**Helping Hands**

**Outreach Ministries**

**Lowell Street**

**Intake Packet**

**Please Fill Out Completely**

**Are you a registered Sex Offender or do you have an arson conviction? Y/N**

**Due to funding received by Helping Hands from HUD we cannot accept anyone with a sex offense or an arson conviction.**

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Program Contract

Helping Hands Outreach Ministries Men’s Recovery Shelter (transitional housing) provides services for men who are reintegrating into the community from rehabilitation centers, incarceration, or other settings. We are a DIRECTED SERVICE PROGRAM that engaged with those who are engaged in their recovery and their lives. This program will review progress made by individuals on a weekly basis. If it is deemed by staff that there is insufficient progress, we will ask you to leave the program.

ALL participants are required to engage in case management services at not less than one meeting bi-weekly. Helping Hands Outreach Ministries will review client files to assess needs services, barriers to employment and other services needed. You are an integral and active participant here. Please address any needs, concerns or other items you feel are important.

Participants are required to remit fees of $115.00 or complete 16 hours of community service per week for a **maximum of 2 weeks**. The case manager MUST approve community service prior to any work being done. Program fees start on Friday and end on Thursday of the following week. Program fees will be prorated at a charge of $16.50 per day for days between Friday and Thursday of the following week.

**The use and/or possession of drugs/alcohol & possessions of paraphernalia are strictly prohibited.** No one using substances need apply. Helping Hands Outreach Center adheres to a strict **zero tolerance** program. Anyone entering the program will be subject to a drug screening and a breathalyzer test and failure of either will be grounds for **denial** into the program until such time as you are drug and alcohol free.

* Anyone using substances will be strongly urged to seek detoxification services. Any paraphernalia will be confiscated and properly disposed of. Spice is considered a drug in this facility. A drug is defined as any mind or mood altering substance **NOT** prescribed by a physician. We do allow the consumption of cigarettes and/or tobacco **ONLY.**
* **ALL** prescription medicine must be reported to staff upon entry and while in the program. Medications are logged and placed in the locked and secured medication locker.
* **ABSOLUTELY** no prescription medications are to be kept in your rooms unless approved by the case manager or the program director. Any unauthorized medications found in rooms will result in immediate termination from the program.
* **ALL** prescriptions must have current and verifiable information.
* Participants are required to attend mutual support (i.e. AA, NA, HA, or SMART) meetings as determined by the client and the case manager.

You are subject to UA/Breath test for random or suspicion of use. Refusal to submit to testing will result in termination from the program. If your asked for a urine test you must **remain in the office until the test is completed** or it will be considered a refusal and you will be terminated from the program **IMMEDIATELY.**

**Unless you are on disability, you are required to seek employment while in the program.**

* Employment search logs, meeting list sheets and community service logs **MUST** be returned Monday of each week.
* Search logs **MUST** have 15 verifiable job searches per week.
* Incomplete or missing job search logs will result in disciplinary action, up to and including termination from the program.
* Volunteer service does **NOT** exempt participants from completing job searches.

**Unless you are on working you are required to be out of the house no later than 9 am, you may return at 12:00 pm for lunch but you must be back out by 1 pm and are allowed to return at 4 pm. Those on disability must be out at 8 am and can return at 12:00 pm and may remain in the house the rest of the day.**

While being out during the day: (Suggested Activities)

* Seeking Employment
* Attending meetings (AA, NA, HA or SMART)
* Doctor or therapy appointments
* Working
* Volunteering

**Program Fees**

The expectation is that you will remain current on your program fees at all times. There are situations when you may fall into arrears and your maximum allowed arrearage for program fees is 3 weeks (Currently $345, subject to change upon change of program fees). If your program fee balance is at this level or higher program participation is subject to termination. You cannot carry a balance of $346 more than 30 days (either consecutive or cumulative)

You are strongly encouraged to engage in the program here and pay fees when they are due or complete 16 hours of community service (For a maximum of 2 weeks). Community service sheets MUST be turned in no later than Monday or the community service hours will not be processed until the following week.

Examples:

* **A program fee payment is paid on Monday past the Friday due date:** This counts as 3 days towards the 30 days allowed.
* **A balance of $346 is carried for a week:** Either counts as 7 days towards the 30 day total or can potentially cause program termination.
* **Within a 6 months period a balance of $346 is carried for 30 days (either consecutive or cumulative) your program participation will be terminated.**
* **A balance of $344 or less is maintained for a week:** Lack of progress with fee requirements can potentially result in termination from the program. The outstanding balance due must be reduced each week a balance is carried until brought fully current.
* **A community service sheet is turned in Wednesday after the Monday due date and the program fee due on that Friday is $230:** This would result in a balance of $345. This results in
* program fee maximum being exceeded. The result would be 7 days counted towards the maximum allowed of 30 days or termination from the program.
* **These requirements are evaluated on a case-by-case basis and communicated by the case manager each week.**
* **We strongly suggest that you meet the requirements while in the program.**
* **The case manager may, based on exceptional circumstances, grant an additional 2 week period. Further exceptions will be considered and granted by the board of directors on a case-by-case basis based on extenuating circumstances.**

**Incident Reports:**

**Any resident who receives 3 incident reports for any reason is subject to disciplinary action up to and including dismissal from the program.**

**Chores are a requirement within our program.**

* Chores are assigned weekly and are required to be completed daily. Time sensitive chores are required to be completed after house meeting (Mon-Fri) and at 6 pm on weekends and are: **Basement Floors, Trash, Community Room, Kitchen, 1st floor bathroom and 3rd floor bathroom**. All other chores may be done at any time during the day.
* Failure to do assigned chores or signing the chore sheet when the chore is completed may result in program termination.

**Curfew:**

**You are responsible to sign in for the night at or before your appointed curfew unless you are working at which point you would write “work on the sign in sheet.** Curfew is as follows:

* **Day 1 to day 13**: 9 pm
* **Day 14 to day 27**: 10 pm
* **Day 28 and beyond:** 11 pm

**Missing curfew for any reason other than work, medical issues or weekend pass will result in automatic dismissal from the program. No exceptions unless approved by the case manager or the program director. Once you sign in for curfew you may not leave the premises for any reason. You are allowed however to go out of the building to smoke a cigarette and come back into the building.**

**Helping Hands is a smoke free facility. Anyone caught smoking ANYWHERE in the house will be immediately dismissed from the program**. This is due to both insurance and fire code requirements. Allowances are made for smokers to go outside to smoke either on the sidewalk or on the deck outside after 11 pm curfew.

There is to be **NO hotplates, microwaves, toaster ovens or crock pots in the rooms.** Cooking of any kind is **not** permitted in the rooms due to insurance and fire code requirements. Anyone caught with the above items in their room will be dismissed immediately.

You must be in your room **no later than 10:55 pm every night** for head count unless you are at work, at the hospital for a medical issue or on a weekend pass. Unless approved by the case manager or program director in advance.

**If you have a medical issue that requires you to be out of the house past curfew at 11 pm you will be required to contact volunteer staff or the house manager upon re-entry into the house and present your hospital paperwork as proof of the time you arrived and the time you left the medical facility. Failure to do so could result in disciplinary action up to and including dismissal from the program.**

Rooms are furnished with a bed, dresser, pillow, bed linens, blankets, a refrigerator, and other furnishings. These items are property of Helping Hands and not to leave the premises. All items are to be returned clean when exiting the program.

Participants are responsible for ensuring the building is secure at all times (except during business hours). Make sure all doors are locked upon entrance and exit from the building. Anyone requiring entry into the building after 11 pm **(i.e. work or from a medical facility) MUST** contact volunteer staff or the house manager to let them know they are re-entering the building. This is to ensure that the doors to the facility are secure. You are issued one set of keys. There is a $10 key charge for replacement of keys.

No pets are allowed in the building at any time.

Unauthorized borrowing is not tolerated at Helping Hands Outreach Ministries. Please be respectful of others property. If you are found to have been engaged in unapproved borrowing, your participation will be terminated indefinitely.

**The following offenses are subject to IMMEDIATE dismissal and grounds for a permanent ban from the program and the property:**

* **Any** act of aggression, violence or confrontation with volunteer staff, house manager, , another resident, case manager or the program director. Acts of aggression, violence or confrontation include but are not limited to: Racial slurs, physical contact, conversations of an aggressive or loud nature, threats either direct or indirect or other situations deemed to be violent to any resident, volunteer staff or paid staff.
* Theft of **ANY** kind from a resident, staff or from helping hands. This may include unauthorized borrowing from another resident in which an issue arises that the lender is not paid back what is borrowed.
* Any guest that does not follow the rules as outlined in this application and is found to be causing an unnecessary issue to another resident.

**ANY** resident found to have a person or persons in their room that is not authorized to be in their room including a male or female guest. All residents are allowed to have

* guests in the community room **only** in clear view of the camera and within the allowed time during the day. **Residents are NOT to give guests any food or drinks from helping hands. Any resident found giving helping hands food or drinks will be subject to an incident report.**
* Anyone found to be or suspected of selling or trading drugs or alcohol of any kind.
* Any resident in the house doing laundry that is not their own.

**Rules in the above section are subject to change without prior notification to residents of Helping Hands Outreach Center and are on a case by case basis.**

Personal hygiene is required of all participants. If you require hygiene products please communicate your needs to staff.

Food and drinks Helping Hands gets from both the Food Bank and from Hannaford is limited and as such should be taken to make sure all residents have a chance to get some. There is to be no taking of an excessive amount of food or drinks. **Any resident caught taking more than their fair share of food or drinks will get and incident report.**

Participants are not allowed in ANY room other than the one assigned by Helping Hands **AT ANY TIME OR FOR ANY REASON. Anyone caught in another residents room will have their participation terminated and will be banned from the program and the property permanently.**

Proper dress is required at all times (Street clothes). Footwear is required at all times.

**The management reserves the right to inspect participants rooms to determine their physical condition.**

* Regarding health
* Safety
* Unauthorized occupancy
* Protection of property
* Make needed repairs
* Alterations/Installations
* Energy conservation
* Contraband
* General inspection

Upon exit from the program, please make sure you leave the room the way it was when you entered the program

You are required to keep your room clean and neat while within the program.

* No personal furnishings are to be in the room you are assigned.
* No alterations to the dwelling are allowed.
* Please do not tack, nail, paint or otherwise alter the physical property
* If there is a concern, please communicate this to volunteer or paid staff.

You may request a weekend pass:

* After (2) weeks in the program.
* No disciplinary actions have occurred.
* With approval from case manager or program director.
* Have less than $115 fees owed.
* One weekend pass is allowed every two weeks
* Weekend pass MUST be in and approved by Thursday

Upon return from a weekend pass you are **required** to contact the house manager or volunteer staff and submit to a UA/Breath test upon return to the program.

Communal living requests that we are respectful of others. Please be courteous and keep noise levels reasonable. TV’s are not permitted in individual rooms unless approved by the case manager or the program director. Volunteer staff are permitted to have TV’s.

The downstairs (community room and kitchen) is closed from 9am – 12 pm and from 1 pm – 5 pm. You may be in the downstairs area from 12pm – 1 pm **ONLY** for lunch and snacks. The downstairs area is open all day on weekends. Sunday, Monday, Tuesday, Wednesday and Thursday the downstairs area is closed at 11 pm. Friday, Saturday and Holidays downstairs is closed at 1 am after 11 pm room checks have been completed.

All residents are required to be in the basement area at 5:55 pm Mon – Fri for house meeting unless at work, IOP or at a medical facility. Recovery meetings may be attended after the house meeting. ALL residents not working, at IOP or at a medical facility are required to attend house meeting. Exceptions are made only by case manager and program director.

I have completely read and understand all the policies of Helping Hands Outreach Ministries Transitional Shelter. I agree to participate in the program fully. I will engage In case management services. I will actively seek employment and remit required program fees. I agree to complete my chore as assigned. I will notify volunteer staff, house manager, case manager or the program director 24 hours prior to program departure.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Signature) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature Date

Helping Hands Application for Participation

50 Lowell St DOA\_\_\_\_\_\_\_\_ Room # \_\_\_\_\_\_

Manchester, Nh 03101 DOE\_\_\_\_\_\_\_\_ Bed # \_\_\_\_\_\_\_\_

DOD\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present (or last) address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone# (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you previously stayed at a shelter? \_\_\_\_\_ Do you smoke? \_\_\_\_\_

**Person to notify in CASE OF EMERGENCY:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to applicant: \_\_\_\_\_\_\_\_\_\_\_

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

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

Phone# (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Church**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pastor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Phone# (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_How long have you attended this church? \_\_\_\_

**Present or Previous Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of Employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone# (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**References:**

Name Address Phone# Occupation

1. \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

**Participant Agreement Form**

1. I AGREE AND SHALL RESPECT ALL THE POLICIES OF HELPING HANDS OUTREACH CENTER.

2. I AGREE THAT ANY INFRACTION OF THESE POLICIES WILL LEAD TO MY DISMISSAL WITHOUT NOTICE.

3. I AGREE THAT EVERY 7 DAYS A PERSONAL REVIEW WILL BE TAKEN TO DETERMINE MY LENGTH OF STAY.

4. I AGREE THAT I AM PHYSICALLY ABLE TO WORK AND THAT I AM EMPLOYABLE OR I AM PERMANANTLY DISABLED AND GETTING SSI OR SSDI AND AM ABLE TO PAY THE REQUIRED PROGRAM FEES

5. I AGREE TO ATTEND THE REQUIRED CASE MANAGEMENT COUNSELLING SESSIONS AS PART OF THE RESIDENCE PROGRAM FOR ACCOUNTABILITY. ANY DECEITFULNESS OR LYING ARE GROUNDS FOR DISMISSAL.

**Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .**

(For Office Use Only)

Date of Application \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Arrival \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Departure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnic Origin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOU WILL BE DISCHARGED IF:

* YOU EXHIBIT VIOLENCE, VERBAL THREATS, FIGHTING OR IF YOU EXHIBIT A BAD ATTITUDE.
* YOU KEEP MEDICATIONS OF ANY KIND IN YOUR ROOM WITHOUT PERMISSION.
* YOU ARE CAUGHT STEALING OR GAMBLING.
* YOU ARE EHIBITING A LACK OF PARTICIPATION OR COOPERATION WITH HELPING HANDS OUTREACH CENTER.
* YOU ARE SUSPECTED OF DRUG USE, DRUG SALES, DRUG DISTRIBUTION OR TEST POSITIVE FOR DRUGS AND/OR ALCOHOL.

YOU ARE SUBJECT TO DISCHARGE AND WILL BE STAFFED IF

* YOU ARE FOUND IN STAFF OFFICES WITHOUT PERMISSION
* YOU USE ANY OFFICE, OFFICE EQUIPMENT OR COMPUTER WITHOUT PERMISSION
* YOU USE FOUL, VULGAR OR ABUSIVE LANGUAGE, INCLUDING INAPPRIPRIATE STORY TELLING (JOKES, ETC.) OR INAPPROPRIATE BEHAVIOR OR GESTURES.

DRUG ANALYSIS CONSENT

I AGREE TO SUBMIT TO ANY BREATHALYZER TEST OR URINALYSIS UPON REQUEST OF THE HOUSE MANAGER. I FURTHER AGREE TO ABIDE BY THE RULES AND REGULATIONS OF THE HELPING HANDS OUTREACH CENTER OR FACE IMMEDIATE DISCHARGE FOR ANY VIOLATION.

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REVIEW OF INCOME

REVIEW OF ANNUAL INCOME OF PREVIOUS YEAR

PRESENT EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW MANY WEEKS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RATE OF PAY\_\_\_\_\_\_\_

PREVIOUS EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW MANY WEEKS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RATE OF PAY\_\_\_\_\_\_\_\_

Other Sources of Income? SSI\_\_\_\_ Disability\_\_\_\_\_\_\_ Pension\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Monthly Benefit\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TOTAL YEAR-TO-DATE INCOME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CERTIFICATION OF INCOME**

One Person Very Low Income Low Income Moderate Income

$0 - $18,050 $18,051- $30,100 $30,101 - $41,700

Check One \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I VERIFY THAT THIS IS MY RANGE OF INCOME AND HEREBY CERTIFY THAT I HAVE NO OTHER INCOME.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HELPING HANDS OUTREACH CENTER**

**REQUIRED INCOME DOCUMENTATION**

**The following documentation is required by the city of Manchester, NH.**

**PROOF OF INCOME – You must supply one of the following:**

* **Copy of your most recent check stub**
* **Copy of your food stamp card (EBT)**
* **Copy of your Medicare or Medicare card**
* **Copy of your most recent IRS tax return**

**IF NO INCOME – You must supply one of the following**

* **Proof of pension**
* **Proof of disability**
* **Proof of Social Security**
* **A copy of your parole record**

**I understand that my acceptance into housing is dependent upon these required documents.**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**New Hampshire Continua of Care**

**HUD CoC APR TH PH ES Client Record Creation Intake Form for HMIS**

(Required by HUD for each client entering your project)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Refer to the 2014 HUD HMIS Data Standards Version 5.1 on the NH-HMIS website at: [www.nh-hmis.org](about:blank) for an explanation of the data elements in this form.

**Record creation** – Indicates the element is required to be collected when the client record is created. Certain data elements such as personal identifiers are necessary to create a unique client record. Data elements that must be collected at the point of “client record creation” are those that will have **only one** value for each client in the HMIS (e.g., Name). The information is collected and entered into HMIS when the client record is first created in the system. Data must be reviewed at each project entry and can be edited at any time to correct errors or to improve data quality.

|  |  |
| --- | --- |
| **Data Collection and HMIS Instruction Tips:**   * Check for signed consent form. * In SP, set backdate. Date should match project entry date. * Respond “Yes” to Veteran Status if the person is someone who has served on active duty in the armed forces of the United States. This does **not** include inactive military reserves or the National Guard unless the person was called up to active duty. | * Do NOT enter “Client doesn’t know” or “Client refused” unless the client tells you they do not know or they refuse to answer. * Reminder: Staff observation should NOT be used to collect information on:   • Ethnicity  • Race  • Gender  These responses must be self‐identified by the client. |
| **Date Form Completed:** \_\_ \_\_/ \_\_ \_\_/ \_\_ \_\_ \_\_ \_\_  **Intake Interviewer’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Case Manager’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Project Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Client’s ID:** \_\_\_\_\_\_\_\_\_\_\_\_  **Client’s Project Entry Date:** \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_  **Location:** (choose appropriate HUD-assigned CoC Code[s])   NH-500 (Balance of State/Concord)   NH-501 (Manchester)  NH-502 (Nashua) |
|  |  |

**New Hampshire Continua of Care**

**HUD CoC APR TH PH ES Client Record Creation Intake Form for HMIS**

(Required by HUD for each client entering your project)

**Section 1: Client creation (in ServicePoint use ClientPoint Search, Client Profile Tab, section Client Record Creation)**

|  |
| --- |
| **Client’s First, Middle, Last Name, Suffix:**   Full name reported  Partial, street name, or code name reported  **Alias\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Name Data Quality:**  Client doesn’t know Client refused  Data not collected |
|  Full SSN reported  Client doesn’t know  **SSN: - - SSN Data Quality:**  Approximate or partial SSN reported  Client refused  Data not collected |
| Is client a **US Military Veteran**?  Yes  No  If Yes to “US Military Veteran,” has client ever **received health care benefits** from a VA Center?  Yes  No  Is client **receiving Veterans Services**?  Yes  No  Is client **eligible for Veterans Services**?  Yes  No  If No to “eligible for Veterans services,” please select **Reason**:   Client not interested  Client doesn’t know  Data not collected  Please select **discharge type** for all persons who answered Yes to “US Military Veteran” and are not currently serving:   |  |  |  | | --- | --- | --- | |  Honorable |  General under honorable conditions |  Under other than honorable conditions (OTH) | |  Bad Conduct |  Dishonorable |  Uncharacterized | |  Client doesn’t know |  Client refused |  Data not collected | |
|  Full DOB reported  Client doesn’t know  **Date of Birth: / / Date of Birth Type:**  Approximate or partial DOB reported  Client refused   Data not collected |
| **Race:** (client can choose up to 5 categories)   American Indian or Alaska Native  Native Hawaiian or Other Pacific Islander  Client doesn’t know   Asian  White  Client refused   Black or African American  Data not collected |
| **Ethnicity:** (choose one):  Non Hispanic/Non-Latino  Hispanic/Latino  Client doesn’t know  Client refused  Data not collected |
| **Gender:**  Female  Male  Transgender male to female  Transgender female to male  Data not collected  Client doesn’t know  Client refused  Does not identify as female, male, or transgender |



**NEW HAMPSHIRE HOMELESS MANAGEMENT SYSTEM (NH-HMIS)**

**Client Acknowledgement Form**

**BY SIGNING THIS FORM, I ACKNOWLEDGE AND AUTHORIZE THE FOLLOWING:**

I confirm my understanding that personal information I provide is for the purpose of assessing my needs (and my family’s needs) for emergency shelter, housing, utility assistance, food, counseling and/or other services. The information may consist of the following:

* My financial situation, to include the amount of my income, and any savings of money and/or food stamps I may have. This information may also include debts I owe for utilities, rent, etc.
* Identifying and/or historical information regarding myself and members of my household under 18.

**I UNDERSTAND THAT**

 **If I am entering an Emergency Homeless Shelter,**

my identifying information, financial information, and any physical or mental health conditions that I may have will only be shared with the New Hampshire Emergency Shelter Network.

o A list of participating shelters will be provided on request.

o All of the shelters in this network follow all state and federal confidentiality laws and regulations.

1. My personal information will not be shared with other agencies outside of this shelter network in any way that identifies me.

 **If I am seeking assistance from a Homelessness Prevention or Rapid Re-Housing Program,**

my identifying information, financial information, and any physical or mental health conditions that I may have will only be shared with the New Hampshire Homeless Service Network.

o A list of participating programs will be provided on request.

o All of the shelters in this network follow all state and federal confidentiality laws and regulations.

o My personal information will not be shared with other agencies outside of this network in any way that identifies me.

 **If I am seeking assistance from any other shelter, or any transitional, or permanent housing Program,**

information I give concerning any physical or mental health conditions that I may have will not be shared with other agencies in any way that identifies me.

* I have the right to view the client confidentiality policies used by NH HMIS.
* Staff members who will see my information have signed agreements to maintain confidentiality regarding my information.
* This agency may share non-identifying information about people served with other parties working to end homelessness.
* This authorization does not guarantee that I will receive assistance.
* This authorization will remain in effect unless I revoke it in writing, and I may revoke authorization at any time.
* If I revoke my authorization, all information about me already in the database will remain, but will not be added to.
* I have the right to request information about who has accessed my information

**Both client and staff must sign acknowledgement of receipt of this notice.**

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Client or Authorized Representative (Sign your name) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print your name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of agency or program representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature if interpreter/translator, if applicable Date

If unable to get acknowledgement, specify why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A copy of this acknowledgement shall be provided to the client or representative, when requested

**NOTE: PAGE 2 MUST BE FILED AND KEPT ON RECORD WITH THE AGENCY**

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March 2013 NH-HMIS Client acknowledgement Form 2

**Your Information Rights**

* Ask us not to share your health information in the manner listed above by making a written request to our agency. We are not required to agree to your request, but if we do we will follow the directions given to us.
* Obtain a copy of this Notice of Privacy Practices. This notice is available in alternative formats upon request.
* See, review, and receive a copy of the information we maintain about you in certain records. You must make this request in writing and you may be charged a fee to pay for the cost of copying your record. There are certain situations when we may not give you the right to review your records. If this happens we will explain why we made this decision.
* Make an amendment (a correction or addition) to your medical information if you feel the information we have is inaccurate or incomplete. You must do this in writing.
* Receive an accounting (a detailed listing) of unauthorized disclosures we have made after July 1, 2012. This listing will not include disclosures made for treatment, payment, or health care operations purposes. You must make this request in writing.
* Ask any questions about how we handle your Protected Health Information or to file a complaint or report a problem.

**NOTE: PAGES 1 AND 3 MUST BE GIVEN TO THE CLIENT**

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March 2013 NH-HMIS Client Acknowledgement Form3