Southwestern Community Services

Since 1965, people helping people in Cheshire and Sullivan counties

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 stub(s) 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

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 HH 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: _____

No. 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 $ _____ Have you applied for fuel assistance? _____

Telephone/Cell Phone $ _____ Benefit amount for last year: _____

Cable $ _____ Have you applied for electric assistance? _____

Internet $ _____ Discount % amount: _____

FOOD AND HOUSEHOLD

Food $ _____ Do you receive food stamps? _____

Non-food Grocery $ _____ If yes, how much? _____

Diapers $ _____ (Please provide documentation)

Laundry $ _____

Childcare $ _____ Do you receive WIC? _____

PERSONAL

Doctor/Dentist $ _____ Do you receive Medicaid/Medicare? _____

Medications $ _____

Meals Out/Delivered $ _____

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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APPLICANT'S 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