

Barriers to Housing Stability Assessment

Client Name: _____ Date of Assessment: ___/___/___

Agency: _____ Staff Completing Assessment: _____

TENANT BARRIERS

Rental History

Have you ever had a lease for an apartment or home in your name?

Yes No Not assessed

Have you had utilities in your name?

Yes No Not assessed

How many times have you been evicted from housing?

0 1 2-3 4-9 10 or more

Would a prior landlord(s) give you a bad reference?

Yes No Not assessed

Credit History

Do you have unpaid rent or utility bills in your name?

Yes No Unknown

Do you have a credit history?

Yes No Unknown

Do you have poor credit?

Yes No Unknown

Criminal History

Have you ever been convicted of one or more misdemeanors?

Yes No Unknown

Have you ever been convicted of a felony?

Yes No Unknown

If yes, did the felony involve drugs, weapons, or a sex crime?

Yes No Unknown

Are you currently on probation?

Yes No

If yes, what is the date your probation expires? ___/___/___

SUMMARY OF IMPACT OF TENANT BARRIERS ON HOUSING

No Effect *Minimal Effect* *Moderate Effect* *Major Effect* *Unsure*

PERSONAL BARRIERS

Family Composition

Do you currently have more than four individuals in your household?

- Yes No Unknown

Do you currently have a male between 12-18 in your household?

- Yes No Unknown

Physical Health

Have your physical abilities or physical health ever caused you to lose your housing?

- Yes No Unknown

Does your physical health or abilities currently affect your ability to get housing?

- Yes No Unknown

Mental Health

Do you have mental health issues that have caused you to lose your housing in the past?

- Yes No Unknown

Do you have mental health issues that currently affect your ability to get housing?

- Yes No Unknown

Substance Use

Has substance use (drugs or alcohol) caused you to lose your housing in the past?

- Yes No Unknown

Does current substance use affect your ability to get housing?

- Yes No Unknown

Domestic Violence/Abuse

Has domestic violence or abuse ever caused you to lose your housing in the past?

- Yes No Unknown

Does domestic violence or abuse currently affect your ability to get housing?

- Yes No Unknown

SUMMARY OF IMPACT OF PERSONAL BARRIERS ON HOUSING

- No Effect*** ***Minimal Effect*** ***Moderate Effect*** ***Major Effect*** ***Unsure***

INCOME BARRIERS

Income

Do you have any regular income (from a job, TANF, disability, child support, etc.) at this time?

- Yes No Unknown

Do you need temporary assistance to get or keep housing?

- Yes No Unknown

Do you need permanent assistance to get or keep housing?

- Yes No Unknown

If you are living in a house or apartment, what percent of income do you spend on housing (rent/mortgage AND utilities)?

- 35% or less 36-50% 51-65% 66-80% 80% or more Unknown

If you are not living in your own house or apartment, how much money can you spend on housing each month?

- \$0 \$1-100 \$101-200 \$201-300 \$301-400 \$401-500
 \$501-600 \$601-700 \$701-800 more than \$801 Unknown

Other Income – Related

Are you currently receiving Social Security or Disability?

- Yes No Ineligible Unknown

Are you currently receiving TANF?

- Yes No Ineligible Unknown

Are you currently receiving assistance from the public housing authority?

- Yes No Ineligible Unknown

Are you currently receiving food stamps?

- Yes No Ineligible Unknown

Do you have a steady, full time job?

- Yes No Unknown

Do you have a high school diploma or GED?

- Yes No Unknown

Job barrier: Is English your second language?

- Yes No Unknown

Job barrier: Do you have a working car or other reliable transportation to get to work?

- Yes No Unknown

Job barrier: If you have small children, do you have affordable child care?

- Yes No Not Applicable Unknown

SUMMARY OF IMPACT OF INCOME BARRIERS ON HOUSING

- No Effect*** ***Minimal Effect*** ***Moderate Effect*** ***Major Effect*** ***Unsure***

Pathways Community Network Client Authorization Form

I understand that **Ninth District Opportunity, Inc.** (this agency) is part of the Pathways Community Network, a computer network designed to reduce the amount of time and effort it takes for me to obtain the social services I need. This agency has my permission to:

- Look at information about me in the Pathways system
- Enter in the system information concerning my situation and need for assistance

I understand that:

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

I also understand that I have the right to refuse to grant this authorization, and that even if I give permission for this agency to access my information in the Pathways system, I can revoke that permission at any time, without penalty. The permission I am giving this agency to view my information and to place information about me in the Pathways system will expire on: _____.

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

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

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

Signature: _____ Date: _____

Print Name: _____ ID: _____ Date of Birth: _____

Witness Signature: _____



PATHWAYS COMMUNITY NETWORK

Family Consent Form

I understand that **Ninth District Opportunity, Inc.** (the "Agency") is part of the PATHWAYS COMMUNITY NETWORK, a computer network that consists of certain organizations that participate in connection with the provision of human services and/or related administrative activities ("Participating Organizations"). The purpose of the PATHWAYS COMMUNITY NETWORK is to reduce the amount of time and effort it takes to process and administer requests for human services to which I/we may be entitled. Through the PATHWAYS COMMUNITY NETWORK, Participating Organizations have access to information maintained under the internet-based system known as the PATHWAYS COMPASS SYSTEM.

Personal Information:

For purposes of this form, "Personal Information" shall mean any and all personal and individually identifying information regarding myself, and any minors for whom I am legally responsible, that is provided or obtained in connection with human services requested or received by myself and any such minors. Personal Information may include (but will not necessarily be limited to) name, age, gender, marital status, veteran status, address, housing status, social security number, and basic information about the goals and the services requested/received by myself and any such minors.

The Agency has my consent ("Consent") to:

- Access and use all Personal Information collected in the PATHWAYS COMPASS SYSTEM in connection with the processing of any request by me for human services, the provision of any such services on behalf of myself or any minor for whom I am legally responsible, and/or any related administrative activities;
- Enter Personal Information into the PATHWAYS COMPASS SYSTEM;
- Disclose Personal Information to Participating Organizations in connection with the processing of any request by me for human services, the provision of any such services on behalf of myself or any minor for whom I am legally responsible, and/or any related administrative activities; and
- Disclose Personal Information to independent researchers under the following circumstances:

In order to improve services for persons in need, experts may need to study data maintained in the PATHWAYS COMPASS SYSTEM. As a result, an independent researcher may need to view various items of Personal Information such as names and social security numbers to ensure that records are not counted twice or to otherwise ensure the validity and integrity of the study being conducted. I hereby consent to Agency granting any such researcher(s) access to Personal Information with the understanding that such person(s) will be required to remove all personally identifiable information before anyone else can examine the data and that this procedure will be done in accordance with applicable professional standards, under strict government and research-institution supervision, and in compliance with all regulations that specifically address services for mental health, substance abuse, HIV/AIDS, and domestic violence.

Initials



PATHWAYS COMMUNITY NETWORK

Family Consent Form

In granting such Consent, I understand that:

- My Consent to the access, use, and disclosure of Personal Information by Agency extends to and includes such access, use, and disclosure by Participating Organizations;
- Agency and Participating Organizations will use and have access to such Personal Information in connection with my request/receipt of human services, system maintenance and improvement, and related administrative activities but will otherwise strive to keep this information confidential;
- Any agencies other than Agency and Participating Organizations will be permitted access to such Personal Information only if I give each such agency my written permission;
- Staff at Agency and each Participating Organization are required to receive regular training on client confidentiality and responsibilities in maintaining the confidentiality of information such as Personal Information;
- The PATHWAYS COMPASS SYSTEM uses passwords and computerized codes designed to protect my privacy and that of any minors for whom I am legally responsible; and
- I can obtain a copy of Personal Information maintained in and accessible via the PATHWAYS COMPASS SYSTEM, except for psychotherapy notes and other information to the extent required to be kept private by law.

I also understand that:

- I have the right to refuse to grant this Consent, and such refusal will not affect my eligibility, if any, or that of any minor for whom I am legally responsible, with respect to any human services;
- Even if I grant this Consent, I can revoke it in writing at any time without penalty;
- Under certain circumstances, Agency or a Participating Organization may be legally required to disclose some or all of the Personal Information covered under this Consent outside of the PATHWAYS COMMUNITY NETWORK. Examples of where this may occur include (i) where there is any evidence of child abuse, (ii) where there is evidence I may harm others or myself, or (iii) where a court orders that any such Personal Information be disclosed. The Consent that I am granting by signing below extends to and includes any and all such disclosures.

Initials



PATHWAYS COMMUNITY NETWORK

Family Consent Form

And, in granting this Consent, I acknowledge that:

I am signing this form freely and have not been forced or coerced to do so. This consent form has been read by me or to me, and I have received a copy of this form. I have been given the opportunity to discuss the content of this form and the Consent being granted under it, and I have been given the opportunity to ask any questions regarding such content and Consent. Any such questions have been answered to my full satisfaction, and I understand the Consent that I am granting by signing below.

By: _____
(my signature) Date

Print Name: _____

To ensure there is no fraudulent use of this consent form, a head of household must be specified, and the names and dates of birth for any and all minor children for whom I am legally responsible must be listed below.

Head of Household (please print):

Name DOB

Minors' Names and Dates of Birth (please print):

NAME DOB

NAME DOB

NAME DOB

NAME DOB

NAME DOB

Ninth District Opportunity, Inc. HPRP Exit Interview/Recertification Form

Name: _____ SS# _____

Pathways Key: _____ Initial Enrollment Date: _____

Exit/Recertification Date: _____

Recertification
(*max. enrollment 18 months*)

- Exit Interview**
- Completed program successfully
 - Non-Participation/Non-Compliance
 - Program unable to meet HH needs
 - Exceeded allotted enrollment period
 - Deceased
 - Unknown

EMPLOYMENT

Has employment status changed since entering the program Yes No

If yes, document the changes below:

Name	SSN	Employer

If no, are the unemployed members continuing to seek employment? Yes No

INCOME

Has income changed since entering the program Yes No

Name	SSN	Source	Amount

If yes, is the household still under 50% of the Area Median Income? Yes No

Area Median Income
(if changed)

Ninth District Opportunity, Inc.
HPRP Exit Interview/Recertification Form

Has any member of the household established entitlement benefits? Yes No

Services rendered during enrollment period:

- | | |
|--|--|
| <input type="checkbox"/> Rental Payment (BR-300.700) | <input type="checkbox"/> Case Management (PH-100) |
| <input type="checkbox"/> Rental Deposit (BR-300.725) | <input type="checkbox"/> Outreach (TJ-650.630) |
| <input type="checkbox"/> Utility Payment (BR-900.910) | <input type="checkbox"/> Housing Search/Placement (BH-390.310) |
| <input type="checkbox"/> Utility Deposit (BR-900.915) | |
| <input type="checkbox"/> Moving Cost Assistance (BH-500) | |
| <input type="checkbox"/> Motel/Hotel Voucher (BH-180.850-53) | |

Total amount of financial assistance during enrollment period: \$_____

Does participant have a combination of income and other resources sufficient to pay for groceries, utilities, health care, basic transportation, day care(if applicable), and full amount of rent? Yes No

Does participant have a savings account with funds sufficient to pay for small emergencies? Yes No

DESTINATION

- Permanent Destination**
 - Permanent supportive housing for formerly homeless persons
 - Rental by client with no housing subsidy
 - Rental by client with housing subsidy
 - Owned by client with no housing subsidy
 - Owned by client with housing subsidy
 - Staying or living permanently with family
 - Staying or living permanently with a friend
- Temporary Destination**
 - Emergency shelter, including hotel paid for with shelter voucher
 - Transitional housing for homeless persons (including homeless youth)
 - Staying or living temporarily with family
 - Staying or living temporarily with a friend
 - Hotel or motel paid for without shelter voucher
 - Place not meant for human habitation
- Institutional Destination**
 - Psychiatric hospital or other facility
 - Substance abuse treatment facility or detox center
 - Hospital (non-psychiatric)
 - Jail, prison, or juvenile detention center
 - Foster care home or foster care group home

Participant Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____

***Ninth District Opportunity, Inc.
Community Action Agency***

Notice of Termination from HPRP

Date:

Dear Client:

You are hereby notified that Ninth District Opportunity, Inc. (NDO) is terminating all financial and support services currently being offered to you through HPRP. This decision is based on the following issue/issues:

- | | |
|---|---|
| <input type="checkbox"/> Completed Program Successfully | <input type="checkbox"/> Non-Participation |
| <input type="checkbox"/> Non- Compliance | <input type="checkbox"/> Program unable to meet HH needs |
| <input type="checkbox"/> Exceeded allotted enrollment period | <input type="checkbox"/> Deceased |

We are required to update your current stability assessment upon exiting the program. Please contact your case manager immediately to schedule your exit interview.

Please be informed that you have a right to appeal the decision to terminate services by requesting a termination appeal. If you choose to appeal, submit a written request to your Case Manager within three business days of receiving this notice. The written request shall specify the reasons for the appeal as they relate to the issue/issues of non-compliance above and the action or relief sought. If you choose not to appeal, please sign the "Waiver of Appeal" below. Should a written request not be received within three business days, and should you fail to sign the "Waiver of Appeal", we will assume that you are not requesting an appeal, and all financial assistance and services will end immediately.

Should your request for an appeal be validated by the NDO HPRP Termination Appeals Team, you will be given the opportunity to present written and oral objections to the decision to terminate your services before opposing witnesses. The hearing will be held before the HPRP Termination Appeals Team. Following the review of your case, a final written notice of the decision to terminate or reinstate services will be issued. If the decision to terminate is upheld, all financial assistance and services will be stopped at that point.

Staff Signature

Date: _____

Client Signature

Date: _____

Waiver of Appeal

I choose to waive my right to appeal the decision regarding my termination from NDO's HPRP.

Client Signature

Date: _____



Community Services Zero Income Verification Form

Date: _____ Applicant: _____

Household Member: _____

Previous Employer: _____

Company

Supervisor _____ Telephone _____

City _____ State _____ Zip _____

Please state the reason for termination/separation: _____

Last Date of Employment: _____ Date of Final Pay: _____

Was the separation temporary? _____ If yes, when is the expected date you can return? _____

How long were you with this employer? _____

Hourly Rate: _____ or Monthly Salary Amt: _____

Average Hrs. Per Wk: _____

Have you applied for unemployment benefits? _____ If yes, were you approved? _____

What is your current benefit status with the Department of Labor? _____

Collateral Contact: _____

Name

Telephone

I, the undersigned, authorize Ninth District Opportunity, Inc. to verify all information provided and understand that if any of the information which I have given is found to be invalid or falsified that I will be required to repay the State of Georgia for all goods and services rendered to me during and under this program. I understand that misrepresentation of information to obtain benefits from this program is illegal and violations will be persued.

X _____

Case Manager

X _____

Client's Signature

Date

Date