VILLAGE OF HOPE

2817 Mission Hill Road Tulalip, WA 98271
360-716-4701
VillageofHope@tulaliptribes-nsn.gov

SUPPORTIVE HOUSING APPLICATION

APPLICANT INFORMATION

☐ Village of Hope Cabins ☐ Village of Hope Cottages

Name: _____ **DOB:** _____

Tribal #: _____ **Parent of Tulalip Child:** _____

Current Mailing Address: _____

_____

Phone Number: _____ **Message Phone:** _____

Tenants will pay a flat-fee for the units. 1 bedroom apartments are $300 per month and 2 bedroom apartments are $400 per month. If a tenant becomes over 30% AMI after they move in, their rent may be adjusted to be 30% of their income. Rents will not go over HUD Housing Trust Fund rent limits. The Program Manager will review and verify tenant income every 6 months. Tenants with disability and SSI will have priority.

Employed: _____ **General Welfare:** _____ **TANF:** _____

Tribal Disability: _____ **SSI:** _____ **Other:** _____

Please List All Household Members:

Name(s)	Date of Birth	Enrollment #(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE ATTACH PHOTO COPIES OF: TRIBAL ID, STATE ID, VERIFICATION OF INCOME

Have you been through a chemical dependency treatment?

How many times?

Description of how you became Homeless:

Are you a victim of Domestic Violence?

Check any Tribal Departments you are currently involved with: (Yes/No)

Family Services: ☐ **Legacy of Healing:** ☐

Behavioral Health: ☐ **Tribal Court:** ☐

Beda?chelh: ☐ **Probation Office:** ☐

TANF: ☐ **Support Enforcement:** ☐

Other: _____

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application or interview may result in my denial to stay at The Village of Hope.

Client Signature: _____ **DATE:** _____

Client Signature: _____ **DATE:** _____

Staff Signature: _____ **DATE:** _____

Consent for Release of Information (ROI)

I hereby authorize the exchange of confidential information specified below between:

Information To Be Released From:	Information To Be Released To:
☐ Tulalip Housing	☐ Tulalip Housing
☐ Tulalip Homeless Shelter	☐ Tulalip Village of Hope
☐ Tulalip Family Services	☐ Tulalip Family Services
☐ Tulalip Health Clinic	☐ Tulalip Health Clinic
☐ Mental Health Services	☐ Mental Health Services
☐ Alcohol Drug Treatment Agency	☐ Alcohol Drug Treatment Agency
☐ Other	☐ Other

SPECIFIC INFORMATION TO BE DISCLOSED:

☐ Compliance with Treatment	☐ Compliance Reports
☐ Intake Assessment/ Evaluation Results	☐ Urinalysis Results/ Drug Testing
☐ Progress Reports	☐ Treatment Recommendations
☐ Income Verification	☐ Other

FOR THE PURPOSE OF:

☐ Application Process	☐ Family Case Planning
☐ Compliance with Tribal Court Orders	☐ Compliance with TANF
☐ Treatment Planning	☐ Other

I understand that my records are protected under the federal and state confidentiality regulations (42 CFR, Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that information disclosed by this authorization may be subject to disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA, 45 CFR, part 164. I also understand that I may revoke this consent at any time, if done in writing, except to the extent that action has been taken in reliance of it. I further acknowledge that the information to be released has been fully explained to me and this consent is given of my own free will.

_____ _____ _____/_____/_____

PRINT NAME SIGNATURE DATE

This authorization will expire 1 year from the date entered here _____. If no date is entered, release will automatically expire in 6 months of the date signed.

Notice of Disclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/ drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR, part 2). The federal rules may prohibit you from making further disclosure of this information unless 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 his purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

TULALIP TRIBES Village of Hope A: 2819 Mission Hill Road P: 360-716-4701

Criminal History Report Procurement Authorization

For company use only

Company: Tulalip Tribes Village of Hope Date: _____

Co. Representative: _____ Company Rep Contact Number: (360) 716- 4701

Applicant Name: _____ _____ _____

(Last) (First) (Middle Name)

Applicant Maiden Name/ Alias (list all): _____

Social Security #: _____- _____ - _____ Driver's license #: _____ State: _____

Date of Birth: _____-_____-_____ Place of Birth: _____

(Month) (Day) (Year)

_____ _____ _____ _____ _____ _____

Height Weight Hair Color Eye Color Race Sex(M/F)

Have you been convicted of a felony? ☐ Yes ☐ No If yes, please give: Please note: Admittance of felony convictions does not automatically disqualify employment.

_____ _____ _____ _____

DATE COUNTY STATE CRIME

Current Phone	Current Street Address	City	State	County

List below addresses at which you have lived in the past seven years, with dates

From	To	Previous Street Address	City	State	County

The undersigned, in connection with an application for employment, hereby authorizes the procurement of an investigate report for both criminal and credit history. This authorizes any law enforcement or judicial agency, corporation, company or others to provide relevant information they may have on the applicant to Background Checks, Inc. This further releases all parties providing information from any and all liabilities or responsibility for doing so. The undersigned hereby acknowledges that they read or have read to them this authorization and they understand it. A copy of this authorization has the same authority as the original.

To the applicant: The Fair Credit Reporting Act and other applicable laws give you certain rights with regard to consumer reports obtained for employment purposes, including, upon request, disclosure of information on you in the reporting agency's file at the time of you request, including the identification of persons who have procured the consumer report concerning you, and reasonable opportunity to respond to any information in the report that is disputed by you. Request for disclosure should be made in writing by certified mail to background Checks, Inc. PO Box 1466, Bothell, WA 98041.

Fax 425-398-9337.

Applicant Signature **Date**