



ʔalʔaltəd ʔə ti sxăxtub

"Be the village!"

Supportive Housing List Application

PERSONAL INFORMATION

First name		Last name	
Date of birth	Tribal number	Parent of Tulalip child	
<i>Please attach copies of both Tribal and State identification.</i>			
Address		City	State Zip
Home phone	Cell phone	Email	

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.

Employment	General Welfare	TANF	Tribal Disability
Other			

Please attach verification of monthly income.

HOUSEHOLD MEMBER(S)

Name	Date of birth	Enrollment number

QUESTIONNAIRE

Please answer each question:

Have you been through a chemical dependency treatment?

Yes No

How many times?

Please describe how you became homeless:

Are you a victim of domestic violence? Please describe:

Check any Tribal departments you are currently involved with (yes or no):

Family Services Yes No

Legacy of Healing Yes No

Behavioral Health Yes No

Tribal Court Yes No

bədaʔchəlh Yes No

Probation Office Yes No

TANF Yes No

Support Enforcement Yes No

Other

Yes No

Date

Applicant Signature

Date

Staff Signature

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 INFORMATION

Last Name	First Name	Middle Name
-----------	------------	-------------

Maiden Name/Alias (list all):

Social Security Number	Driver's License Number	State
------------------------	-------------------------	-------

Date of Birth	Place of Birth	Height	Weight	Hair	Eyes	Race	Sex
---------------	----------------	--------	--------	------	------	------	-----

Have you been convicted of a felony? No Yes

If yes, please list below: *(note: admittance of felony convictions does not automatically disqualify applicant)*

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	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 your 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 425-398-9937

Date	Applicant Signature
------	---------------------

CONSENT FOR RELEASE OF INFORMATION (ROI)

I hereby authorize the exchange of confidential information specified below:

Information To Be Released From:

- Tulalip Housing
- Tulalip Homeless Shelter
- Tulalip Family Services
- Tulalip Health Clinic
- Mental Health Services
- Alcohol/Drug Treatment Agency
- Other

Information To Be Released To:

- Tulalip Housing
- Tulalip Homeless Shelter
- Tulalip Family Services
- Tulalip Health Clinic
- Mental Health Services
- Alcohol Drug Treatment Agency
- Other

Specific Information To Be Disclosed:

- | | |
|---|--|
| <input type="checkbox"/> Compliance with Treatment | <input type="checkbox"/> Compliance Reports |
| <input type="checkbox"/> Intake Assessment/Evaluation Results | <input type="checkbox"/> Urinalysis Results/Drug Testing |
| <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Treatment Recommendations |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other |

For The Purpose Of:

- | | |
|--|---|
| <input type="checkbox"/> Application Process | <input type="checkbox"/> Family Case Planning |
| <input type="checkbox"/> Compliance with Tribal Court Orders | <input type="checkbox"/> Compliance with TANF |
| <input type="checkbox"/> Treatment Planning | <input type="checkbox"/> Other |

I understand that my records are protected under the federal and state confidentiality regulations (42 CFR, Part2) and cannot be disclosed without my written consent unless otherwise provided for 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.

Date	Name	Signature
------	------	-----------

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 to 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 patient.

TULALIP TRIBES Village of Hope, Building A: 2819 Mission Hill Road | Phone: 360-716-4701