# 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@BethsaidaCTorg

**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**:

☐ No schooling completed
☐ Nursery school to 4th grade
☐ 5th grade or 6th grade
☐ 7th grade or 8th grade
☐ 9th grade
☐ 10th grade
☐ 11th grade
☐ 12th grade, No diploma
☐ High School Diploma
☐ GED
☐ Post-secondary school

**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:**

| | | | |
|---|---|---|---|
| ☐ Alcohol | Date of last use: _____ | ☐ Cocaine | Date of last use: _____ |
| ☐ Crack | Date of last use: _____ | ☐ Hallucinogens | Date of last use: _____ |
| ☐ Inhalants | Date of last use: _____ | ☐ Prescription Drug | Date of last use: _____ |
| ☐ Opiates | Date of last use: _____ | ☐ Sedatives | Date of last use: _____ |
| ☐ Other | Date of last use: _____ | ☐ 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:**

| | | | |
|---|---|---|---|
| ☐ Social skills | ☐ Goal development/implement | ☐ Parenting | ☐ Support Groups |
| ☐ Job training | ☐ Further education | ☐ Motivation | ☐ Other |
| ☐ Case management | ☐ Daily living skills | ☐ Mental health | ☐ 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:**

| | | | |
|---|---|---|---|
| ☐ Social skills | ☐ Goal development | ☐ Parenting | ☐ Support Groups |
| ☐ Job training | ☐ Further education | ☐ Motivation | ☐ Other |
| ☐ Case management | ☐ Daily living skills | ☐ Mental health | ☐ 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.
*When a woman needs a hope, a home, a family*

# *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 beg 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)

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**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.**

**CONNECTICUT STATUTE CHAPTER 899 PROTECTS ALL RECORDS FOR CONFIDENTIALITY, P.L. 93-579.**