TRANSITIONAL HOUSING PROGRAM

PROGRAM APPLICATION FORM FOR

ASHBY HOUSE
DIGNITY COMMONS
HOUSE OF DIGNITY

OPERATION DIGNITY INC.
Transitional & Permanent Housing
3850 San Pablo Ave, Suite 102
Emeryville, CA 94608
PH: 800-686-9036
LOCAL: 510-287-8465
FAX: 510-287-8469

OPERATION DIGNITY INC.
3850 San Pablo Ave, Suite 102
Emeryville, CA 94608
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REQUIRED DOCUMENTATION FOR APPLICATION:

- PROOF OF VETERAN'S STATUS (DD214 OR STATEMENT OF SERVICE FROM THE VA REGIONAL OFFICE)
- STATE ISSUED ID CARD OR DRIVER'S LICENSE
- SOCIAL SECURITY CARD
- VERIFIABLE PROOF OF INCOME
- CURRENT TB TEST (Within 7 Days) of Entry
- BIRTH CERTIFICATE(S) AND SOCIAL SECURITY CARD(S) FOR CHILDREN UNDER THE AGE OF 18 YEARS (FAMILY APPLICANTS ONLY)

The above listed items need to be provided to this office before final approval for residency. This application must be complete or you will not be considered for the program.

Marguerite Bachand
Executive Director

OPERATION DIGNITY INC.
3850 San Pablo Avenue, Suite 102
Emeryville, CA 92608
PH: 510-287-8465
FAX: 510-287-8469

Operation Dignity Program Application

This application does not guarantee housing assistance of any kind.

INITIAL INTAKE AND ASSESSMENT FORM

Date: ____/____/_____

HEAD OF HOUSEHOLD:

Name: First: _____ Last: _____

Social Security Number: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female

Race: ☐ Native American/Alaskan
☐ Asian
☐ Black or African American
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Other: _____

Ethnicity: ☐ Hispanic
☐ Non-Hispanic

Current/ Last Address: _____

Phone number where we may reach you: _____

Contacts: Where we can reach you - please provide at least **3** contacts

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____ ___	_____	_____

How many adults (age 18 or over) are in your household? _____

Additional Adult Household Member(s)

Name: First: _____ **Last:** _____

Social Security Number: _____ **Date of Birth:** _____

Gender: □ Male □ Female

How many children (under 18) are in your household? : _____

Full name	Gender (M/F)	DOB	Social Security #	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*Child, Step-Child or Other

Is anyone in the household currently pregnant? □ Yes □ No

If yes, how many months? _____ Name: _____

Are they receiving services? □ Yes □ No

What services?: _____ Where?:_____

How many additional family members do you expect to join the household? _____

Household Income: (Account for all income received by household adults)

Source	Amount (Monthly)
□SSI	$_____
□SSDI	$_____
□Social Security	$_____
□General Assistance	$_____
□Temporary Aid to Needy Families (TANF)	$_____
□Child Support	$_____
□Veteran's Benefits	$_____
□Earned Income (Job)	$_____
□Unemployment Benefits	$_____
□Medicare	$_____
□Medicaid	$_____
□Food Stamps	$_____
□Other _____	$_____
□No financial resources	$_____
□Assets income	$_____
TOTAL MONTHLY INCOME:	$_____
Assets: What is the total value of your assets?	$_____

Usual Occupation: _____ **Last Job (& Dates):** _____

Housing History:

What is your current living situation?

- ☐ Street, park, abandoned building
- ☐ Emergency shelter
- ☐ Transitional housing
- ☐ Psychiatric facility*
- ☐ Substance abuse treatment facility*
- ☐ Hospital*
- ☐ Jail/prison*
- ☐ Domestic Violence Situation
- ☐ Living with Relative/Friends
- ☐ Rental Housing
- ☐ Other (specify): _____

How long have you been there?

- ☐ Less than 1 day
- ☐ 1-30 days
- ☐ 31-180 days
- ☐ 181-365 days
- ☐ 1-2 years
- ☐ More than 2 years

*Do not count these if you have stayed there for 30 days or less.

Homeless History:

Please list below ALL places you have resided in the past two (2) years, including apartments, residences, emergency shelters or other locations. Please begin with the most recent location, even if you are currently homeless, and continue with all other previous locations until you have listed your homeless and/or residential history for the last two (2) years. You may use the back of this form and/or attach additional sheets, if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you ever been evicted? ☐ Yes ☐ No

If yes, when?: _____ Reason: _____

Health/Disability:

Do you have a medical and/or mental health disability? ☐ Yes ☐ No

Disability/Health Problems: _____

_____

Physician's Name and Location: _____

Please list all medications you are currently prescribed: _____

_____

Have you ever received treatment for a substance abuse issue? ☐ Yes ☐ No

What is your drug(s) of choice?: _____

What is your sobriety date?: _____

Do you or a member of your household need disability accommodations? ☐ Yes ☐ No

If yes, please indicate a reason: _____

Convictions:

Are you currently on probation or parole? ☐ Yes ☐ No

Reason for conviction: _____

Conditions of probation/parole: _____

Additions:

If there is any remaining information you feel is important and should be added to your application, please use the space below: _____

_____

_____

_____

_____

_____

_____

Applicants for housing or residents who fail to provide accurate information may be expelled from housing at any time.

Signature: _____ Date: _____

OPERATION DIGNITY PROGRAM APPLICATION

The housing you are applying for is transitional housing for formerly homeless persons. The housing is also specifically tied to other eligibility and programmatic criteria. Some of the housing units are set aside for families with disabilities, some are set aside for survivors of domestic violence, some are set aside for persons with HIV/AIDS and still others are set aside for persons recovering from drug or alcohol addiction. This portion of the application will determine which of the housing units you are eligible for.

Have you ever applied to the Operation Dignity program before? □ Yes □ No

If yes, did you enter the program? □ Yes □ No

Are you willing to receive service coordination from the Operation Dignity program? □ Yes □ No

Are you willing to participate in your self-developed Service Plan? □ Yes □ No

What services do you need and what services do you currently receive:

Services	Services You Need or Currently Receive	Name of Program	Contact Person	Phone Number
Alcohol or Drug Abuse Services	□ need □ currently receive			
Education	□ need □ currently receive			
Employment/ Job Training	□ need □ currently receive			
Food	□ need □ currently receive			
Case Management	□ need □ currently receive			
Childcare	□ need □ currently receive			
Counseling	□ need □ currently receive			
Domestic Violence	□ need □ currently receive			
HIV/AIDS-Related Services	□ need □ currently receive			
Housing	□ need □ currently receive			
Legal	□ need □ currently receive			
Life Skills (outside of case management)	□ need □ currently receive			

Medical Care	□ need □ currently receive			
Mental Health Services	□ need □ currently receive			
Outreach	□ need □ currently receive			
Transportation	□ need □ currently receive			
Other	□ need □ currently receive			

Have you ever applied for housing or been housed through any Housing Authority in Alameda County (Public Housing, Section 8 Certificate or Voucher Program)? □ Yes □ No

If yes, from where and what program? _____

TO BE COMPLETED BY THE APPLICANT

I hereby affirm the enclosed information is true and complete to the best of my knowledge. I understand that any misrepresentation or omission will be grounds for cancellation of my application for housing assistance. I have read, or had read to me, and understand the Federal Privacy Act Statement attached to this application.

I understand the Operation Dignity Program may need to contact individuals and/or agencies to verify the above information. I further understand that my signature below serves as a time-limited consent to contact any individuals and/or agencies within the Dignity Commons/Operation Dignity Program (see attached). Disclosure of the information herein is required for eligibility determination and service coordination. I understand that if I have provided any false information, this may disqualify me from participation in the Shelter Plus Care Program. This form has been completed and read to me, prior to this signature. The consent is subject to revocation by the undersigned at any time, and if not earlier revoked it shall terminate on exit from the program.

WARNING: Section 001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any department or agency of the U.S. Government as to any matter within its jurisdiction.

NOTE: All information must be complete and accurate for consideration. This is <u>not</u> an entitlement program. This application does not guarantee assistance of any kind.

Signature: _____ Date: _____

To: Veteran Applying for Housing

From: Operation Dignity

Because the Veteran's Affairs (VA) is a partial funder of Operation Dignity beds, you are being referred to see the VA's Grant & Per Diem Program (GPD) Liaison at the VA Northern California Health Care System. You must communicate with the Liaison within 7 business days of admission to any Operation Dignity Transitional Housing Program. This is required by both Operation Dignity and the VA.

Please contact the Liaison assigned to your program.

House of Dignity (HOD)

Masaki Hirayama, LCSW 510-587-5053 OR 510-915-7899
Oakland VA-Oakland Behavioral Health Clinic (OBH)
1301 Clay Street, CA 94612 **or** 525 21st Street, Oakland, CA 94612
(by appointment only)

Ashby House (AH) or Dignity Commons (DC)

Sue Jacky, LCSW, 510-587-3405 or 510-277-7560
Oakland VA-Oakland Behavioral Health Clinic (OBH)
525 21st Street, Oakland, CA 94612

NOTE: Failure to follow up with the Liaison as requested above could result in your discharge from Operation Dignity Transitional Program. Other health care appointments may also be requested of you as a participant in this program.

Notification of Megan's Law Search

Operation Dignity conducts a search of the Megan's Law public records on every person referred to or receiving services. If you are found to have any history of sexual offense that requires you to register as such under California Law, you may be denied/terminated from the program. This only applies to sex offenders who are required by law to register with local law enforcement.

In addition, Operation Dignity will search the database annually. If a participant appears on Megan's Law database, their service may be terminated. The annual database search will be conducted every December.

If a collaborative partner discloses to staff that a participant is in the database, an investigation of the database will be conducted. If the participant appears on Megan's Law database, their services will be terminated.

If an Operation Dignity staff identifies a person registered with the Megan's Law database, the staff member will make every reasonable effort to maintain the registrant's privacy while enforcing the denial or termination of services.

If you believe that the website is not correct and that your name should not be listed in the Megan's Law database, you may choose to appeal the decision for denial/termination of services.

I hereby acknowledge that I have been informed that a search of the Megan's Law public record will be conducted of my name at www.meganslaw.ca.gov.

I understand that such information will only be used for program purposes related to confirming service eligibility.

I understand I have the right to receive a copy of this notification.

Issued:_____ Declined:_____

Applicant's Signature_____Date:_____

A photocopy of this authorization is as valid as the original.

Applicant's Initials: _____

OMB Number 2900-0260
Estimated Burden 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

VA Northern CA Healthcare System
150 Muir Road,Martinez, CA 94533

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Operation Dignity staff(including House of Dignity, Dignity Commons, Ashby House and Operation Dignity Emergency Shelter) 3850 San Pablo Ave Emeryville, CA 94608

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

Verbal and written exchange of medical information (ie-ppd results; chest X-ray results; upcoming appointments; attendance at appointments; diagnoses and urinalysis results)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Coordination of admission, on-going care, services and healthcare operations.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

For the duration of my participation in the Grant & Per Diem (GPD) Program and/or in the Operation Dignity Emergency Shelter (ODES) Program

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY