

Bethsaida Housing APPLICATION for

Katie Blair House and the Patricia's Place Program

If you need help filling out this application, please call (860) 886-7511 (extension 216 for Katie Blair House, extension 210 for Patricia's Place Program. Si Usted necesita ayuda para completar este aplicación, por favor llame (860) 886-7511 x 201

Eligibility and Program Requirements

The main goals of Bethsaida's housing and support service programs are to help participants: obtain & remain in permanent housing by increasing earned and other income, and to increase daily living skills to become self-sufficient. We believe employment and/or volunteering and maintenance of sobriety from drugs/alcohol are key elements to any participant's ability to ultimately live independently.

To be eligible: A woman must be at least 18 years old. If an applicant has struggled with drug or alcohol addiction and is interested in recovery, we recommend she has 1 month or more of clean time. Bethsaida's housing programs cannot accept applicants with charges of child molestation or assault. Program requirements: Ability to find/retain employment (unless receiving SSI or SSDI), participate in the program, and pay occupancy fees in a timely basis.

Checklist for submitting a complete application

These records need to be submitted:

- A completed application (available on Bethsaida website at www.BethsaidaCT.org)
- Completed bed-bug policy agreement
- Completed release of information form (listing the referring agency)
- Proof of all income
- Resume (if available)
- A copy of the applicant's drivers' license or state I.D.
- A copy of the applicant's social security card
- If the applicant will be bringing a vehicle to Bethsaida, proof of insurance, registration, and a valid driver's license must be provided.

All completed forms need to be returned to:

Bethsaida Community, Inc.

P.O. Box 913, Norwich CT 06360, faxed to (860) 886-7512 or emailed

Katie Blair House call (860) 886-7511 x 216 or
email KBH@BethsaidaCT.org

Patricia's Place Program call (860) 886-7511 x 210 or
email PPP@BethsaidaCT.org

BETHSAIDA HOUSING APPLICATION

Application Date: _____

First Name: _____

Last Name: _____

Date of Birth: _____

Social Security Number: _____ - _____ - _____

Phone number: _____

Email: _____

Referral Source: Self Family Friend Agency (name of agency) _____

For agency referral: Case Manager's name: _____ Phone number: : _____

For agency referral: Case Manager's email: _____

Citizenship: USA citizen Permanent resident Other

Gender (optional): Male Female
 Transgender Male to Female Transgender Female to Male

Do you have any children? Yes No If yes, how many children? _____

If any children are minors, in whose care are they currently? _____

Do you understand, speak, read or write in any language other than English? Please list languages:

Understand: _____ Speak: _____ Read: _____ Write: _____

Where do you consider your home town (city of origin)? City: _____ State: _____

HOMELESSNESS Are you homeless now? (Please refer to the CT Balance of State CoC Homeless Verification Form) Yes No

If not homeless now, will you be in 2 weeks? Yes No

In your lifetime, how many times have you been homeless? _____

Primary reason for homelessness _____

Have you previously received help from another agency to pay a security deposit or rent? If yes, when (dates), how much?

Agency: _____ Total security deposit \$ _____ When? _____ Total rent \$ _____

When? _____

EMPLOYMENT & BENEFITS *Bethsaida Community Inc. has encourages ALL clients to seek and obtain employment, which is reflected in the agency mission statement.*

Please list all income received each month

INCOME TYPE	MONTHLY AMOUNT
Alimony or Other Spousal Support	\$
Child Support	\$
Earned/Employed income	\$
General Assistance	\$
Pension from a former job	\$
Private disability insurance	\$
Retirement income from Social Security	\$
SSDI	\$
SSI	\$
TANF	\$
Unemployment	\$
VA Service connected disability compensation	\$
VA Non-Service connected disability pension	\$
Workers compensation	\$

Please list all non-cash benefits received each month

NON CASH BENEFITS	RECEIVED? YES/NO
SNAP - Food stamps	
Special supplemental nutrition program for WIC	
TANF child care services	
TANF transportation	
Other TANF funded services	
Section 8, Public housing or rental assistance	
Temporary rental assistance	

Employment Status:

If "Employed:" Name of Employer: _____
Type of Employment: _____

Are you currently working part-time? Yes No

If yes, how many hours did you work last week? _____

Are you currently working full-time? Yes No

If yes, how many hours did you work last week? _____

For your last 2 jobs, please list:

Name of the employer _____ Dates of employment _____

Name of the employer _____ Dates of employment _____

If you are accepted into a Bethsaida housing program, you are expected to find work as soon as possible. Until you are able to find a job, you are required to do volunteer work. What type of volunteer work are you interested in?

If you are not working, are you looking for work? Yes No

If not, why not? _____

Are you able and willing to work on a regular basis? Yes No

If yes, what type of work can you perform? What do you feel you are qualified to do?

If you are NOT able to work or unwilling to work, please explain why:

If you are unable to work do you have proof from a licensed professional who can diagnose and treat a long-term disability?: Yes No For Flora O'Neil or Katie Blair House programs, please refer to the CT Balance of State CoC Disability Verification Form located at: <http://www.csh.org/csh-in-the-field/connecticut/2578-2/>

If you have documentation of a long-term disability, and have been chronically homeless (homeless 4 times in a 3 year period adding up to 1 year or homeless an entire year) you may be eligible for permanent supportive housing (KBH may not be a good option – discuss with the Case Manager)

EDUCATION

Education (Head of Household):

Are you currently in school or working toward a degree? Yes No

Highest Grade Completed:

- | | | |
|--|---|--|
| <input type="checkbox"/> No schooling completed | <input type="checkbox"/> 9th grade | <input type="checkbox"/> High School Diploma |
| <input type="checkbox"/> Nursery school to 4th grade | <input type="checkbox"/> 10th grade | <input type="checkbox"/> GED |
| <input type="checkbox"/> 5th grade or 6th grade | <input type="checkbox"/> 11th grade | <input type="checkbox"/> Post-secondary school |
| <input type="checkbox"/> 7th grade or 8th grade | <input type="checkbox"/> 12th grade, No diploma | |

Vocational training or apprenticeship certificate: Yes No

MEDICAL/MENTAL HEALTH

Do you have health insurance?:

Yes No

If yes, what type?

Medicaid Medicare State children's health insurance program
 Veterans Administration medical services

Employer-provided health insurance COBRA Private pay
 State health insurance for adults

Physical Health Affects Income And/or Housing: Yes No

Do you have any medical conditions that limit your ability to work? Yes No

If yes, please explain: _____
(proof of limitation needs to be documented by a licensed physician)

Do you have a mental health diagnosis? Yes No

If yes, what is your diagnosis? _____

Are you on medications for this diagnosis? Yes No

Please list prescribed medications and amounts:

Medication: _____	Dosage: _____
Medication: _____	Dosage: _____
Medication: _____	Dosage: _____

Have you ever had any suicide attempts? Yes No If yes, how many and when was the last episode? _____

When was your last physical exam? _____

If you currently have a primary care physician (a doctor) please list name, address and phone #:

Do you have an eating disorder? Yes No

If yes, please explain: _____

SUBSTANCE ABUSE HISTORY

Have you been treated for alcohol or drug addiction? Yes No (If yes, where?)

Name of treatment facility, city and state _____

Dates you were treated: _____

Name of treatment facility, city and state _____

Dates you were treated: _____

Have you ever overdosed? Yes No If yes, how many times? _____
When was the last time? _____

If you have used any of the following in the past, please check the substance(s) & list the date of last use:

- | | | | |
|------------------------------------|-------------------------|--|-------------------------|
| <input type="checkbox"/> Alcohol | Date of last use: _____ | <input type="checkbox"/> Cocaine | Date of last use: _____ |
| <input type="checkbox"/> Crack | Date of last use: _____ | <input type="checkbox"/> Hallucinogens | Date of last use: _____ |
| <input type="checkbox"/> Inhalants | Date of last use: _____ | <input type="checkbox"/> Prescription Drug | Date of last use: _____ |
| <input type="checkbox"/> Opiates | Date of last use: _____ | <input type="checkbox"/> Sedatives | Date of last use: _____ |
| <input type="checkbox"/> Other | Date of last use: _____ | <input type="checkbox"/> Over counter | Date of last use: _____ |

What is your drug of choice? _____ **Age of first use:** _____

If you currently see a substance abuse counselor, please list name, address & phone #:

RELATIONSHIPS

What is your marital status? *(this question is optional)*

- Married Single Divorced Separated

Are you currently involved in an intimate relationship? *(this question is optional)*

- Yes No

Sexual orientation *(this question is optional):* _____

GENERAL HISTORY

As a child, was your family ever homeless? Yes No

If during your childhood you experienced numerous situations of homelessness, how much time in total would you estimate that you/your family were homeless?

_____ Days _____ Weeks _____ Months _____ Years

As a child, was your family structure consistent? Yes No
(as an example – for 15 years lived with same family members)

Were you “bounced around” from house to house? Yes No

Were you in institutional care before the age of 18? Yes No

How old were you when you first became homeless? _____

Check any of the following with which you believe you may need assistance:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Social skills | <input type="checkbox"/> Goal development/implement | <input type="checkbox"/> Parenting | <input type="checkbox"/> Support Groups |
| <input type="checkbox"/> Job training | <input type="checkbox"/> Further education | <input type="checkbox"/> Motivation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Case management | <input type="checkbox"/> Daily living skills | <input type="checkbox"/> Mental health | <input type="checkbox"/> Substance Abuse |

HISTORY OF ABUSE

Many women who come to Bethsaida have experienced some form of abuse. Please check ALL that apply in your life experience.

Have you suffered from neglect:

As a CHILD: Yes No As an ADULT: Yes No

Have you suffered from physical abuse:

As a CHILD: Yes No As an ADULT: Yes No

Have you suffered from verbal abuse:

As a CHILD: Yes No As an ADULT: Yes No

Have you suffered from sexual abuse/rape:

As a CHILD: Yes No As an ADULT: Yes No

CRIMINAL HISTORY AND LEGAL ISSUES

Have you been arrested or convicted of a felony? Yes No

If yes, when? _____ For what? _____

Are you currently on probation for a felony? Yes No

If yes, please explain: _____

Do you have any pending legal issues? Yes No

If yes, please explain: _____

Have you ever been in jail? Yes No

If yes, explain _____

My signature here authorizes Bethsaida to conduct a criminal background check

X _____

ASSISTANCE

Check any of the following with which you believe you may need assistance:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Social skills | <input type="checkbox"/> Goal development | <input type="checkbox"/> Parenting | <input type="checkbox"/> Support Groups |
| <input type="checkbox"/> Job training | <input type="checkbox"/> Further education | <input type="checkbox"/> Motivation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Case management | <input type="checkbox"/> Daily living skills | <input type="checkbox"/> Mental health | <input type="checkbox"/> Substance Abuse |

Please ensure that you have read the attached Bed Bug Policy and have returned the Bed Bug Policy Agreement (to be considered a complete application).

Please note: all program participants are encouraged to get a "renters insurance policy" to protect their personal belongings while participating in any Bethsaida program.

My signature below indicates that I have read, understand, and answered the statements and questions to the best of my abilities. I understand that any falsification of information will deem my application ineligible.

Signature

Date

Thank you for your interest in Bethsaida.



BETHSAIDA COMMUNITY, INC'S **Bed Bug Policy**

In order to reduce and prevent the presence and spread of bed bugs, all of the following procedures must be implemented.

1. Prior to move-in:

- a. When a potential participant receives an application for entry to Bethsaida's housing programs, it will include the bed bug policy. The completed application returned to Bethsaida must include the signed Bed Bug Policy Agreement (see page 4) in order for the application to be considered complete. Staff will sign the agreement and put it in their client file on the day of move-in. This signed receipt is their acknowledgement that they were previously informed that they must bring all their belongings in tied plastic bags. No luggage or cloth bags will be accepted at move-in.
- b. New participants will be asked to only bring belongings that can be placed in heated dryers. Items that cannot be placed in dryers will have to remain tied in plastic bags in the shed for up to 30 days. During these 30 days the participant must arrange for their untreatable items to be picked up and removed from the shed. Anything that is not removed after the 30 days will be considered trash.

2. At admission:

- a. If participants arrive with luggage/cloth bags they will be reminded that they received a copy of the policy prior to move-in day and were given the guidelines. The new participant will be required to place their belongings in plastic bags provided by staff. Each bag will be labeled with the client's last name and first initial before being put in the dryer.
- b. If a participant arrives with luggage of any sort they will not be permitted to bring it into the house. For clients who have a driver/loved one with them, the luggage or any other inappropriate items will be returned with the driver whenever possible.
- c. If a participant cannot return their luggage with their driver, the empty luggage will be placed in a plastic bag, tied and labeled for storage in the shed for up to 30 days. The bag will be labeled with:
 - i. The client's last name and first initial
 - ii. Date of admission
 - iii. Bag x of x (if more than one bag)
- d. No personal items/clothing will be permitted inside the house until everything has been treated with dry heat. Before entry to the program, the clothing/shoes in the plastic bags will be placed in a dryer at high heat (minimum of 180 degrees) for a min of 20 minutes.
- e. The clothes the client is wearing will be placed in the dryer as soon as possible. The participant will shower before spending the night in her bed. After showering, the clothes worn that day will be removed and immediately placed in a plastic bag, tied and dried before being placed in the dirty laundry.
- f. If the participant refuses to place any belongings in the dryer, the personal items will be immediately placed in a plastic bag, tied, labeled with the appropriate information and stored in the shed for up to 30 days.

g. All participants will also view the CT Coalition Against Bed Bugs video:

http://www.ct.gov/caes/lib/caes/documents/bed_bugs/video/bedbugs!_h264.mov

3. Returning to KBH, KBH or FON from an approved over-night stay:

- a. After an overnight/weekend stay, a participant must change their clothes immediately once back. The client will put the dirty clothes and all clothes taken out of the house for the overnight into the heated dryer for at least 20 minutes.
- b. If a participant returns with additional personal belongings (clothes, blankets/linens, sneakers) then all items are put in a heated dryer for the minimum 20 minutes on the highest heat level.

4. If a participant reports of being bitten or has suspicious bites or rashes it will be treated as an emergency until bed bugs can be confirmed or ruled out

- a. Maintain calm professionalism. **Do not** stigmatize the person who has bed bugs, but respond quickly to any reports.
- b. If a participant suspects that they are being bitten or that another participant is being bitten they are to report it to staff immediately. An incident report should be completed, signed by the participant and case manager and put in the client file.
- c. The Case Manager will also forward a copy of the incident report to the Executive Director. If needed, a canine inspection may be scheduled with a pest management professional.
- d. If possible, trap the insect in a clear container (bag) and put in the freezer in order to assist with the process. Bethsaida will work the state officials to confirm or deny the presence of bed bugs and treatment.
- e. No furniture, mattresses, clothing is to be removed from the suspected infested area. The linens from that participant's bed should be washed in hot water and dried on high heat immediately.
- f. Staff will inspect the living area of the reporting participant and report any findings to the Executive Director. This includes the mattress and mattress cover; at no time should the mattress cover be removed by staff. Never self-treat because of risks to health and widespread pesticide resistance in bed bug populations.
- g. Nothing should be placed on the affected bed. Anything that does touch the bed **MUST** be included in the plastic bag and heating procedure.
- h. If an infestation is confirmed, staff should do their best to avoid a panic situation with the participants. Participants should be updated on a need-to-know basis. All participants should be informed that bed bugs are not the result of being "dirty" and any person affected by bed bugs should not be isolated.

5. Proactive measures for the prevention of bed bugs.

- a. Follow the Policy for all new participants and current participants returning from overnight stays.
- b. Regularly use a canister vacuum cleaner to vacuum all cracks and crevices of room and furniture. Mattresses and box springs should also be vacuumed.
- c. All carpeting should be vacuumed on a regular basis.



**BETHSAIDA COMMUNITY INC.
Bed Bug Policy Agreement**

I, _____, have received a copy of the Bethsaida Bed Bug Policy. By signing this form I acknowledge that I have read and understand the requirements for moving into the house. I understand that all of my belongings must be transported in plastic bags and treated in the dryer upon arrival. I understand that I am not to transport any of my belongings in any form of luggage, cloth bags, suitcases, duffle bags, etc.

I understand that these same rules apply when returning from an overnight stay.

Participant Name

Date

Staff

Date

FOR OFFICE USE ONLY

Did the client follow the guidelines set forth in this policy in preparing to move in?

YES NO

Date of move-in

RELEASE OF INFORMATION

I, _____ D.O.B _____ SS# _____
(Applicant name)

For the purpose of: _____

Hereby authorize: _____
(Name and address of agency or individual making disclosure)

To disclose to and/or obtain from Bethsaida Community, Inc., the following:

Please INITIAL the appropriate items: Verbal release _____ Written Release _____ Electronic Release _____

- _____ Medical Records: information related to physical or mental ability to work or participate in job training and a report of any contagious disease or illness.
- _____ Psychiatric records: A Discharge Summary which will include: a diagnosis, medication, prognosis, and recommendations.
- _____ Substance abuse records: Discharge summary
- _____ Other (please specify)

This information is to be used specifically for the purpose of my participation in a Bethsaida Community Inc. housing program. Any other use is prohibited.

"The confidentiality of this record is required under chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes." I understand that the records to be released may contain information pertaining to psychiatric, drug and/or alcohol abuse treatment, and may also contain confidential HIV (AIDS) related information. This consent is subject to revocation at any time except to the extent that the program, which is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this consent will expire 365 days after it is signed.

Witness Signature

Applicant's Signature

Title

Date Signed

Date signed by witness

STATEMENT REGARDING CONFIDENTIAL INFORMATION
DRUG AND ALCOHOL ABUSE RECORDS:

In the event that the information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse patient records regulation: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

HIV RELATED INFORMATION:

In the event that the information released constitutes confidential HIV related information protected under state law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.