your application is incomplete or not legible it could delay the application process.

Have you applied to PH in the past?  YES  NO Today's Date: \_\_\_\_\_

Date last applied: \_\_\_\_\_

Were you accepted? \_\_\_\_\_

If you were not accepted please explain:

### DEMOGRAPHIC INFORMATION

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Please let us know who referred you or how you heard about Project Hope:

Head of household:  Yes  No

If no, name of head of household: \_\_\_\_\_ Relationship: \_\_\_\_\_

Ever received services under different name?  Yes  No

If yes, then provide:

First name: \_\_\_\_\_ Middle name: \_\_\_\_\_

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

#### Marital Status:

Never Married  Married  Divorced  Separated

Are you applying with a spouse/partner?  Yes  No

If applying with a spouse/partner please provide his/her name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number: \_\_\_\_\_

Gender:  Male  Female

Driver's License/State ID: \_\_\_\_\_ State: \_\_\_\_\_

U. S. Citizen  Yes  No Alien Status: \_\_\_\_\_

(You must have a valid driver's license or state ID to be considered for the PH program)

Mailing Address: \_\_\_\_\_

Street

City/State/Zip

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Hispanic/Latino: Yes \_\_\_ No \_\_\_

Race (please pick at least one racial designation, choose all that apply):

American Indian or Alaska Native  Black or African American  White  Asian

Native Hawaiian or Other Pacific Islander

**Military Status:** Served/serving in U.S. Military (*veteran*):  Yes  No  
Before 2002 \_\_\_Yes \_\_\_ No

**Disabling Condition:** Do you have a disabling condition?  Yes  No

**Describe your situation: Are you homeless?**  Yes  No

**Where did you stay last night** (*choose one*):

- |  |   |
|--|---|
| <input type="checkbox"/> Apartment or house that you own         | <input type="checkbox"/> Permanent housing for homeless persons             |
| <input type="checkbox"/> Bus                                     | <input type="checkbox"/> Prison   |
| <input type="checkbox"/> Camping                                 | <input type="checkbox"/> Psychiatric hospital or other psychiatric facility |
| <input type="checkbox"/> Car or Vehicle                          | <input type="checkbox"/> Room, apartment, or house that you rent            |
| <input type="checkbox"/> Emergency shelter                       | <input type="checkbox"/> Staying in family member's room, apt. or house     |
| <input type="checkbox"/> Foster care home/foster care grp home   | <input type="checkbox"/> Staying in a friend's room, apartment or house     |
| <input type="checkbox"/> Hospital (non-psychiatric)              | <input type="checkbox"/> Substance abuse treatment facility or detox center |
| <input type="checkbox"/> Hotel or motel paid for with a voucher  | <input type="checkbox"/> Transitional housing for homeless persons          |
| <input type="checkbox"/> Hotel or motel paid for without voucher | <input type="checkbox"/> Transportation site or station                     |
| <input type="checkbox"/> Jail                                    | <input type="checkbox"/> Migrant Shelter                                    |
| <input type="checkbox"/> Juvenile detention facility             | <input type="checkbox"/> On the street, under a bridge, etc.                |
| <input type="checkbox"/> Don't Know                              | <input type="checkbox"/> Refused  |
| <input type="checkbox"/> Other                                   |   |

**If you are currently housed, are you being evicted within 7 days?**  Yes  No

**How long were you there?** (*choose one*):

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Less than 1 week | <input type="checkbox"/> 1 to 2 weeks       | <input type="checkbox"/> 3 Wks to 1 month | <input type="checkbox"/> 2 to 3 months |
| <input type="checkbox"/> 4 to 6 months    | <input type="checkbox"/> 7 months to 1 year | <input type="checkbox"/> More than 1 year |  |

**Where did you stay before last night?** (*choose one*):

- |  |   |
|--|---|
| <input type="checkbox"/> Apartment or house that you own         | <input type="checkbox"/> Permanent housing for homeless persons             |
| <input type="checkbox"/> Bus                                     | <input type="checkbox"/> Prison   |
| <input type="checkbox"/> Camping                                 | <input type="checkbox"/> Psychiatric hospital or other psychiatric facility |
| <input type="checkbox"/> Car or Vehicle                          | <input type="checkbox"/> Room, apartment, or house that you rent            |
| <input type="checkbox"/> Emergency shelter                       | <input type="checkbox"/> Staying in a family member's room, apt. or house   |
| <input type="checkbox"/> Foster care home/foster care grp home   | <input type="checkbox"/> Staying or living in a friend's room, apt or house |
| <input type="checkbox"/> Hospital (non-psychiatric)              | <input type="checkbox"/> Substance abuse treatment facility or detox center |
| <input type="checkbox"/> Hotel or motel paid for with a voucher  | <input type="checkbox"/> Transitional housing for homeless persons          |
| <input type="checkbox"/> Hotel or motel paid for without voucher | <input type="checkbox"/> Transportation site or station                     |
| <input type="checkbox"/> Jail                                    | <input type="checkbox"/> Varied from place to place                         |
| <input type="checkbox"/> Juvenile detention facility             | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Migrant Shelter                         |   |
| <input type="checkbox"/> On the street, under a bridge, etc.     |   |

**Total number of times homeless** (*including this time - choose one*):

- 0  1  2  3  4  5 to 7  8 to 10  11 or More

**Number of times homeless in the past three years** (*choose one*):

- 0  1  2  3  4  5 to 7  8 to 10  11 or More

**How long have you been homeless this time?** (*choose one*):

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Less than 1 month  | <input type="checkbox"/> 1 to 3 months | <input type="checkbox"/> 4 to 6 months | <input type="checkbox"/> 7 to 11 months     |
| <input type="checkbox"/> 12 mos. to 2 years | <input type="checkbox"/> 3 to 5 years  | <input type="checkbox"/> 6 to 10 years | <input type="checkbox"/> More than 10 years |

**Reasons or contributing factors to homeless situation (may check more than one):**

- Abuse or violence in my home
- Alcohol/substance abuse problems
- Asked to leave
- Bad credit
- Couldn't pay utilities
- Discharge from foster care
- Discharged from jail
- Discharged from prison
- Family member or personal illness
- Legal problems
- Lost a job/couldn't find work
- Medical expenses
- Mental illness
- Moved to find work
- Problems with public benefits
- Relationship problems or family break-up
- Reasons related to my sexual orientation
- Unable to pay rent/mortgage
- Other \_\_\_\_\_

**Tell us about your last permanent address (where you last lived for 90 days or more):**

Last Permanent Address: \_\_\_\_\_  
 Last Permanent City: \_\_\_\_\_ State/Province: \_\_\_\_\_  
 Last Permanent Zip Code: \_\_\_\_\_ Dates resided from \_\_\_\_\_ to \_\_\_\_\_

Please list all states that you have lived in since the age of 18:

State: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ Dates lived there: \_\_\_\_\_  
 State: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ Dates lived there: \_\_\_\_\_  
 State: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ Dates lived there: \_\_\_\_\_  
 State: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ Dates lived there: \_\_\_\_\_

**Employment:**

Currently Employed:  Yes  No  
 How Many Hours Worked Last Week: \_\_\_\_\_ Where: \_\_\_\_\_  
 Type of Work:  Permanent  Temporary  Seasonal  Contract Based  
 If not employed, are you looking for work:  Yes  No  
 If not employed, what was timeframe of last job: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Type of work: \_\_\_\_\_  
 If not employed explain why: \_\_\_\_\_

**Income from work & other sources:**

Received Income From Work Last Month:  Yes  No  
 Income from Employment in Dollars: \$ \_\_\_\_\_

**Income received from other sources:**  Yes  No

Unemployment:	\$ _____	Retirement from Soc Security:	\$ _____
Supplemental Security Income:	\$ _____	Veteran's Pension:	\$ _____
Social Security Disability Income:	\$ _____	Pension from Former Job:	\$ _____
Veteran's Disability Payment:	\$ _____	Child Support:	\$ _____
Private Disability Insurance:	\$ _____	Alimony/Other Spousal Supp:	\$ _____
Worker's Compensation:	\$ _____	Aid to the Needy and Disabled:	\$ _____
Temp Assist for Needy Families:	\$ _____	Old Age Pension (OAP):	\$ _____
General Assistance:	\$ _____	Other Sources:	\$ _____
		Describe: _____	\$ _____

Non-Cash Benefits	Eligible	Application Submitted	Currently Receiving	Past Recipient
Food Stamps - \$_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicare Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Florida Kid Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women Infants Children (WIC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veteran's VA Medical Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CDS - Child Care Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rental Assistance, Section 8, Housing Vouchers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Housing assistance through any other agency: \_\_\_\_\_

Other benefit sources: \_\_\_\_\_

**Education:**

Are you in school now: Yes No

Working on a degree/certification: Yes No

Do you have a vocational or apprenticeship certificate: Yes No

Highest level of education completed (*choose one*):

- No schooling
- 9<sup>th</sup> grade
- High School Diploma
- Preschool to 4<sup>th</sup> grade
- 10<sup>th</sup> grade
- GED
- 5<sup>th</sup> or 6<sup>th</sup> grade
- 11<sup>th</sup> grade
- Post Secondary
- 7<sup>th</sup> or 8<sup>th</sup> grade
- 12<sup>th</sup> grade, no diploma

Received Degrees (*choose all that apply*):

- Technical Degree or Certificate
- Masters Degree
- Doctoral, all but dissertation
- Associates Degree
- Doctoral Degree
- Other Graduate Degree
- Bachelors Degree
- Post-Doctoral Work

**Children** (*for minors up to age 17*):

**Total number of children:** \_\_\_\_\_

Last Name	First Name	Sex	DOB	Race	Name of School/Daycare	SSN

If child(ren) is/are **between ages 4-17** and not in school explain why (*may check more than one*):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> None                                 | <input type="checkbox"/> Residency requirements          | <input type="checkbox"/> Birth certificates             |
| <input type="checkbox"/> Physical exam requirements           | <input type="checkbox"/> Immunization requirements       | <input type="checkbox"/> Transportation                 |
| <input type="checkbox"/> Lack of available preschool programs | <input type="checkbox"/> Legal guardianship requirements | <input type="checkbox"/> Availability of school records |

If **younger than age 4**, why not in daycare (*may check more than one*):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Expense                         | <input type="checkbox"/> Do not qualify for CDS     | <input type="checkbox"/> Availability of records         |
| <input type="checkbox"/> Not wanting to enroll           | <input type="checkbox"/> Immunization requirements  | <input type="checkbox"/> Transportation                  |
| <input type="checkbox"/> Lack of available/open programs | <input type="checkbox"/> Physical Exam requirements | <input type="checkbox"/> Legal guardianship requirements |

Who has legal custody of the child(ren)?: \_\_\_\_\_ Where are they living?: \_\_\_\_\_

Do you or the other parent have visitation rights?  Yes  No

If yes, how often & where does this occur? \_\_\_\_\_

Is there a safety concern? If yes, please explain: \_\_\_\_\_

Have you ever been investigated for child abuse and/or neglect:  Yes  No - If yes, list dates involved: \_\_\_\_\_

If yes, explain incident: \_\_\_\_\_

DCF caseworker's name: \_\_\_\_\_ Phone: \_\_\_\_\_

City/State/County: \_\_\_\_\_ Dates of involvement: \_\_\_\_\_

What was the outcome? \_\_\_\_\_

**Domestic Violence:**

Experienced Abuse:  Current  In the Past  No

If Current or Past, How Recent:

- |   |  |                                       |   |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Immediately prior to contact | <input type="checkbox"/> 24-48 hours ago | <input type="checkbox"/> Last week    | <input type="checkbox"/> Last month     |
| <input type="checkbox"/> Past 3 months                | <input type="checkbox"/> 3 - 6 months    | <input type="checkbox"/> 6 -12 months | <input type="checkbox"/> More than 1 yr |
| <input type="checkbox"/> Don't know                   |  |                                       |   |

Is there a current safety concern:  Yes  No

**Health Information:**

General Health (*choose one*):  Excellent  Very Good  Good  Fair  Poor

Currently Pregnant:  Yes  No  Don't Know  Not Applicable

If yes, what is the due date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

Physical Disability:  Current  In the Past  No

If yes, type of disability: \_\_\_\_\_

Expected to be of long duration:  Yes  No

Are you able to work or re-train?  Yes  No

Developmental Disability:  Current  In the Past  No

If yes, type of disability \_\_\_\_\_

Diagnosed HIV/AIDS:  Yes  No  Don't Know

**Drugs:**

a. Have you ever used drugs?  Yes  No

If yes, when and what: \_\_\_\_\_

b. When was the last time you used drugs? \_\_\_\_\_

c. Have you ever been in a drug treatment program?  Yes  No

If yes, dates, city and state, name of treatment facility: \_\_\_\_\_

d. Have you ever been arrested for any drug related offenses?  Yes  No

If yes, dates, city and state, offense: \_\_\_\_\_

**Substance Use:**

- a. When was the last time you had something alcoholic to drink? \_\_\_\_\_
- b. How much do you drink at one time? \_\_\_\_\_
- c. How many times did you drink last month? \_\_\_\_\_
- d. Is there a history of alcoholism in your family? \_\_\_\_\_
- e. Has your drinking caused any problems for you? Yes No  
Please explain: \_\_\_\_\_
- f. Have you ever been arrested for any alcohol related driving offenses? Yes No  
Please explain: \_\_\_\_\_
- g. Have you ever been in an alcohol treatment program? Yes No  
If yes, when and where: \_\_\_\_\_

**Mental Health History** (*psychiatric or emotional*):

Have you ever received treatment for an emotional problem or mental disorder? Yes No  
 If yes, please list the diagnoses: \_\_\_\_\_  
 Who is your mental health provider? \_\_\_\_\_  
 Have you ever been prescribed medications for a mental, emotional or behavioral concern?  
Yes No - If yes, please list:  
 Name(s) of medication(s): \_\_\_\_\_  
 Dates taking medication: \_\_\_\_\_

**Criminal Background:**

Have you ever been arrested or ever been charged of a crime? Yes No  
 If yes, list dates, city, county, state, and explain: \_\_\_\_\_  
 \_\_\_\_\_  
 Are you currently involved in any court/legal proceedings? Yes No  
 If yes, list dates, city, county, state, and explain: \_\_\_\_\_  
 \_\_\_\_\_

**ANSWER THE FOLLOWING QUESTIONS IN DETAIL** (*attach an additional sheet if necessary*):

What steps have you taken, so far, to prevent you from becoming homeless?  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

Once you obtain housing, what are your:

- 1. *Educational Goals*: \_\_\_\_\_
- 2. *Career Goals*: \_\_\_\_\_
- 3. *Life Goals*: \_\_\_\_\_

**REFERENCES:** (*List people, unrelated to you, who we can contact for references.*)

**Personal/Professional Reference:**

Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 How long have you known: \_\_\_\_\_

**Personal/Professional Reference:**

Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
How long have you known: \_\_\_\_\_

**Personal/Professional Reference:**

Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
How long have you known: \_\_\_\_\_

*I give Project Hope permission to CONTACT ALL REFERENCES & run a CRIMINAL BACKGROUND CHECK (see pages 13 & 14 Fair Credit Reporting Act). I understand that if I fail to provide written permission, my application will not be processed.*

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

**ATTEST OF INFORMATION**

*I attest that all the information provided in this application is honest and accurate to the best of my knowledge. I understand that any deliberate misrepresentation of the information could result in my being denied acceptance into or expelled from transitional housing.*

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Printed Name

**Please complete ALL 14 pages** to include *Fair Credit Reporting Act & CMIS Release*.  
**Incomplete or illegible applications will be returned.**

Return completed application to:  
Project Hope \* 830 NE 28<sup>th</sup> St. #201 \* Ocala, FL 34470

*All applicants are to be assured of confidential treatment of personal information to the extent possible. PH shall obtain written permission for the release of information, unless such release is otherwise authorized by law.*



*Project  
Hope*

## Address & Employment History

Name of Applicant: \_\_\_\_\_

Intake Appointment: \_\_\_\_\_

### List the places you have resided in the past 5 years.

1. Address: \_\_\_\_\_  
Name of apartment complex: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
County: \_\_\_\_\_ Dates resided: \_\_\_\_\_ to \_\_\_\_\_
2. Address: \_\_\_\_\_  
Name of apartment complex: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
County: \_\_\_\_\_ Dates resided: \_\_\_\_\_ to \_\_\_\_\_
3. Address: \_\_\_\_\_  
Name of apartment complex: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
County: \_\_\_\_\_ Dates resided: \_\_\_\_\_ to \_\_\_\_\_
4. Address: \_\_\_\_\_  
Name of apartment complex: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
County: \_\_\_\_\_ Dates resided: \_\_\_\_\_ to \_\_\_\_\_
5. Address: \_\_\_\_\_  
Name of apartment complex: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
County: \_\_\_\_\_ Dates resided: \_\_\_\_\_ to \_\_\_\_\_
6. Address: \_\_\_\_\_  
Name of apartment complex: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
County: \_\_\_\_\_ Dates resided: \_\_\_\_\_ to \_\_\_\_\_
7. Address: \_\_\_\_\_  
Name of apartment complex: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
County: \_\_\_\_\_ Dates resided: \_\_\_\_\_ to \_\_\_\_\_



**List the places you have been employed in the past 5 years.**

**Present Employer:**

Name of Company: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Assigned Tasks: \_\_\_\_\_ Start Date: \_\_\_\_\_

Assigned Days & Hours: \_\_\_\_\_ Pay Rate: \_\_\_\_\_

1. Previous Employer:

Name of Company: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Assigned Task: \_\_\_\_\_ Start & End Dates: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

2. Previous Employer:

Name of Company: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Assigned Task: \_\_\_\_\_ Start & End Dates: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

3. Previous Employer:

Name of Company: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Assigned Task: \_\_\_\_\_ Start & End Dates: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

4. Previous Employer:

Name of Company: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Assigned Task: \_\_\_\_\_ Start & End Dates: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

5. Previous Employer:

Name of Company: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Assigned Task: \_\_\_\_\_ Start & End Dates: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

# Project Hope of Marion County

## Consent to Release Information

**Project Hope** has policies and procedures to protect confidential information when received on the telephone or during an interview. Our notice of Privacy Practices is available to you.

If you consent, we have the ability to share your information with our collaborating entities to be used for intake assessment. You can choose to share all or part of the information that you have submitted including basic demographic information, residential, employment skills/income, military/legal, service needs, goals, and outcomes. This cannot take place unless you provide written consent by signing and dating this **Consent to Release Information**. No medical, mental health or substance use history will be shared unless you provide express written consent. Your information and information contained on the application about other residents will be shared for a period of no more than 4 years from today's date.

I, \_\_\_\_\_ authorize **Project Hope** to disclose to appropriate entities any information regarding my general condition, past and present, and/or information about other family members or other residents contained in the application concerning services provided to and/or required by me and others I have listed on the application. This consent may be revoked by me or any other family member or resident, at any time except to the extent that action has been taken in reliance thereon. This consent unless expressly revoked earlier will expire four years from the date indicated below. I declare that the information I give is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Project Hope of Marion County/Pathways Community Network  
Client Authorization Form**

I understand that **Project Hope**, may be a part of the **Pathways Community Network**, a computer network designed to reduce the amount of time and effort it takes for me to obtain the social services I need. **This agency** has my permission to:

- ✓ Enter in the system information concerning my situation and need for assistance
- ✓ Review information about me in the **Pathways** system

I understand that:

- ✓ Agencies in the **Pathways** system will keep this information confidential.
- ✓ Other agencies will be able to look at this information only if I give each of these agencies my permission.
- ✓ Staff at each agency receives regular training on client confidentiality and their legal responsibility to keep my information private.
- ✓ The **Pathways** system uses passwords and computerized codes to protect my privacy.
- ✓ Shared information may include my name, age, gender, marital status, veteran status, address, housing status, and basic information about my goals and the services I receive.
- ✓ I can obtain a copy of information about me collected by the **Pathways** system, except for psychotherapy notes and other information kept private by law.

I also understand that I have the right to refuse to grant this authorization, and that even if I give my permission for **this agency** to access my information in the **Pathways** system, I can revoke that permission, in writing, at any time, without penalty. The permission I am giving **this agency** to view my information and to place information about me in the **Pathways** system will expire four-years from today's date: \_\_\_\_\_.

I also understand that under certain circumstances, **this agency** or **Pathways** may be legally required to disclose some or all of my confidential information. This may happen if there is any evidence of child abuse, if there is evidence I may harm others or myself, or if a court orders that my information be disclosed.

In order to improve services for persons in need, experts may study data from the **Pathways** system and other sources. As a result, an independent researcher may need to view personal information, such as names and social security numbers, to make sure that records are not counted twice or duplicated. This researcher will remove all personally identifiable information before anyone else examines the data, so that the privacy of those who received services is protected. This procedure is done in accordance with HIPAA and professional standards, under strict government and research institution supervision, and in compliance with all regulations that specifically address those who have received services for mental health, substance abuse, HIV/AIDS, and domestic violence.

I authorize **this agency** to enter my information, and to view information about me in the **Pathways system**.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Witness

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

The following children under 18 and/or adult dependents are covered by this authorization form.

_____	_____	_____
name	age	relationship to client

_____	_____	_____
name	age	relationship to client

_____	_____	_____
name	age	relationship to client

_____	_____	_____
name	age	relationship to client

_____	_____	_____
name	age	relationship to client

_____	_____	_____
name	age	relationship to client

**FAIR CREDIT REPORTING ACT  
DISCLOSURE AND AUTHORIZATION**

**Disclosure:** In order to evaluate your application for Project Hope’s self-sufficiency program or, if accepted, to assist management with decisions, Project Hope may obtain consumer reports, investigate consumer reports and criminal history records check regarding you. These reports are any information from a consumer reporting agency bearing upon your credit history, character, reputation, personal characteristics, medical information, or mode of living which is used or collected for the purpose of informing any decision regarding your prospective or actual program relationship.

You have certain rights regarding these reports and their use as defined under the Fair Credit Reporting Act and as summarized in “A Summary of Your Rights under the Fair Credit Reporting Act” which has been provided to you.

**Authorization:** I voluntarily authorize Project Hope to obtain consumer reports, investigative consumer reports and criminal history records check about me in order to make informed decisions regarding my proposed or actual program relationship with Project Hope. The information obtained may include medical information. I acknowledge that I have rights under the Fair Credit Reporting Act including those discussed in “A Summary of Your Rights under the Fair Credit Reporting Act” which I have received and reviewed.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth       Male       Female

\_\_\_\_\_  
Drivers License #      State

\_\_\_\_\_  
Maiden Name/Alias

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Other Aliases

## **A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT**

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of every “consumer reporting agency” (CRA). Most CRA’s are credit bureaus that gather and sell information about you – such as if you pay your bills on time or have filed bankruptcy – to creditors, employers, landlords, and other businesses. You can find the complete text of the FCRA, 14 U.S.C. 1681-1681u et seq., at the Federal Trade Commission’s web site (<http://www.ftc.gov>) The FCRA gives you specific rights, as outlined below. You may have additional rights under state law. You may contact a state or local consumer protection agency or a stated attorney general to learn these rights.

- **You must be told if information in your file has been used against you.** Anyone who uses information from a CRA to take action against you – such as denying an application for credit, insurance, or employment – must tell you, and give you the name, address, and phone number of the CRA that provided the consumer report.
- **You can find out what is in your file.** At your request, a CRA must give you the information in your file, and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You are also entitled to one free report every twelve months upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.
- **You can dispute inaccurate information with the CRA.** If you tell a CRA that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its finding to the CRA. (The source must also advise national CRAs – to which it has provided the data – of any error). The CRA must give you a written report of the investigation, and a copy of the report, if the investigation results in any change. If the CRA’s investigation does not resolve the dispute, you may add a brief statement to your file. The CRA must normally include a summary of your statement in future reports. If an item is altered or a dispute statement is filed, you may ask that anyone who has recently received your report be notified of the change.
- **Inaccurate information must be corrected or deleted.** A CRA must remove or correct inaccurate information from its files, usually within 30 days after you dispute it. **However, the CRA is not required to remove accurate data from your file unless it is outdated or cannot be verified.** If your dispute results in any change in your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the CRA must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.
- **You can dispute inaccurate information items with the source of the information.** If you tell anyone – such as a creditor who reports to a CRA – that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute. In addition, once you’ve notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.
- **Outdated information may not be reported.** In most cases, a CRA may not report negative information that is more than seven years old; ten years for bankruptcies.
- **Access to your file is limited.** A CRA may provide information about you only to people with a need recognized by the FCRA – usually to consider an application with a creditor, insurer, employer, landlord, or other business.
- **Your consent is required for reports that are provided to employers, or that contain medical information.** A CRA may not give out information about you to your employer, or prospective employer, without your written consent. A CRA may not report medical information about you to creditors, insurers, or employers without your permission.
- **You can choose to exclude your name from CRA lists for unsolicited credit and insurance offers.** Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll free number for you to call if you want your name and address excluded from future lists. If you call, you must be kept off the lists for two years. If you request, complete and return the CRA form provided for this purpose, you must be taken off the lists indefinitely.
- **You may seek damages from violators.** If a CRA, a user or (in some cases) a provider of CRA data, violated the FCRA, you may sue them in state or federal court.