

Office Use Only:

Date Received: _____

Reviewed: _____

Initials: Rec _____ Rev _____

A: ___ D: ___ H: ___

CTID _____



HOTEL INC

Community Engagement and Development

Application for Partnership

****Completion of this application does not guarantee partnership with HOTEL INC****

Name:

Address:

Phone:

Email:

Preferred Method of Communication: Email _____ Phone _____ Text _____

Are you interested in our Foundations Program (housing)?

Housing Status: Rent ___ Own ___ Living with Friends/Family ___ Street/Car ___

Are you employed, if so where? If unemployed, what is preventing you from working?

Full Time

Part Time

Temporary

Disabled

Retired

What areas of your life do you need resources or guidance to increase your overall well-being?

Nutrition/Food Housing Health Employment Legal Faith Relational

When you picture your life with improved well-being, what does that look like? *(What would you be doing with your time? Who would you be spending time with? What would your nutrition look like? What physical activity would you participate in? What would your living situation be?)* **Which of these things is most important?**

How has your situation changed over the past year?

What are some things you have been doing to change your current situation?

What would you describe as your strengths? If this is difficult for you, what have others said were your strengths?

How long do you anticipate partnering with HOTEL INC to achieve your desired wellbeing?

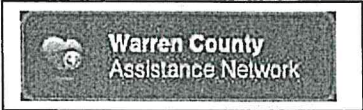
0-3 months 3-6 months 6 months or longer

Have you received assistance from any other organizations in the past year?

Yes _____ No _____

If so, please list the names and the amount/type of assistance received.

*******At this time, HOTEL INC is not able to provide assistance with past due rent or utilities. We are happy to connect you with other community partners who are currently receiving funding for this type of assistance. *******



WARREN COUNTY ASSISTANCE NETWORK
 Shared Case Management Software - CharityTracker
 Release of Information (ROI)

Last Name: _____ First Name _____ MI: _____ CTID: _____
 Address: _____ City/State: _____ Zip: _____
 Date of Birth: _____ SSN: _____ Phone: _____
 Email Address: _____ DL/ID Number: _____

Warren County Assistance Network, hereinafter referred to as "CharityTracker", is a shared, computerized record keeping system that captures information about people experiencing need for emergency services, including but not limited to assistance with utility bills, medications, rent/mortgage payments, etc. Hope House Ministries (Adminstrating Agency) adminlsters CharityTracker on behalf of participating agencies of the CharityTracker Assistance Network, including HOTEL INC (Participating Agency).

I understand that all information gathered about me is personal and private and that I do not have to participate in CharityTracker. I have had an opportunity to ask questions about CharityTracker and to review the basic identifying information, which is authorized by this release for the Charity Tracker Assistance Network Participating Agencies to share. I also understand that information about non-confidential services provided to me by CharityTracker participating agencies may be shared with other CharityTracker Participating Agencies. This Release of Information will remain in effect for 3 years from the date noted under my signature at the bottom of this page unless I make a formal request to this Organization that I no longer wish to participate in CharityTracker.

I further give HOTEL INC authorization to contact agencies on my behalf to gather information necessary to assist in my case management, including but not limited to landlord, utility companies, employers, physicians, pharmacies, social services, food stamp office, medicaid/medicare, government agencies (such as social security or vital statistics), etc.

Dependent's Name	Date of Birth	Social Security Number	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I authorize HOTEL INC as a CharityTracker Participating Agency, to share my basic, identifying and non-confidential service transactions/information with other CharityTracker Participating Agencies. I authorize the use of a copy of this original to serve as an original for the purposes state above. I further authorize HOTEL INC (Participating Agency), as a participating agency to share my dependent's basic, identifying and non-confidential service transactions/information with other CharityTracker participating agencies.

X _____ X _____
 Client and/or Parent-Legal Guardian's Authorizing Signature Agency Representative Signature

 Date Date

The original of this Release of Information shall be kept on file with the Agency for a minimum