

# PROJECT HOPE ELIGIBILITY QUESTIONS

## 1. County residence

I live in Ramsey County.

I am homeless **and** I receive *or* have applied for cash, food stamps, or medical assistance from Ramsey County.

I am homeless, I stay in Ramsey County, and I do not receive cash, food stamps, or medical assistance from any other county.

**If you did not check at least one line under question 1, do not complete the rest of this packet. You are not eligible for Project HOPE.**

**If you checked at least one line under question 1 and one line under question 2, go on to the next section.**

## 2. What kind of help are you looking for?

Rent/mortgage payment

Electric, gas or water bill payment

Deposit/first month's rent

Help getting into shelter

**Answer questions 3 and 4 if you are looking for RENT, MORTGAGE, DEPOSIT or UTILITY ASSISTANCE.**

## 3. Have you used county Emergency Assistance in the last 12 months?

Yes. Complete the rest of this packet and wait to be seen by Project HOPE.

No or Don't know. Continue to question 4.

## 4. If you answered no to question 3: Have you applied for Emergency Assistance for help with this problem?

Yes. Complete the rest of this packet and wait to be seen by Project HOPE.

No.

**If you answered no to question 4 : do not complete the rest of this packet. You are not eligible for Project HOPE. Go to Ramsey County and apply for Emergency Assistance.**  
If you are **denied**, come back to this office between 8:30 a.m. and 5 p.m., Monday through Friday, and ask for the Benefits attorney of the day, or call our intake line at 651-222-4731.

**PLEASE MAKE SURE YOU SIGN ALL PAGES**

Household Type (check one):

- Single (one person)       Foster Parent       Non-Custodial Caregiver(s)  
 Female Single Parent       Two Parent Family       Couple with No Children  
 Male Single Parent       Grandparent(s) & Child       Other

Name (List <u>ALL</u> family members)	Relationship to Head of Household (son, wife, significant other, etc.)	SSN*	Birth Date	Gender (M/F/T)	Race (enter all #'s that apply from list below)	Disabled? (if yes, enter type from list below)	Check if Veteran
	Head of Household						

\* Enter full or partial social security number. If not available, write "DN" (Don't Know) or "R" (Refused).

Mailing address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Any message phone (name and number): \_\_\_\_\_

**RACE categories (if Hispanic ethnicity, enter number 5 AND any other number that applies):**

- (1) Black or African American      (4) Asian      (7) Other: \_\_\_\_\_  
 (2) White      (5) Hispanic/Latino      (8) Don't know  
 (3) American Indian/Alaskan Native      (6) Pacific Islander      (9) I do not wish to answer this

**DISABILITY categories:**

- (a) Mental health problem      (b) Learning disability      (c) Brain injury      (d) HIV/AIDS  
 (e) Physical disability requiring housing accommodations (wheelchair ramp, first floor, etc.)      (f) Other physical problem  
 (g) Vision impairment      (h) Alcohol \_\_\_ or drug \_\_\_ abuse      (i) Other: \_\_\_\_\_

**\*\*\*\*\*Income Information for Entire Household\*\*\*\*\***

Source	Amount	Which household member?	Source	Amount	Which household member?
Employment Wages			Food Stamps (SNAP)		
MFIP (TANF)			Unemployment Benefits		
SSI			MFIP Child Care assistance	n/a	
Social Security			WIC	n/a	
Child Support			Other, list: _____		
MSA/GA			Other, list: _____		

Do you receive any of the following?

- Section 8 assistance or public housing                       Other housing subsidy

**Health Insurance Information for Entire Household\***

Source	Which household member?	Source	Which household member?	Source	Which household member?
Medical Assistance		Employer-provided		Veterans' Administration	
Medicare		MinnesotaCare		Other: _____	

**Homelessness history: \***

A. Have you been homeless in the last 3 years (including now)?      YES                       NO

If YES: How many times (including this one)? \_\_\_\_\_ For how many months total? \_\_\_\_\_

B. If you are homeless now, how long has it been since you lived at a permanent address? \_\_\_\_\_

Where was your last permanent address (city and state)? \_\_\_\_\_

**Check if a household member has been in any of the following in the last 6 months:\***

- |  |   |
|--|---|
| <input type="checkbox"/> Foster home                         | <input type="checkbox"/> County jail or workhouse |
| <input type="checkbox"/> Group home                          | <input type="checkbox"/> State or federal prison  |
| <input type="checkbox"/> Inpatient mental health treatment   | <input type="checkbox"/> Halfway house            |
| <input type="checkbox"/> Inpatient drug or alcohol treatment | <input type="checkbox"/> Juvenile detention       |

When was the person released? \_\_\_\_\_

List any household members age 24 or under who have been in foster care: \* \_\_\_\_\_

**\*Our funders require us to get this information.**

If you are receiving county benefits, what is your case number? \_\_\_\_\_

Fill out this following section if you are being **EVICTED** or **AT RISK** of being evicted.

- A. How long have you lived at your current address? \_\_\_\_\_
- B. What kind of eviction notice have you received?  Oral  Written  Court (UD)  
Date the notice said you need to move: \_\_\_\_\_  
Court date: \_\_\_\_\_
- C. How much must you pay? \_\_\_\_\_  
When does it need to be paid? \_\_\_\_\_
- D. If you are evicted, where will you go? \_\_\_\_\_

If you have school-age children:

- A. In what **school district** are your children enrolled? \_\_\_\_\_
- B. If your children are enrolled in the **St. Paul** schools, what schools do they go to?  
\_\_\_\_\_  
\_\_\_\_\_

How do you spend your income?

	\$ Amount spent last month	\$Amount spent this month
A. Rent		
B. Utilities		
C. Cable		
D. Phone		
E. Car		
F. Gas		
G. Bus		
H. Child		
I. Diapers		
J. Food		
K. Personal		
L. Other		

Any special expenses or circumstances leading to your housing crisis:

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

Does anyone in your household expect to get a **new source of income** in the next 30 days? \_\_\_ Yes \_\_\_ No

If YES, who and what? \_\_\_\_\_



# Project Hope

## TENNESSEN WARNING

### YOUR PRIVACY RIGHTS

This sheet tells you about your rights under the Minnesota Government Data Practices Act. This act protects your privacy but also lets us give information about you to others if a law requires it and we tell you before we do it. This sheet tells why and when we will ask for and give information about you.

• **Do I lose my rights to legal confidentiality by signing this release form?**

No, your confidentiality information retains legal protection. We will release only information necessary to satisfy state audit requirements.

• **Why do we ask for this information?**

We may ask you for information so we can:

- Tell you from others persons who have the same name or similar name.
- Decide if you are eligible to receive services from Project Hope, a Ramsey County Family Homeless Prevention Project.
- Assist you in getting medical, mental health, financial or social services from outside agencies.
- Make reports, do research, audits and evaluate our program.
- Advocate for additional services as determined by your needs.

• **Do we you have to answer the questions we ask?**

Generally the law does not say you have to give us information. However, without some of the information requested, we may not be able to find the appropriate help for you. Giving us incorrect information or not providing complete information, may delay or eliminate some services you would be eligible for.

• **With whom may we share the information we are requesting?**

The following are examples of agencies or organization we may need to share information with on your behalf and are not intended to provide a complete list. This does not mean we always share information about you with these people.

- State of Minnesota or Ramsey County evaluators may review our file to determine we did provide services.

• **You have the right to copies of information about you:**

You may ask if we have any information about you. If we have information about you, you may ask for copies You may have to pay for these copies. You may give other people permission in writing to see and to have copies of private data about you. If you have any questions about the information, you may ask to have it explained to you.

• **How do you appeal if you think information is not accurate or complete?**

Your objection must be in writing and must be sent to the Central Office law work manager of SMRLS:

Southern Minnesota Regional Legal Services, Inc.  
Alliance Bank Building  
55 East Fifth Street, Suite 400  
St. Paul, MN 55101

If you have any questions about the information on this form, ask a staff person.  
I understand my rights and have been given a copy for my records.

\_\_\_\_\_  
**Print Full Name**

\_\_\_\_\_  
**Signature**

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

**HOPE COLLABORATIVE PARTNER AGENCY  
RELEASE OF INFORMATION**

I have applied for funding for housing or utilities with one of these HOPE Collaborative partner agencies:

- Community Action Program of Ramsey and Washington Counties
- Neighborhood House, including the East Side Family Center
- Southern Minnesota Regional Legal Services, Inc.

I give permission for these three agencies to share information about me and my household between them. I agree to allow these agencies to share my information so they can:

- Coordinate services and assistance for me.
- Seek funding to help solve my housing or utility crisis.
- Enter some of my information into the federal Homeless Management Information System in order to get funding.

**When you sign this form, it shows that you understand:**

- The agencies will share your information only for the purposes in this form, or as otherwise allowed or required by law.
- You do not have to agree to release your information. The agencies will not deny you help if you do not want them to share your personal information, but not sharing your information may affect the ability to identify services for you.
- Signing this form does not mean that any of the HOPE Collaborative agencies has agreed to help you.
- This release is valid unless and until you cancel it in writing.
- If you permit us to share your information, you may change your mind and cancel this release at any time. If you cancel this release, your information will not be shared except if it has already been shared.

**A copy of this form is as valid as the original.**

\_\_\_\_\_  
*Dated*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Relationship (if form is signed by parent or guardian)*

## Minnesota's HMIS Data Privacy Notice & Consent

We collect personal information about the people we serve in a computer system called Minnesota's HMIS (Homeless Management Information System). Many social service agencies use this computer system.

### Why?

- To help keep this program and others like it going. We are required to use HMIS.
- So we know how many people we serve and the types of people we serve at our agency and in the state.
- So we all understand what people need and can plan services to meet these needs.

### Who can see information that is in Minnesota's HMIS?

- People who work for this agency will use it to help provide services to you or your family.
- Auditors or funders who have legal rights to review the work of this agency.
- Some people who work for Wilder Research (in St. Paul). Wilder runs Minnesota's HMIS. When Wilder works on the system, they may see information about you.
- People using HMIS information to write reports. Researchers must sign an agreement to protect your privacy before seeing HMIS information. Your private information will never appear in research reports.
- The law says we have to report physical or sexual abuse of children and vulnerable adults. If we think there is abuse or neglect in your household, we will report it to Child or Adult Protection.
- We may release your information to protect the health or safety of you or others.
- Others when we are required by law, including officials with a valid subpoena, warrant, or court order.

We will not release your data for any other use unless you permit us, in writing.

### Your Rights

- If you do not want your name, social security number, or date of birth entered in HMIS, tell the intake worker. This agency will not refuse to help you for denying this.
- You have the right to a copy of the Minnesota's HMIS information about you. (Unless we cannot give it because of certain legal proceedings.)
- You have the right to correct mistakes in HMIS information about you.
- If you think this agency or Minnesota's HMIS violated your privacy rights, you have the right to complain or appeal. Ask a staff person for a complaint and appeal form. Or, write to Minnesota Coalition for the Homeless, HMIS Grievance, Suite 306, 122 West Franklin Avenue, Minneapolis, MN 55404.

### Signed Consent

Each adult and unaccompanied youth must sign for him or herself. A parent/guardian should sign for children under 18.

For:

\_\_\_\_\_  
Print First and Last Name – use back of page for children's names & birth dates

\_\_\_\_\_  
Date of birth

My signature shows that I permit you to enter my personal information into Minnesota's HMIS.  
(You do not have to sign this form to receive services from this agency.)

X

\_\_\_\_\_  
SIGNATURE OF CLIENT OR GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date



VERIFICATION OF CITIZENSHIP/ALIEN ELIGIBILITY (3/12)

Client Name: \_\_\_\_\_

Case Number: \_\_\_\_\_ Date of Intake: \_\_\_\_\_

This client has been determined eligible based on the following: Check one blank and sign if required.

\_\_\_\_ Declaration of citizenship signed by client.

\_\_\_\_ Copy of document placed in file on \_\_\_\_\_ verifying that client is alien eligible for services.

\_\_\_\_ SMRLS employee signature verifying s/he has seen an appropriate original alien status document which is impossible/illegal to copy. (A \_\_\_\_\_)

\_\_\_\_ Telephone advice only/limited action. *No* in person contact. SMRLS employee confirmed eligibility. \*\*For use when PIKA is not available.

USC \_\_\_\_\_ LPR \_\_\_\_\_ OTHER \_\_\_\_\_

\_\_\_\_ Client signed statement for emergency representation with summary information affirming alien eligibility obtained orally from client noted in file by SMRLS employee.

\_\_\_\_ Victim of violence. Client meets the LSC alien eligibility exception as victim of violence or extreme cruelty. \*\*LSC and/or non-LSC funds may be used.



● **CITIZEN (CIUDADANO/A)**

I declare that I am a citizen of the United States.  
*Por esto declaro que soy ciudadano/a de los Estados Unidos.*

\_\_\_\_\_  
SIGNATURE (FIRMA)

\_\_\_\_\_  
DATE (FECHA)

● **ELIGIBLE ALIEN**

SMRLS employee has seen the documentation as to alien eligibility which is impossible/illegal to copy.

\_\_\_\_\_  
SIGNATURE (by SMRLS employee)

\_\_\_\_\_  
DATE

● **EMERGENCY (EMERGENCIA)**

I will be able to produce the document/s to verify my immigration status on or before \_\_\_\_\_.  
*Podré entregar el/los documento/s para verificar mi estado de inmigración en o antes del \_\_\_\_\_.*

\_\_\_\_\_  
SIGNATURE (FIRMA)

\_\_\_\_\_  
DATE (FECHA)

SOUTHERN MINNESOTA REGIONAL LEGAL SERVICES, INC. (SMRLS)

**AUTHORIZATION FOR THE  
RELEASE OF INFORMATION**

I, \_\_\_\_\_, authorize and instruct

\_\_\_\_\_ to release to Southern Minnesota Regional Legal Services, Inc. (SMRLS), 55 East Fifth Street, Suite 400, St. Paul, MN 55101 (651-222-5863), and any of its employees, including:

**Ben Weiss, Latisha Salinas** and \_\_\_\_\_

the following information:

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

The information is being requested to evaluate my legal rights and/or to pursue an administrative appeal.

I understand that this information will be used by SMRLS only as stated above. It will not be disclosed to other sources unless specifically authorized by law. I have been informed that I may refuse to authorize the release of this information, and SMRLS has explained to me the consequences of my refusal to release the information. I understand that SMRLS' use of this form does not indicate that SMRLS has agreed to accept me as a client or to represent me.

This authorization will remain in full force and effect, subject to my right to revoke it any time, until \_\_\_\_\_.

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

\_\_\_\_\_  
*Dated*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Social Security Number*