

HOUSING AND FAMILY SERVICES
Housing Information Sheet

Name: _____ Phone/Message _____ Today's Date _____
Address: _____ City _____ Zip _____
Email Address: _____
Have you ever gone by any other name than what is written above? Yes No
If yes, please list: _____
Are you currently receiving any services through TrueNorth? Yes No
If yes, please explain: _____
How did you hear about TrueNorth Community Services? _____

Household Information

Total Household Monthly Income _____
Does anyone in your household have a disabling condition? Yes No
If yes, please name the Household members here:

Do you have a DHS worker? Yes No If yes, what is your DHS Case Worker's Name? _____

Required For All Household Members

Full Name	Relationship to Head of Household	Social Security Number	Active Duty US Military Veteran?	Date of Birth mm/dd/yyyy	Gender	Race (Select all that apply)	Ethnicity
	<input type="checkbox"/> Self (Head of household)	_____-_____-_____ OR <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/_____ OR <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Non-Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse
	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-family member	_____-_____-_____ OR <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/_____ OR <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Non-Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse
	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-family member	_____-_____-_____ OR <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/_____ OR <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Non-Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse

Full Name	Relationship to Head of Household	Social Security Number	Active Duty US Military Veteran?	Date of Birth mm/dd/yyyy	Gender	Race (Select all that apply)	Ethnicity
	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-family member	_____-_____-_____ OR <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/_____ OR <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Non-Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse
	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-family member	_____-_____-_____ OR <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/_____ OR <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Non-Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse
	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or partner <input type="checkbox"/> Other family member <input type="checkbox"/> Other non-family member	_____-_____-_____ OR <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/_____ OR <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Non-Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse

Required for all Adults in the Household

Full Name	Where did you sleep last night?	How long have you slept in that location?	Have you been continuously homeless for at least one year?	How many times have you been homeless in the past three years?
	<input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Own Home (Mortgage or Land Contract) <input type="checkbox"/> Place not meant for human habitation (a vehicle, anywhere outside) <input type="checkbox"/> Rental <input type="checkbox"/> Staying or living in a family member's room, apartment, or house <input type="checkbox"/> Staying or living in a friend's room, apartment, or house <input type="checkbox"/> Other: _____	<input type="checkbox"/> One day or less <input type="checkbox"/> Two days to one week <input type="checkbox"/> More than one week, but less than one month <input type="checkbox"/> One to three months <input type="checkbox"/> More than three months, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more If 4 or more, how many Months have you been homeless? _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse
	<input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Own Home (Mortgage or Land Contract) <input type="checkbox"/> Place not meant for human habitation (a vehicle, anywhere outside) <input type="checkbox"/> Rental <input type="checkbox"/> Staying or living in a family member's room, apartment, or house <input type="checkbox"/> Staying or living in a friend's room, apartment, or house <input type="checkbox"/> Other: _____	<input type="checkbox"/> One day or less <input type="checkbox"/> Two days to one week <input type="checkbox"/> More than one week, but less than one month <input type="checkbox"/> One to three months <input type="checkbox"/> More than three months, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more If 4 or more, how many Months have you been homeless? _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Refuse

*****Complete this form if you are experiencing a housing crisis*****

I, _____ verify that my household is experiencing a housing crisis.

Please provide a brief explanation of your current living situation in the space below.

Signature: _____

Date: _____

**Consent for the Release of
Confidential Information
Housing and Family Services**

Name: _____ Last 4 Digits of SS#: _____ Birth Date: _____

Address: _____ City: _____ Zip: _____ Phone Number: _____

In order to plan for and provide the best possible care for myself and/or my family, various agency professionals will need to share information. I give my permission to share my and/or my family's personal information as needed. I understand that this information will be used to help determine if I and/or my family are eligible for services and benefits and how best to coordinate services. The agencies ***I have initialed below*** have my permission to share information about myself and/or my family. This consent is valid until I notify TrueNorth Community Services in writing that I wish to cancel consent

Please initial yes in the appropriate box

Agency	Yes	Instructions	Agency	Yes	Instructions
Transitional Supportive Housing I.S.T.			Landlord Name -		
Community Mental Health			Consumers Energy or Great Lakes		
DHS/ FIA			DTE		
Health Department			Propane Provider Name-		
TrueNorth Community Services			Five Cap		
Local School Districts			Love Inc.		
Webster House			Michigan Works		
Department of Corrections			Salvation Army		
Health Care Provider-			Other -		
United Way			Other -		
Physician			Other -		

***Note: This form does not permit information about AIDS or HIV, TB, Hepatitis or substance abuse to be shared.
A separate Authorization to Share Specific Information form must be used for this type of information.***

Consent applies to minors (youth under age 18) living in the household. **List names of minor children, initial and date:**

Minor _____ Parent/Guardian Initials and Date _____
 Minor _____ Parent/Guardian Initials and Date _____
 Minor _____ Parent/Guardian Initials and Date _____
 Minor _____ Parent/Guardian Initials and Date _____

- I understand that my treatment records are protected under state and federal regulations governing confidentiality of patient records.
- The regulations are the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 & 164.
- I understand that I may end this consent upon written notice.
- I understand that there may have been information shared and services provided based on this consent when it was in effect. Ending this consent cannot change that. Any notice to end this consent must be in writing.
- I understand that generally TrueNorth Community Services may not condition my assistance on whether I sign a consent form, but in certain circumstances I may be denied assistance if I do not sign a consent form.
- I have read and understand the information and that this information provided is true and accurate. and my signature indicates that I give my full permission to share information.

Signature _____ **Date** _____
 (Signature of parent, guardian, or authorized representative)