Southwestern Community Services

People helping people in Cheshire and Sullivan Counties since 1965

Homeless Prevention/Intervention Program
Information Sheet

The Homeless Prevention/Intervention Program is designed to prevent the incidence of homelessness and to help with:

- Short-term loan subsidies to defray rent and utility arrearages for families that have received an eviction or utility termination notice
- Conduct and finance mediation programs for landlord-tenant disputes
- Locate legal service programs for the representation of indigent tenants in eviction proceedings
- Assist clients in retaining their home by making a small payment to prevent a foreclosure

ELIGIBILITY REQUIREMENTS

1. Before submitting an application with our Homeless Prevention/Intervention Administrator, you MUST have been seen by your local welfare office of the town/city you live in and you must have a written "Notice of Decision" from them, or be able to verify a scheduled appointment
2. You must have a formal Demand for Rent/Notice to Quit and a legal lease or rental agreement if you are seeking assistance for rent
3. You must have a shut off notice from your utility company and be able to state that if you are without this utility you will be homeless if you are seeking assistance for utility costs
4. You must have the ability and be able to provide documentation that you will be able to afford future rent, mortgage, utility, etc. charges
5. You must complete and return an application with the following items:
    - completed application including current budget
    - notice of item you need assistance with
    - a copy of your four (4) most recent pay stubs and/or other sources of income
    - a recent copy of all bank statements, if applicable

Applicants may be denied if they do not submit completed applications and documentation; if they do not meet income guidelines; if it is determined they cannot afford their current housing; if they have consistently failed to pay rent or pay on a prior Prevention/HSGP loan; and/or if they cannot show the steps they are taking to make different choices.

Please drop off completed application with supporting documentation at our SCS Office in Keene or Claremont. If you have any questions, please contact a representative at 603.719.4295.

This is not an emergency program.

The application process takes at least seven (7) business days from the time a COMPLETED application is received. If you are experiencing an emergency and need assistance immediately, please contact your local welfare office of the town you reside in, call NH 211 from a NH phone, or call 1-866-444-4211 from an out-of-state phone.

63 Community Way
PO Box 603
Keene, NH 03431
Phone: (603) 352-7512
Fax: (603) 352-3618

United Way
Call Toll Free: (800) 529-0005
TTY-NH: (800) 735-2964

96-102 Main Street
PO Box 1338
Claremont, NH 03743
Phone: (603) 542-9528
Fax: (603) 542-3140

Revised 12.13.2018

Date: / /

Applicant: _____ SSN: - - DOB: / /

Co-Applicant: _____ SSN: - - DOB: / /

Physical Address: _____ _____ _____ _____
Street City State Zip Code

Mailing Address: _____ _____ _____ _____
Street City State Zip Code

Phone: - - ☐ Home ☐ Cell ☐ Work ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How were you referred to our program? _____

HOUSEHOLD DEMOGRAPHICS: No. of Men: _____ Women: _____ Children: _____ Total Residents: _____

☐ Single Parent (Male) ☐ Single Parent (Female) ☐ Two Parents ☐ Single Person ☐ 2+ Adults, No Children

HOUSEHOLD MEMBERS HEAD OF HOUSEHOLD FIRST Last, First	SOCIAL SECURITY #	DATE OF BIRTH	TANF	GENDER	DISABLED	RACE/ETHNICITY	EDUCATION LEVEL	FOOD STAMPS	HEALTH INS.	VET	MONTHLY INCOME	MI,SA,DV,DD,PD
1.			☐	☐	☐	☐	☐	☐	☐	☐		☐
2.			☐	☐	☐	☐	☐	☐	☐	☐		☐
3.			☐	☐	☐	☐	☐	☐	☐	☐		☐
4.			☐	☐	☐	☐	☐	☐	☐	☐		☐
5.			☐	☐	☐	☐	☐	☐	☐	☐		☐
6.			☐	☐	☐	☐	☐	☐	☐	☐		☐
7.			☐	☐	☐	☐	☐	☐	☐	☐		☐
8.			☐	☐	☐	☐	☐	☐	☐	☐		☐
TOTAL INCOME:												

*MI = Mental Illness *SA - Substance Abuse *DV = Domestic Violence *DD = Developmentally Disabled *PD = Physically Disabled

Monthly Rent: $ _____ How long at this address? _____ Move-In Date: _____

Number of Bedrooms: _____ Subsidized? ☐ Yes ☐ No If yes, your portion of the rent: $ _____

Includes: ☐ Heat ☐ Hot Water ☐ Electric ☐ Cooking Gas Estimates: Gas _____ Electric _____

Landlord Name: _____ Landlord Phone: _____

Landlord Address: _____

Do you have a signed lease? ☐ Yes ☐ No Amount owed: $ _____

Reason for eviction action: _____

Notices and Court Date: _____

Please answer ALL of the following questions as completely as possible.

1. How did your City/Town Welfare office assist you? (Please be specific).

2. Have you previously held a Prevention or Security Deposit Loan with us?

3. Please explain why you are behind on your rent/mortgage/utility payments?

4. What is your plan to remain current with your payments in the future:

5. What is your current income at this time? From what source?

Total Household Income

Please list all sources of income for all household members. Include documentation with this application.

TYPE OF INCOME	AMOUNT	TYPE OF INCOME	AMOUNT

TOTAL MONTHLY INCOME: $ _____

MONTHLY EXPENSES: Please list all regular monthly expenses. For the housing section, please use figures for the new apartment, not the one you are residing in. Fill in all blanks. Put -0- or N/A if it does not apply to you.

HOUSING

Rent/Mortgage $ _____
Electricity $ _____
Gas/Oil/Heat $ _____
Telephone/Cell Phone $ _____
Cable $ _____
Internet $ _____

Have you applied for fuel assistance? _____
Benefit amount for last year: _____
Have you applied for electric assistance? _____
Discount % amount: _____

FOOD AND HOUSEHOLD

Food $ _____
Non-food Grocery $ _____
Diapers $ _____
Laundry $ _____
Childcare $ _____

Do you receive food stamps? _____
If yes, how much? _____
(Please provide documentation)
Do you receive WIC? _____

PERSONAL

Doctor/Dentist $ _____
Medications $ _____
Meals Out/Delivered $ _____

Do you receive Medicaid/Medicare? _____

TRANSPORTATION

Auto Payment $ _____
Gas $ _____
Auto Insurance $ _____

OTHER

Rent-to-own $ _____
Loans/Credit Cards $ _____
Other $ _____
TOTAL $ _____

PAST DUE BILLS

Rent $ _____
Electricity $ _____
Gas/Oil/Heat $ _____
Telephone $ _____
Cable $ _____
Other $ _____
TOTAL $ _____

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Applicants' Authorization to Furnish Information

I/We authorize any relative, physician, lawyer, banker, check cashing service, employer, former employer, insurance company, health care provider, mental health professional, pharmacy, hospital, emergency care facility, ambulance service, police, Sheriff, State Police, firefighter, EMT, Red Cross, Salvation Army, or any persons or organizations with information concerning my / our circumstances to furnish such information to Southwestern Community Services.

I/We further authorize the Internal Revenue Service, Social Security Administration, any State or County Division of Health and Human Services, Division of Children Youth and Families, Bureau of Elderly and Adult Services, NH Legal Assistance, and City/Town Welfare Department, shelter/ housing provider, Department of Employment Security, Veterans' Administration, other departments of Southwestern Community Services, or any non-profit agency or any City/Town departments, to release information from their files to Southwestern Community Services Housing Stabilization Services for the purpose of verifying information submitted to us.

Applicant's Signature _____ Date _____

Co-Applicant's Signature _____ Date _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice

Southwestern Community Services has always maintained the privacy of your personal information. We are now required by the federal Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, and HIPAA regulations, 45CFR Part 160 & 164, to provide you with you this Notice of our privacy practices, our legal duties and your rights concerning your private health information. Southwestern Community Services must follow the practices described in this Notice as long as this Notice is in effect. This Notice will take effect on 8/21/14 and will remain in effect until it is replaced. Southwestern Community Services reserves the right to revise or change this Notice at any time. Any such revisions will affect information we already have about you and any information we receive in the future. If there is any significant change in our privacy practices, this Notice will be changed and the new Notice will be available upon your request. A copy of the current Notice will also be available on our website, www.scshelps.org. You may request a copy of this Notice at any time. If you have any questions regarding this Notice, or if you wish to receive another copy, please contact:

HIPAA Privacy Officer/Director of Human Resources
Southwestern Community Services
63 Community Way
Keene, NH 03431
603-719-4203
www.scshelps.org

Uses and Disclosures of Your Health Information

Southwestern Community Services uses and discloses your personal health information for purposes of treatment, payment and healthcare operations. For example:

TREATMENT: We may use or disclose your personal health information to provide, coordinate, assess, or manage your healthcare treatment between health care providers.

HEALTHCARE OPERATIONS: We may use or disclose your personal health information in connection with the administration of your medical plan, including such operations as claims adjudication, professional review, underwriting, coordination of benefits with other plans providing coverage, fraud and abuse detection programs, audit services, quality assessment and improvement activities, and other general administrative activities.

PAYMENT: Your medical information may be used or disclosed to determine and remit proper payment for covered services under your medical plan.

DIRECT CONTACT: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. *You also have the right to refuse to provide authorization for this office to contact you regarding these matters.*

DISCLOSURES REQUIRED BY LAW: Southwestern Community Services may use or disclose your health information when it is required to do so by law. For example, your health information may be disclosed to comply with a court order, an administrative order, a subpoena, a discovery request, report information related to victims of abuse or neglect, to a law enforcement official for a law enforcement purpose, or other lawful process.

PUBLIC HEALTH: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability. Your health information may be disclosed to a person subject to the jurisdiction of the FDA (Food & Drug Administration) for public health purposes related to the quality, safety or effectiveness of FDA-regulated products or activities such as collecting or reporting adverse events, dangerous products, and defects or problems with FDA-regulated products.

HEALTH OVERSIGHT ACTIVITIES: We may use or disclose your health information for oversight activities authorized by law, including audits, civil, administrative or criminal investigations, or other activities necessary for appropriate oversight.

RESEARCH: We may use your personal health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

GOVERNMENT FUNCTIONS: Your health information may be used or disclosed to carry out specialized government functions, such as protection of public officials, for national security, to correctional institutions, or to another agency administering a public benefits program.

DECEDENTS: Your health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

OTHER DISCLOSURES: Southwestern Community Services does not use or disclose your personal health information for marketing purposes nor does it sell your information for any purpose. Any use of your personal health information for any purpose other than referenced above will require your written authorization. You may revoke any such authorization in writing. Upon receipt of the written revocation, we will stop using or disclosing protected health information about you, except to the extent that we have already taken action in reliance on the Authorization.

Special Situations

DISCLOSURE TO HEALTH PLAN SPONSOR:

Your personal health information may be disclosed to the sponsor of your group health plan for the purpose of administering benefits under the plan.

OTHER DISCLOSURE:

- Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:
- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

WORKER'S COMPENSATION:

Southwestern Community Services may provide your personal health information for worker's compensation or similar programs which provide benefits for work related injuries or illness.

Your Rights Regarding Health Information about You

You have the following rights regarding the personal health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information which Southwestern Community Services maintains. To inspect and/or copy your health information, please submit your request in writing to the HIPAA Privacy Officer at the address or telephone number given above. If you request a copy of information, we may charge a fee for the costs of copying, mailing or other supplies needed to fulfill your request.

Right to Amend

If you feel that the health information we maintain about you is incorrect or incomplete, you may ask to amend the information by contacting the HIPAA Privacy Officer at the address or telephone number given above. You may request an amendment for as long as the information is maintained by Southwestern Community Services. Your request, submitted in writing to the HIPAA Privacy Officer, may be denied if it does not include a reason to support the request. In addition, it may be denied if you request to amend information that:

- is not part of the health information kept for or by Southwestern Community Services;
- was not created by us unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information you would be permitted to inspect or copy; or
- the information you seek to amend is complete and accurate.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures" if any such disclosure was made for any purpose other than treatment, payment or healthcare operations. To request an accounting of disclosures, you must submit your request in writing to the HIPAA Privacy Officer listed above. Your request must state a time period which may not be longer than six (6) years and may not include dates prior to August 21, 2014.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. *However, we are not required to agree to your request.* Your request to limit or restrict use of your health information must be made in writing to the HIPAA Privacy Officer listed above and the request must include the information you wish to limit, whether you wish to limit use, disclosure, or both, and to whom the limits may apply, for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you concerning your health information only in certain ways or at certain locations. For example, you may request that we only contact you at work, at home or by mail. Any such request must be in writing to the HIPAA Privacy Officer noted above. Where possible, we will accommodate all reasonable requests.

Right to a Paper Copy of This Notice

Even if you have received this Notice electronically, you are entitled to receive a paper copy of this Notice. A request for a copy of the Notice should be sent to the HIPAA Privacy Officer at the address above. You may also obtain a copy of this at our website, www.scshelps.org.

How to File a Complaint

If you believe your privacy rights have been violated by Southwestern Community Services, you may file a written complaint addressed to the HIPAA Privacy Officer, Southwestern Community Services, 63 Community Way, Keene, NH 03431. The complaint must be in writing. Or, you may file a written complaint with the federal government by contacting the Secretary of the Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201. *You will not be penalized or retaliated against for filing a complaint.*

My signature acknowledges that I have received a copy of this notice.

Name (please print) _____ Date _____

Signature _____

CLIENT ACKNOWLEDGEMENT FORM

NEW HAMPSHIRE HOMELESS MANAGEMENT SYSTEM (NH-HMIS)
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS FORM CAREFULLY.

READ FIRST: Please be aware that sharing your confidential information collected by _____ with other NH-HMIS-participating agencies may help you avoid being screened repeatedly, receive services more quickly, and minimize how many times you have to tell your "story." This will enhance the community's ability to provide the most effective services and housing possible. If you decide you want _____ to release your confidential information, you may use this form for authorization. The ways in which this agency may use or disclose your information must comply with the Privacy Notice, which is posted in public view at this agency and attached to this form.

This organization is required to use The New Hampshire Homeless Management Information System (NH-HMIS) as the place to keep your personal information. Our staff must collect information about you to provide our various services to you.

Information that tells us about your past, present or future health or mental health is called "Protected Health Information." In order to provide you with the best services possible, it is important that all of the agencies working with you are able to share information in order to plan and coordinate the services that you need. There are Federal and State laws that protect the privacy of your protected health information. Our agency and NH-HMIS comply with the requirements of these laws, and our employees will only use or disclose Protected Health Information about you in order to provide you with services and to comply with applicable laws. We are required by law to provide you with this Notice of Privacy Practices to explain our responsibilities in safeguarding the privacy of your Protected Health Information. Listed below is an explanation of how we may use or disclose Protected Health Information about you. If we have a need to use or disclose your Protected Health Information for any reasons other than those listed below, you will be asked to sign a written authorization giving us your permission to share that information. If you sign an authorization for us to share your Protected Health Information with an outside agency, we will follow your instructions. We and NH-HMIS are required by law to follow the practices listed below.

- **For Government Programs**: Our organization may require that we disclose protected health information about you to other government agencies to determine if you are eligible for government benefits or programs such as Social Security benefits.

- **For Public Health Activities**: We may use or disclose Protected Health Information about you for public health activities. For example, if you have been exposed to a communicable disease, we may report it to the State and take other actions to prevent the spread of this disease.
- **For Abuse and Neglect Reports and Investigations**: We are required by law to report any cases of suspected abuse or neglect of children or vulnerable adults.
- **To Avoid Harm:** We may disclose protected health information about you to law enforcement under certain conditions. For example, if you harm a member of our staff or another client while on our property, if you damage our property or if our professional staff believes that you are likely to cause serious harm to others or yourself, we will contact law enforcement. NH-HMIS may also disclose Protected Health Information in case of a threat to the public, such as a terrorist attack or emergency disaster.
- **For Court proceedings**: If you are ever in court and your treatment becomes an issue, we may be required by law to provide information about you to the court subsequent to a court order.

Your Information Rights

You have the right to:

- 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 us not to share your health information in the manner listed above by making a written request to our agency. Under certain conditions we may need to override your request, but otherwise we will follow the directions you have given us.
- Ask any questions about how we handle your Protected Health Information or to file a complaint or report a problem.

NOTE: PAGES 1 AND 2 MUST BE GIVEN TO THE CLIENT.

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, or a Day Center Project,** 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.

- A list of participating shelters will be provided on request.
- All of the shelters in this network follow all state and federal confidentiality laws and regulations.
- 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 Project,** 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.

- A list of participating projects will be provided on request.
- All of the shelters in this network follow all state and federal confidentiality laws and regulations.
- 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 project,** 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.

❑ **If I am seeking assistance from Coordinated Entry,** my identifying information, financial information, and any physical or mental health conditions that I may have will be shared with the New Hampshire Homeless Service Network.

- A list of participating programs will be provided on request.
- All of the projects in this network follow all state and federal confidentiality laws and regulations
- All clients have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs.

❑ **If I am seeking assistance from a PATH Project**,

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.

- A list of participating projects will be provided on request.
- All of the providers in this network follow all state and federal confidentiality laws and regulations.
- My personal information will not be shared with other agencies outside of this network 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.

_____ _____

Client or Authorized Representative (Sign your name) *Date*

_____

Print your name

_____ _____

Signature of agency or program representative *Date*

_____ _____

Signature of 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: PAGES 3 AND 4 MUST BE FILED AND KEPT ON RECORD WITH THE AGENCY.