Ilé Te Shangó Diversity & Empowerment Foundation
Financial Assistant Application Form

Your application must include this checklist and copies of all corresponding documentation.

1) If you have no income: Please have the person or people who provide your support send a letter explaining that they support you, but do not claim you as dependent on their taxes.
2) If you have been denied Medical Assistance: If you have been denied Medical Assistance through the State, please send us a copy of your 'Letter of Denial.' We cannot finalize your application without this letter.
3) If you have income: If you file a federal income tax return you must: Attach a copy of your most recent Internal Revenue Service Tax return, i.e. (IRS 1040 Form). If you did not file a federal income tax return you must: Document below that you are not required to file and the reason why.

   _____

   _____

   _____
4) Did someone claim you as a dependent on their federal income tax return? If yes, you must: Include a copy of the most recent federal income tax return of anyone who claimed you as a dependent.

Utilities & Rental Document Check List	
	Copy of Rental Eviction Notice & Rental Lease Agreement
	Copy of Current Gas Statement
	Copy of Current Power Statement
	Copy or Current Water Statement

Family and Non-Family Document Checklist			
Primary Applicant		Spouse	
	Copy of ID Front & Back		Copy of ID Front & Back
	Copy of Social Security		Copy of Social Security
	Copy of Health Insurance Card Front & Back		Copy of Health Insurance Card Front & Back
	Copy of (3) Current Pay Stub		Copy of (3) Current Pay Stub
	Copy of Lease		Copy of Lease
Children 17 and under		18 or Older / Family or Non-Family Member	
	Copy of ID Front & Back		Copy of ID Front & Back
	Copy of Social Security		Copy of Social Security
	Copy of Health Insurance Card Front & Back		Copy of Health Insurance Card Front & Back
			Copy of (3) Current Pay Stub
****If family member is under Social Security Benefits, we will need a current Social Security Benefit Letter****			
	Copy of Social Security Benefit Letter		
****If the individual is Unemployed, We will need a current Unemployment Letter****			
	Copy of Unemployment Letter		

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Ilé Te Shangó Diversity & Empowerment Foundation
Financial Assistant Application Form

Official Section Only		Account Number:	
Client Name:		Cellphone Number:	
Referred By:		Caseworker Name:	
Appointment Date:		Appointment Time:	

Race / Ethnicity

Are you Hispanic, Latino, or of Spanish origin? (optional)	Yes	No

If Hispanic/Latino (check all that apply - optional):

Mexican		Mexican American		Puerto Rican		Chicano/ a		Cuban		Other	

Race (optional) - check all that apply

White		Black or African American		American Indian or Alaska Native		Asian Indian	
Chinese		Filipino		Japanese		Korean	
Vietnamese		Native Hawaiian		Guamanian or Chamorro Samoan		Other	

Household Information Your income and family size help us decide what programs you qualify for. With this information. Who needs to be included on this application: • your spouse, if married • your children who live with you • your partner who lives with you.

Head of Household Information

Marital Status		Gender		Sexual Preference	
Single		Male		Heterosexual	
Married		Female		Bisexual	
		Nonbinary		Gay	
		Other		Other	

Personal Information

First Name:	Middle Name:	Last Name:
Date of Birth:	Social Security Number:	
Home Address:		Apt. Number:
City:	State:	Zip Code:

Employment Information

Company Name:		Work Number:	
Employment Address			Suite Number:
City:	State:	Zip Code:	
Gross wages/tips per pay period:	How often are you paid?	Weekly:	Bi-Weekly:
$	Monthly:	Semi-Monthly:	Annually:

Insurance

Does you or family member or non-family member has health insurance?	Yes:		No:	

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Provide total number living in the current household.	
	Total Adults including age of 18 & Over Living in the same household.
	Total Children below 17 years of age

Spouse Information		
First Name:	Middle Name:	Last Name:
Date of Birth:	Social Security Number:	
Home Address:		Apt. Number:
City:	State:	Zip Code:

Employment Information			
Company Name:		Work Number:	
Employment Address			Suite Number:
City:	State:	Zip Code:	
Gross wages/tips per pay period:	How often are you paid?	Weekly:	Bi-Weekly:
$	Monthly:	Semi-Monthly:	Annually:

Children If Any: (If none leave the section blank.)

1) Children's Information			
First Name:	Middle Name:	Last Name:	
Date of Birth:	Social Security Number:		Age:
Home Address:		Apt. Number:	
City:	**State:**	**Zip Code:**	
Currently in School:	Yes:	No:	

2) Children's Information			
First Name:	Middle Name:	Last Name:	
Date of Birth:	Social Security Number:		Age:
Home Address:		Apt. Number:	
City:	**State:**	**Zip Code:**	
Currently in School:	Yes:	No:	

3) Children's Information			
First Name:	Middle Name:	Last Name:	
Date of Birth:	Social Security Number:		Age:
Home Address:		Apt. Number:	
City:	**State:**	**Zip Code:**	
Currently in School:	Yes:	No:	

4) Children's Information			
First Name:	Middle Name:	Last Name:	
Date of Birth:	Social Security Number:		Age:
Home Address:		Apt. Number:	
City:	**State:**	**Zip Code:**	
Currently in School:	Yes:	No:	

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If the child is 18 of age or over and working, we will need the following information:

1) Children Information 18 years or Over		
First Name:	Middle Name:	Last Name:
Date of Birth:	Social Security Number:	
Home Address:		Apt. Number:
City:	State:	Zip Code:

Currently in School:	Yes:	No:

If not working and the Child is still in High School leave this section blank.

Employment Information			
Company Name:		Work Number:	
Employment Address			Suite Number:
City:	State:	Zip Code:	
Gross wages/tips per pay period:	How often are you paid?	Weekly:	Bi-Weekly:
$	Monthly:	Semi-Monthly:	Annually:

2) Children Information 18 Years or Over		
First Name:	Middle Name:	Last Name:
Date of Birth:	Social Security Number:	
Home Address:		Apt. Number:
City:	State:	Zip Code:

Currently in School:	Yes:	No:

If not currently working and the Child is still in High School leave this section blank.

Employment Information			
Company Name:		Work Number:	
Employment Address			Suite Number:
City:	State:	Zip Code:	
Gross wages/tips per pay period:	How often are you paid?	Weekly:	Bi-Weekly:
$	Monthly:	Semi-Monthly:	Annually:

Ilé Te Shangó Diversity & Empowerment Foundation
Financial Assistant Application Form

This section is for family members or non-family members living in the same household.

1) Family or Non-family Member Information			
First Name:	Middle Name:		Last Name:
Date of Birth:	Social Security Number:		
Home Address:			Apt. Number:
City:	State:		Zip Code:
Employment Information			
Company Name:		Work Number:	
Employment Address			Suite Number:
City:	State:	Zip Code:	
Gross wages/tips per pay period:	How often are you paid?	Weekly:	Bi-Weekly:
$	Monthly:	Semi-Monthly:	Annually:

2) Family or Non-family Member Information			
First Name:	Middle Name:		Last Name:
Date of Birth:	Social Security Number:		
Home Address:			Apt. Number:
City:	State:		Zip Code:
Employment Information			
Company Name:		Work Number:	
Employment Address			Suite Number:
City:	State:	Zip Code:	
Gross wages/tips per pay period:	How often are you paid?	Weekly:	Bi-Weekly:
$	Monthly:	Semi-Monthly:	Annually:

3) Family or Non-family Member Information			
First Name:	Middle Name:		Last Name:
Date of Birth:	Social Security Number:		
Home Address:			Apt. Number:
City:	State:		Zip Code:
Employment Information			
Company Name:		Work Number:	
Employment Address			Suite Number:
City:	State:	Zip Code:	
Gross wages/tips per pay period:	How often are you paid?	Weekly:	Bi-Weekly:
$	Monthly:	Semi-Monthly:	Annually:

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Landlord Information			
Name of Residential:		Landlord Name:	
Office Number:	Fax Number:		
Office Address:		Suite Number:	
City:	State:	Zip Code:	

How do you pay your rent?		Eviction Notice:	
	Office	Yes:	No:
	Portal App		
		Date of Evection:	
Note:			
		Amount Owed:	$

If the Client is using a Portal App, we may need to use his or her username and password to assist with payments.

Must Read to Clients

All Information is under the HIPPA Regulation 45 CFR Parts 160, 162, and 164 that Ile Te Shango Foundation does not give or share any information without prior consent. All information is secured with your permission do you agree to these terms and conditions?

Yes _____ Date Agreed_____ No _____ Date Disagree _____

Please sign if you agree to provide Ile Te Shango Foundation to use your username and password to login into his or her portal App to make rental payments.

Print Full Name: _____

Signature: _____ Date: _____

Username: _____Password: _____

Please sign if you wish not to provide Ile Te Shango Foundation to use your username and password to login to make payments.

Print Full Name: _____

Signature: _____ Date: _____

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NPP Compliance Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected personal, health, and financial information. The notice contains a client's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected personal, health, and financial information is used and disclosed for payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The Privacy Act of 1974, a United States federal law, establishes a Code of Fair Information Practice that governs the collection, maintenance, use, and dissemination of personally identifiable information about individuals that is maintained in systems of records by federal agencies. By signing this form, you consent to our use and disclosure of your protected personal, health, and financial information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES _____ NO _____

May we leave a message on your answering machine at home or on your cell phone? YES _____ NO _____

May we discuss your medical condition with any member of your family? YES _____ NO _____

If YES, please name the members allowed:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

This consent was signed by: _____ (Print Name Please)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Financial Break Down

We encourage you to use our budget worksheets to get a more accurate assessment. Review worksheets to help you estimate your monthly budget and manage your available financial resources.

Client must provide the following financial breakdown expenses.			
$	Cable / Internet (Non-Essential)	**$**	Medical (Essential)
$	Car Insurance (Essential)	**$**	Movie Streaming (Non-Essential)
$	Car Payments (Essential)	**$**	Power (Utilities)
$	Cellphone (Essential)	**$**	Rent (Essential)
$	Clothing (Essential)	**$**	Power (Utilities)
$	Gas (Utilities)	**$**	Sewage / Trash (Utilities)
$	Gas for Car (Essential)	**$**	Water (Utilities)
$	Groceries (Essential)	**$**	Other:
$	Loans (Total Loans i.e.: payday loans / student loans or others) (Essential)	**$**	Other:

Total Expenses			**Total Income**	
$	Total Amount for Essential's		$	Primary Income Before Taxes
$	Total Amount for Non-Essential's		$	Spouse Income Before Taxes
$	Total Amount Utilities		$	18 or over Income Before Taxes
$	Total Amount for Other's		$	Family Member Income Before Taxes
$	**Combined Total Expense**		$	Non-Family Member Income Before Taxes
			$	Social Security Benefits
			$	**Combined Total Income Before Taxes**

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Client Understanding

I understand that the documentation requested will not be returned to me.

I understand that the information provided by me will be used to determine financial assistance and financial responsibility for my services at Ile Te Shango Foundation.

I further understand that the information I submit concerning my annual household income and size is accurate and subject to verification by Ile Te Shango Foundation.

I understand to cooperate with the application process for State Financial Assistance if requested to do so by Ile Te Shango Foundation, before I will receive financial assistance through Ile Te Shango Foundation.

I understand, if I am approved for financial assistance but later obtain employment during my eligibility period, I must contact (702) 900-1867 with this updated employment information.

I understand that upon receipt of a financial assistance approval letter, my financial assistance coverage will only be valid for 6 Months from the date of the letter, and as a courtesy Ile Te Shango Foundation will adjust balances 6 Months before my approval date.

I understand that if I do not qualify for financial assistance, I will receive a denial letter from the Ile Te Shango Foundation providing the reason for the denial.

I understand that if any information I have provided is determined to be false, it may result in a reversal of my financial assistance approval, and I will be liable for all charges and fines. I grant permission for the Ile Te Shango Foundation to verify any of the information I have provided.

This consent was signed by: _____ (Print Name Please)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Nevada Community Management Information Systems (CMIS)

Client Consent for Data Collection and Release of Information

What is CMIS?

The CMIS is a data system that stores information about homelessness services. Bitfocus, Inc. manages the CMIS for the CoCs within the state of Nevada. The purpose of the CMIS is to improve services that support people who are homeless or at risk of homelessness to get housing, and to have better access to those services while meeting requirements of funders such as the U.S. Department of Housing and Urban Development (HUD).

What is the purpose of this form?

With this form, you can give permission to have information about you collected and shared with Partner Agencies that help Nevada provide housing and services. A current list of Partner Agencies is available at http://nvcmis.bitfocus.com/.

BY SIGNING THIS FORM, I AUTHORIZE the state of Nevada and Bitfocus to share CMIS information with Partner Agencies. The CMIS information shared will be used to help me get housing and services. It will also be used to help evaluate the quality of housing and service programs. I understand that the Partner Agencies may change over time.

The information to be collected and shared includes:

- Name, date of birth, gender, race, ethnicity, social security number, phone number, address
- Basic medical, mental health, substance use, and daily living information
- Housing Information
- Use of crisis services, veteran services, hospitals, and jail
- Employment, income, insurance, and benefits information
- Services provided by Partner Agencies
- Results from assessments
- My photograph or other likeness (if included)

BY SIGNING THIS FORM, I UNDERSTAND THAT:

Bitfocus and Partner Agencies will keep my CMIS information private using strict privacy policies. I have the right to review their privacy policies.

- I can receive a copy of this Consent and the Client Information Sheet
- I may refuse to sign this Consent. If I refuse, I will not lose any benefits or services.
- This Consent will expire 5 years from my last CMIS recorded activity.

I may revoke this Consent earlier at any time by returning a completed Revocation of Consent form, available at http://nvcmis.bitfocus.com/, to nevada@bitfocus.com.

- The revocation will take effect upon receipt, except to the extent others have already acted under this Consent.
- My CMIS information may be viewed by auditors or funders who review the work of the Partner Agencies, including HUD, The Department of Veteran Affairs, and The Department of Health and Human Services. I understand that the list of auditors and funders may change over time.
- My CMIS information may be shared to coordinate referral and placement for housing and services.
- My CMIS information may be further shared by the Partner Agencies to other agencies for care coordination, counseling, food, utility assistance, and other services.
- My CMIS information will be used to help evaluate the quality of social services.
- My CMIS information may be used for research; however, my identity will remain private.

SIGNATURE:

_____ _____
Of Patient / Client or Representative Date

_____
Printed Name

Refusing Consent and De-Identification of Information

If you refuse consent to have your information shared with Partner Agencies, the following information will be entered into the system for your profile and will be deemed anonymous or "de-identified".

1. Your Social Security Number will be entered as all 0s, and the Social Security Number Data Quality field will be set to Client Refused.
2. Your Date of Birth will be entered as 01/01/ [year of birth] and the Date of Birth Data Quality field will be set to Approximate or Partial DOB Reported.
3. Your First Name will be entered as Anonymous.
4. Your Last Name will be entered as the Unique Identifier automatically assigned by Clarity Human Services; and
5. The Name Data Quality field will be set to Client Refused.

FOR AGENCY USE ONLY:

Client Opted Out (Refused Consent) _____ Staff / Agency Initials)

Witness Staff & Agency _____ Date _____

Participant Rights and Responsibilities

I am applying for assistance through Ile Te Shango Foundation. I understand there are multiple components in the application process that I agree to complete to the best of my ability.

I authorize my Case Manager to obtain the information needed to determine my meeting program qualifications for the Homeless Prevention Program services and to develop a personalized plan of care.

I certify that I have not manufactured or produced methamphetamine on the premises of federally assisted housing (24CFR 960.204, 24CFR 982.553); and I am not a sex offender subject to a lifetime registration requirement under a State sex offender registration program (24CFR 960.204, 24CFR 982.553).

Persons applying for assistance through the Homeless Prevention Program have rights and responsibilities.

RIGHTS

- You have the right to choose whether to apply for assistance through this program.
- You have the right to choose the service providers from whom you will receive your HOPWA services, to the extent that they are available.
- You have the right to receive the HOPWA services you need; these may or may not include all the services you desire.
- You have the right to receive timely, respectful, high-quality services from the staff of all providers without regard to age, ethnicity, gender, disability, religion, sexual orientation, values and beliefs, and marital status.
- You have the right to request copies of all signed documents and have access to your service record.
- You have the right to participate in the development of your plan of care.
- You have the right to receive current information and education about housing services and resources.
- You have the right to file a complaint, grievance, and appeal for decisions with which you do not agree.
- You have the right to request an interpreter to enhance communication.

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RESPONSIBILITIES

- You are responsible to conduct yourself in a courteous, cooperative, assertive, and respectful manner.
- You are responsible for keeping scheduled appointments, responding in a timely manner to all appointments, and accepting offered and necessary services.
- You are responsible for notifying the project sponsor if any illness interferes with scheduled appointments.
- You are responsible for working with your Community Connect Case Manager to develop a plan of care, and actively participate in its implementation.
- You are responsible for providing all documentation needed to acquire housing services.
- You are responsible for notifying your Community Connect Case Manager when you have problems in obtaining housing services or when you are dissatisfied with your care.
- You are responsible for following health care instructions to the best of your ability.
- You may be responsible for a portion of the costs of your housing services.
- You are responsible for notifying your Community Connect Case Manager of any changes such as an address, income, and living arrangements.

CLIENT COMPLAINT, GRIEVANCE, AND APPEAL PROCEDURES

- You have been informed of the project sponsor's client complaint, grievance, and appeal procedures.
- You have the right to file a complaint, grievance, and/or appeal.
- You have the responsibility to initiate these actions.

I have had the opportunity to discuss this, and I am fully aware of the Participant's Rights and Responsibilities outlined above. The Housing Coordinator will provide a signed copy to the client.

_____

Client Full Name

_____ _____

Client Signature Date

_____ _____

Case Manager Signature Date

Termination Policy

Program dismissal will be implemented for severe or persistent violations after intervening steps have been exhausted. The client and/or the household are responsible for following the rules of their lease/mortgage, community, and program guidelines. The Ile Te Shango Foundation believes in intervening with gradual steps before terminating the client from the program.

Reasons for dismissal from the program are as follows:

- Immediate program termination may be warranted in instances of fraud, bribery, threats of violence, or any other corrupt or criminal acts.
- Threats of violence include verbal and non-verbal actions that threaten the safety of themselves, neighbors, staff, and landlords.
- The client or household will be terminated from the program due to criminal behavior or activity in the unit or property damage to a leased unit.
- The client or household doesn't comply with the program guidelines that have been signed during the initial assessment.
- Termination will take place in the event of the death of the HOPWA-eligible participant when there are surviving family members.
- The client or household no longer qualifies for services in accordance with program eligibility requirements.
- The client or the household has reached the program eligibility limit.
- The client or household member fails to pay their portion of rent.
- The client or household member fails to complete the annual recertification.
- The client or household member is evicted from housing.
- The client and household members vacate the housing property and stop communicating with their Case Manager.

I understand that I may be terminated from the program should I not follow the rules of my lease/ mortgage, community, and program guidelines. It is my responsibility to communicate with my case manager and provide any income changes within 10 days.

Failure to comply may cause termination of the program.

_____
Client Full Name

_____ _____
Client Signature Date

_____ _____
Case Manager Signature Date

Termination Policy (04/2024)

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