COMMUNITY ACTION TEAM (CAT)
HOUSING SOLUTIONS ASSESSMENT/INTAKE PACKET

Coordinated Entry:

Funding is limited and financial assistance is not guaranteed. To ensure a fair and equitable process all requests for assistance will be entered through Coordinated Entry. Coordinated Entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are assessed for, referred, and connected to housing and assistance based on their strengths and needs. Contact and demographic information for individuals/households applying for assistance may be maintained on the Coordinated Entry by-name list until which time it is removed.

Client Eligibility:

- Must prove that the household has ability to financially sustain housing without assistance.
- Must meet income eligibility.
- Must be homeless or at risk of homelessness (documentation required).
- Due to funding restrictions we will not assist with: Unmanaged single room occupancy, halfway house, drug rehabilitation, rent to own, or subsidized rent portions.
- Must be a Columbia County resident. Some private funding sources may require the applicant to be an established Columbia County Resident for 6 months or longer.

Intake Procedure:

- After the request for assistance is received, an assessment, review, and a request for any further information/documentation will be made within seven (7) business days of receipt.
- Eligibility will be determined within three (3) business days of receipt of all required information/documentation.
- If monetary assistance request is denied, a verbal notification will be attempted as well as a written notice stating the reasons for denial. Said notice will contain a copy of the Grievance Policy and Procedure.

Services for Deaf and/or hearing impaired customers:

Oregon Telecommunication Relay Service is a service that links Deaf and/or Hearing impaired persons via telephone.

TTY/Voice 711 or 1-800-735-2900 **Hours: 9 a.m. to noon, 1 p.m. to *5* p.m.**

To use this service, dial the number listed above. Give the agent the number you would like to call and he or she will stay on the line to relay the conversation. You can communicate directly with the person you contacted. All calls and information are confidential.

NOTE:

- Any rental assistance payments from CAT will be directly mailed to landlord, only if the landlord is willing to work with the tenant and CAT. The payable process takes 7 to 14 business days.
- CAT staff will not steer clients into any particular housing. We may make suggestions and inform you of options based on household needs/barriers but it is the applicant/client(s) responsibility to find/select housing that best fits their needs.

****Please turn in the following documentation when you turn in your packet, additional documentation may be required/requested.**

1) Photo ID for all adults listed
2) Social Security cards for everyone in the household
3) Proof of income for the last 30 days for the household (e.g. pay stubs, current year Social Security letter)
4) Any notices given by landlords, family members, etc. pertaining to your housing situation.

****Absence of the requested forms may delay evaluation and eligibility determination.**

Office Use Only

CAT Staff:

- ❑ Heather Johnson 503-366-6559
- ❑ Melissa Kyles 503-366-6561
- ❑ Kayla Davis 503-366-6591
- ❑ Kristen Erickson 503-366-6558
- ❑ Lacy Chamberlain 503-366-6557
- ❑ _____

Initial Assessment type and date:

☐ CAT Office ☐ Phone/Email
☐ Outreach ☐ Other: _____

Date contacted ____/____/____

Pending Assistance:

_____
_____
_____
_____
_____
_____
_____

Task List:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Unable to Assist:

☐ Zero income
☐ No contact/disappeared
☐ Missing documents/information
☐ Other: _____
_____
_____
_____

Ineligible due to:

☐ Lack of sustainable housing plan
☐ Housing status
☐ Income exceeds eligibility
☐ Zero funding available
☐ Other: _____
_____
_____
_____

X – Connected
R – Referred
N – Not eligible

Referrals:

___**Apartment List**
___**Private Landlords**
___**Subsidized Housing** (Woodland Trails 503-397-4938, Sol Havn 503-728-3169)
___**Senior Subsidized Housing** (Columbia Hills 503-397-6131, Victorian 503-987-1842)
___**CityTeam Overnight Shelter Voucher** (526 Grand Ave, Portland)
___**Columbia Health Services** (503-397-4651)
___**Community Meals** (Lutheran Church) Tuesday & Thursday
___**DHS**
___**Self Sufficiency** (Food Stamps/TANF/Jobs Program 503-397-1784)
___**Adults and People with Disabilities** (503-397-5863)
___**Eisenschmidt Pool Shower Pass**
___**Energy Assistance** (503-397-3511)
___**Food Bank** (St. Helens 503-397-9708, Scappoose 503-543-7495, Rainier 503-556-0701, Clatskanie 503-728-3126, Vernonia 503-429-1414)
___**Healthy Families** (Sunday Kamppi 503-366-0800)
___**Mental Health** (CCMH 503-397-5211, Medicine Wheel 503-396-5322)
___**Mortgage/Foreclosure Assistance** (503-325-8098)
___**OHP** (Columbia Health Services 503-397-4651, Medicine Wheel 503-396-5322)
___**Oregon Law Center** (503-397-1628)
___**OTAP** (1-800-848-4442), **Assurance Phone** (1-888-321-5880)
___**Parole and Probation** (503-397-6253)
___**Pregnancy Center** (503-397-6047)
___**SAFE** (503-397-6161)
___**Section 8** (NOHA 1-800-927-9275)
___**Self Help Housing** (503-366-6550)
___**Senior Services** (503-366-6542)
___**Shelter-Community House on Broadway** (360-425-8679)
___**Tenant Landlord Hotline** (1-877-296-4076)
___**Transitional Housing** (Sheriff Department 503-397-6253)
___**Unemployment Office** (503-397-4995)
___**Veteran Service Officer** (503-366-6580) / **VASH** (971-200-0351)
___**Vocational Rehab** (503-366-8383)
___**Warming Center** (503-410-5800)
___**Weatherization** (503-366-6552)
___**WIC** (503-397-4651)
___**Work Source** (503-397-6495)
___**Other**_____

Name (First, Middle, Last)	Relation to head of household	AGE	D/O/B MM/DD/YY	SOCIAL SECURITY NUMBER	Gender	Military Experience (Y/N)	Language (E,S,C,I)	Education (K-12/12+)	Disabled? (Y/N)	Pregnant? (Y/N)	Race: Hispanic or Latino? (Y/N)	Race: African American(Y/N)	Race: Am.Indian/Alaska Native (Y/N)	Race: Asian (Y/N)	Race: Nat. Hawaiian/ P.Islander (Y/N)	Race: White (Y/N)	Race: Don't Know/ Refused (Y/N)	Non-Cash Benefits: Food Stamps/SNAP (Y/N)	Non-Cash Benefits: State Health Insurance	Non-Cash Benefits: Medicaid/OHP (Y/N)	Non-Cash Benefits: Medicare (Y/N)	Non-Cash Benefits: VA Medical (Y/N)	Non-Cash Benefits: Other Health Insurance	Non-Cash Benefits: TANF Child Care (Y/N)	Non-Cash Benefits: WIC (Y/N)
	Self																								

Military Service Era:

Household Contact Info:

Phone number: _____ ❑Message ❑Cell ❑Home

E-Mail Address: _____@_____.com

Physical Address: _____City:_____State:_____Zip: _____
❑ Same as Mailing Address

Mailing Address: _____City:_____State:_____Zip:_____

Are you a victim of Domestic Violence?
❑ Yes ❑No

If yes, how long ago did it occur? _____

If yes, are you currently fleeing?
❑ Yes ❑ No

Risk of homelessness: (check only one)

❑ Literally Homeless
❑ 72 hour notice
❑ 7 days or less
❑ 7-14 days
❑ 15-30 days
❑ More than 30 days

Where did you stay last night? (Check only one):

❑ Rent with no subsidy
❑ Rent with subsidy
❑ Section 8/ NOHA
❑ Own Home with subsidy
❑ Own home
❑ Hotel/Motel
❑ Foster Care/Group Home
❑ Nursing Home
❑ Staying/Living with Friends
❑ Staying/Living with Family
❑ Substance Abuse Treatment Facility
❑ Hospital (Non-Psychiatric)
❑ Psychiatric Hospital/Facility
❑ Jail,Prison or Juvenile Detention
❑ Other_____
❑ Car
❑ Street
❑ Camping
❑ Iron Tribe
❑ Transitional Housing
❑ Emergency Shelter

Length of Stay:

❑ One day or less
❑ Two days to 1 week
❑ More than 1 week/Less than 1 month
❑ 1 to 3 months
❑ 4 to 12 months
❑ 1 year or longer

1. **Please give us a short summary of your housing situation:**

_____
_____
_____
_____
_____

2. **Total Assistance Requested**
   a. How much are you requesting from Community Action Team? $ _____
   b. How much do you have to put towards your rent or deposit? * $_____
      * Our funding is very limited and we are required to utilize every avenue possible when it comes to assistance. Your household may be required to pay a portion towards your rent/deposit.

3. **How long have you been a resident of Columbia County**? _____

4. **Complete A or B below:**
   a. If Homeless:
      - What caused you to be homeless? _____
        _____
      - Last Night did you stay in/on the streets, emergency shelter, or safe haven? Yes/No
      - Approximate date homelessness started: _____/_____/_____
      - Can someone document the length of time you have been homeless? Yes/No
      - Number of **times** you have been homeless in the past 3 years: _____
      - If 4 or more times, total number of **months** homeless in the last 3 years: _____
      - Total number of months **continuously homeless** on the street, emergency shelter, or safe haven in the past 3 years: _____

   b. If housed:
      - Approximate date you moved into your current place: _____/_____/_____
      - Landlord information
        1. Name of Landlord: _____
        2. Landlord Phone number: _____
        3. Address of landlord: _____
      - Have you received a notice to vacate your current residence? Yes/No
      - How will you pay your rent next month? _____

5. **Have you been working with anyone to receive assistance with your housing within the last 12 months?**

Who:	**Amount received this month:**
Family:	
Friends:	
Church Name:_____	
Agency: _____	
Other: _____	

❑ No resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent household from becoming literally homeless.

Budget and Barriers

RESOURCES:

SOURCE	MONTHLY AMOUNT:	PERSON RECEVING:
___No Income		_____
___Unemployment	$_____	_____
___Employment	$_____	_____
___Food Stamps	$_____	_____
___TANF	$_____	_____
___SSI	$_____	_____
___SSDI	$_____	_____
___Social Security	$_____	_____
___Child Support	$_____	_____
___Pension	$_____	_____
___VA Pension (non-svs connected)	$_____	_____
___VA Pension (Svs Connected)	$_____	_____
___Widows Benefits	$_____	_____
___Trust Fund	$_____	_____
___Alimony	$_____	_____
___Tribal Benefits	$_____	_____
___Family	$_____	_____
___Other: _____	$_____	_____
Total Resources	**$_____**	_____

EXPENSES:

ITEM	CURRENT	BACK OWING
___Rent	$_____	$_____
___Security Deposit	$_____	$_____
___Mortgage	$_____	$_____
___Electric	$_____	$_____
___Natural Gas	$_____	$_____
___Water/Sewer	$_____	$_____
___Garbage	$_____	$_____
___Phone	$_____	$_____
___Internet	$_____	$_____
___TV	$_____	$_____
___Food	$_____	$_____
___Child Support	$_____	$_____
___Child Care	$_____	$_____
___Car Payment	$_____	$_____
___Car Insurance	$_____	$_____
___Gasoline	$_____	$_____
___Car Repair	$_____	$_____
___Household Items	$_____	$_____
___Laundry	$_____	$_____
___Health Insurance	$_____	$_____
___Cigs/Alcohol	$_____	$_____
___Medical Bills	$_____	$_____
___Medication	$_____	$_____
___Court Fees	$_____	$_____
___Credit Cards	$_____	$_____
___Storage Unit	$_____	$_____
___Other: _____	$_____	$_____
Total Expenses	**$_____**	**$_____**

BARRIERS:

	√ (if applies)	Name:
Physical Disability	_____	_____
Mental Health Disability	_____	_____
Developmental Disability	_____	_____
Alcohol Abuse	_____	_____
Drug Abuse	_____	_____
Chronic Health Condition	_____	_____
Companion/Service Animals	____ Type:	_____
HIV Positive	_____	_____
Lack of rent/mortgage	_____	
Lack of Screening Fees	_____	
Lack of Security deposit	_____	
Lack of Day Care	_____	

	√ (if applies)	Name:
Owe money to Past Landlord	_____	
Damages to past rentals	_____	
Evictions/Last 10 yrs	_____	_____
Mortgage Foreclosure	_____	
Bankruptcy/Last 10 yrs	_____	_____
Illegal Chemical Conviction	_____	_____
Misdemeanor Convictions	_____	_____
Sex Offender	_____	_____
Felony Convictions/last 10 yrs.	_____	_____
Theft Convictions	_____	_____
Assault Convictions	_____	_____

Housing Options/Resource Eligibility/ Asset Worksheet

Applicant:

Name: _____ Date: _____

- Are there any financial or support networks available to your household that can be used to help you remain in your current housing or to obtain other appropriate housing? ◯ YES ◯ NO
  If yes, please explain: _____

- Does anyone in the household have a checking or savings account? ◯ YES ◯ NO
  If yes, please note account balances and attach bank statement for last 30 days.
  Checking $ _____ Savings $ _____

- *Non Cash Assets:*

TYPE OF ASSET	TOTAL VALUE	FEES OR PENALTIES	CASH VALUE (TOTAL VALUE MINUS PENALTIES)	INTEREST RATE	ACTUAL ASSET INCOME (MULTIPLY CASH VALUE BY INTEREST RATE)
TOTALS:					

❑ To the best of my knowledge, I have no assets to report.

By signing these forms, I declare that all of the information provided to Community Action Team, Inc. Housing Solutions is true and correct to the best of my knowledge. I understand that if it is discovered that I have provided false information I could be denied services.

_____

Applicant Signature Date

OFFICE USE ONLY

CAT Staff:

Subsequent Housing Options: *Please assess with the applicant what appropriate subsequent housing options might be available to the household.*

- Are there any appropriate subsequent housing options for this household? ◯ YES ◯ NO
  *If yes, please explain:*_____.

- Have you verified that no other appropriate subsequent housing options are available? (I.e. Friends/family/ hotel/motel/other agencies) ◯ YES ◯ NO

Financial Resources and Support Networks: *Please assess with the participant all financial resources and support networks that might be available to the household.*

- Have you verified that the household lacks the financial resources and support networks to maintain housing? ◯ YES ◯ NO

Staff Signature _____ Date: _____

EQUAL HOUSING OPPORTUNITY

COMMUNITY ACTION TEAM, INC. INCOME VERIFICATION

(Only for new income prior to receiving the first paycheck)

Applicant's Name: _____ Last 4 digits of SSN: _____

_____ _____
Applicant's Signature Date

Employer Agency: _____ Phone: _____ Fax: _____

Employer Address: _____City: _____ Zip: _____

OFFICE USE ONLY

Dear Employer:

The person listed above is applying for assistance through CAT. Part of the criteria for this process includes income verification to determine this household's financial eligibility. We are required by Federal regulations to verify the income of all program participants. Please complete all the information below. Thank you for your assistance.

Place of employment: _____

Employee's title, position or type of work: _____

Date employment began: _____ Date employment ended: _____

Number of hours worked per week (use average if inconsistent): _____

Hourly wages: $_____ **or** Annual gross salary: $_____

Gross year-to-date earnings: $_____ as of what date: _____/_____/_____

Number if weeks employed each year: _____

Tips, commission, other: Year $_____ Week $_____ Month $_____

Expected change in pay: $_____ hourly/monthly/annually Effective date: _____
(circle one)

_____ _____
Employer Signature Date Company

_____ _____
Employer Name (Printed) Phone Number

Record of Oral Verification:

CAT Staff: _____

Person Contacted: _____ Representing: _____

Information supplied: Date and time: _____

_____

_____

_____

_____

_____

Please return to: CAT, Inc. Housing Solutions Programs, 125 N. 17th St. Helens, OR. 97051
(Phone) 503-397-3511 (FAX) 503-397-3290

COMMUNITY ACTION TEAM, INC.
HOUSING SOLUTIONS

GENERAL RELEASE OF INFORMATION

Consent: I give permission for Community Action Team, Inc. to share and exchange information with other staff at the agencies listed below for the purpose of providing assistance to me.

Information Covered: I understand that depending on the program policies previous or current, information regarding my household or myself may be needed. Verification and inquiries that may be requested include but are not limited to:

Identity Verification	Social Security/Disability Status	Employment/Income/Asset Verification
Marital Status	Criminal/Credit/Rental History	Medical/Mental Health Information

Groups or Individuals that may be asked: The groups or individuals that may be asked to release the about information (depending on program requirements) include but are not limited to:

Potential Landlords	Previous Landlords	Medical and Mental Health Providers
Current Landlords	Past and Present Employers	Department of Human Services & their contractors
Utility Companies	Social Security Administration	Oregon Housing and Community Services (OHCS)
Foods Banks	Courts and Probation & Parole	Northwest Oregon Housing Authority (NOHA)
Homeless/DV shelters	Law Enforcement Agencies	Federal, State and/or local Tribal Benefits Agencies
Continuum of Care	Support and Alimony Providers	Credit Report Providers and Credit Bureaus
Public Health Agencies	Child Care Providers	Veteran's Administration
Retirement Systems	Vocational Rehabilitation (DHS)	Housing and Service Providers
Financial Institutions	Community Action Agencies	Drug and Alcohol Treatment Facilities
Schools and Colleges	Other _____	Other _____

Computer Matching HMIS Notice and Consent: I understand and agree that CAT, Inc. may conduct computer-matching programs (OPUS & ServicePoint) to verify the information supplied for my application rectification. If a computer match is done, I understand that I have a right to notification of any adverse information found and a chance to dispose of incorrect information. CAT, Inc. may in the course of its duties, exchange automated information with other Federal, State, County or Local agencies, including but not limited to: State Employment Security Agencies, Department of Defense; Office of Personnel Management; the US Postal Service; The Social Security Administration and State Welfare and Food Stamp agencies; OHCS-OPUS partner Agencies.

Conditions: I understand that this authorization cannot be used to obtain any information about me that is not pertinent to my eligibility for, and/or continued participation in a CAT, Inc. housing assistance program. I understand *this release is valid for the duration of my program/assistance or one year unless otherwise noted.* I understand that I can revoke this consent at any time, by notifying Community Action Team, Inc. (Note: If this occurs, client could write revoked on bottom of this form with date).

All adults over the age of 18 must sign this release of information.

_____	_____	_____
Printed Name	**Signature**	**Date**
_____	_____	_____
Printed Name	**Signature**	**Date**
_____	_____	_____
Printed Name	**Signature**	**Date**

Columbia County Homeless Management Information System (HMIS)
CLIENT CONSENT FOR DATA COLLECTION AND RELEASE OF INFORMATION

What is the HMIS? HMIS is a computer data system that collects and stores information on individuals and families using services. The data will be used to describe the number and characteristics of program clients. It tracks the type of service given and how often services are used. HMIS is used to assess local service needs and to assist our community to make informed decisions about the most effective service delivery models.

What is the purpose of this form?
With this form, you can give permission to have information about you collected and shared with partner agencies that help Community Action Team provide housing and services. Partner agencies are listed below.

Oregon Housing and Community Services (OHCS)	Rural Oregon Continuum of Care (ROCC)
Northwest Oregon Housing Authority (NOHA)	Department of Human Services (DHS)
Medicine Wheel Recovery Services (MWRS)	Clatsop Community Action Team (CCA)
Community Action Resource Enterprise (CARE)	Department of Veteran's Affairs (VA)
Housing and Urban Development (HUD)	Columbia Community Mental Health (CCMH)

BY SIGNING THIS FORM, I AUTHORIZE Community Action Team to share HMIS information with partner agencies. The HMIS information shared will be used to help me get housing and services. It will also be used to better understand and improve housing and homeless service programs. I understand that the partner agencies may change over time. The information to be collected and shared includes:

Name, birthday, gender, race, ethnicity, social security number, phone number, address	
Basic medical, mental health, substance use, and daily living information	
Housing Information	Use of crisis services, hospitals, and jail
Employment, income, insurance, and benefits	Results from assessments

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- Community Action Team and partner agencies will keep my HMIS information private using strict privacy policies. I have the right to review their privacy policies.
- I can receive a copy of this Consent and the Client Information Sheet
- I may refuse to sign this Consent. If I refuse, I will not lose any benefits or services.
- This Consent will expire 10 years from my last HMIS recorded activity.
- I may revoke this Consent at any time in writing. The revocation will take effect upon receipt, except to the extent others have already acted under this Consent, and after partner, agencies and Community Action Team have been notified so that revocation does not interfere with care or service coordination.
- My HMIS information may be further shared by the partner agencies to other agencies for care coordination, counseling, food, utility assistance, and other services.
- My HMIS information may be viewed by auditors or funders who review work of the partner agencies, including HUD, the Dept. of Veteran Affairs, the Dept. of Health and Human Services, and Oregon Housing and Community Services (OHCS). I understand that the list of auditors and funders may change over time.
- My HMIS information may be used to help evaluate the quality of services provided. It may also be used for research purposes that align with Community Action Team's goals and mission.

SIGNATURE:

_____	_____	_____
Printed Name	Signature of Client or Representative	Date
_____	_____	_____
Printed Name	Signature of Client or Representative	Date

Community Action Team
Mutual Respect Policy

Client Participation

Any individual seeking services will not be denied access to services, if they are unable to answer the questions asked during the assessment process.

Mutual Respect Policy

It is the goal of Community Action Team to provide services of the highest quality, and to provide those services in a manner that is professional, respectful, and based on the dignity and rights of the people we serve. Likewise, we expect our clients to treat staff members and other clients in a manner that is respectful, and based on the dignity and rights of others.

Anti-discrimination Policy

The program will not discriminate against any individual or family because of race, color, national origin, religion, gender, disability, familial status, sexual orientation/gender identity, source of income, or domestic violence. Reasonable accommodations will be offered to all disabled persons who request them at any time during the application or selection process, and throughout program involvement.

Dispute Resolution Process

Community Action Team has the right to deny services or terminate services to any individual who: engages in behavior that presents a danger to other people or disrupts the delivery of services to other clients; creates a hostile environment; or commits acts of fraud, deceit, or trickery. Any individual who is denied services or is terminated from services has the right to appeal that decision and may inquire about the agency's dispute resolution process.

_____	_____	_____
Client Name (print)	Client Signature	Date
_____	_____	_____
Client Name (print)	Client Signature	Date