2020 PROJECT PLACE APPLICATION FOR REMOTE PROGRAMS & SERVICES
1145 Washington St. Boston, MA. 02118 clientservices@projectplace.org Tel: (617) 542-3740 x271 Fax: (617) 542-3860

Client Needs Assessment

We use this to assess your current needs
and ensure you have needed support to address any concerns.
Project Place will develop a plan to address needed resources and options.

		Notes
Do you have access to shelter?	○ Yes ○ No	
Do you have access to food and clean water?	○ Yes ○ No	
Do you have access to personal protective gear to avoid illness?	○ Yes ○ No	
Soap or hand sanitizer to clean hands	○ Yes ○ No	
Disinfectants to clean surfaces	○ Yes ○ No	
Mask to wear in public	○ Yes ○ No	
Gloves	○ Yes ○ No	
Do you have enough clean clothing and/or access to laundry machines?	○ Yes ○ No	
Is your physical health currently stable?	○ Yes ○ No	
Are you experiencing any symptoms?		
Sore Throat	○ Yes ○ No	
Cough	○ Yes ○ No	
Temperature	○ Yes ○ No	
Chills	○ Yes ○ No	
Muscle Pain	○ Yes ○ No	
Headache	○ Yes ○ No	
New loss of taste or smell	○ Yes ○ No	
If you are in recovery, is this a current concern for you?	○ Yes ○ No	
Have you been using today?	○ Yes ○ No	
Within the past week?	○ Yes ○ No	
Is it possible you are detoxing from any substances that may be dangerous for your health?	○ Yes ○ No	
Narcotics?	○ Yes ○ No	
Alcohol?	○ Yes ○ No	
Benzodiazepine?	○ Yes ○ No	
Stimulants?	○ Yes ○ No	
Are you currently experiencing a mental health crisis?	○ Yes ○ No	
Do you have supports?	○ Yes ○ No	
Are you familiar with the BEST team?	○ Yes ○ No	
Are you concerned about your safety or the safety of another person or group of people?	○ Yes ○ No	
Are you currently fleeing domestic violence?	○ Yes ○ No	

Other Notes:

Any information we ask on the application is used to help us to best support you in obtaining employment.
It is important to complete all sections of this application. An incomplete application will not be considered.
All information you provide on this application is considered confidential. Criminal history will not disqualify you from our services.

RELEASE OF INFORMATION

Client Name: _____

Date of Birth: _____ **S.S. #:** _____

I hereby give permission to **Project Place** to exchange information in order to collaborate with community partners to assist me in meeting personal goals while I am a Project Place client.

Furthermore, I give permission to Project Place staff to have two-way communication with the following individuals or service providers in order to collaborate and assist me in meeting my employment, housing and personal goals while I am a Project Place client.

Name/Title	Agency	Email	Phone/Fax

The information exchanged between Project Place staff and service providers is related to: *mark an X next to all that apply*

Housing	___	Recovery supports	___	Legal Obligations	___
Physical Health	___	Mental Health	___	Other	___

Project Place staff and I have discussed this release of information, and I fully understand its purpose. I voluntarily consent to the disclosure of the above information.
I further release Project Place, their programs and employees from any liability arising from said release of information if done substantially in accordance with applicable law.

☐ I , _____ . affirm that I have reviewed with client, _____, the above information and have recorded their answers accurate and honestly.

_____ _____
Signature of Intake Coordinator Date

Federal regulations prohibit any further disclosure of information obtained without the specific written consent of the person to whom it pertains.

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COVID-19 Boston Homeless Assistance Network (HAN) Release: Client Authorization for Coordinating Services

☐ _____ (Client name), hereby verbally authorizes each *Homeless Assistance Network (the "Network")* member (see below) to share any and all personal information with any other member of the Network as may be necessary to provide and coordinate services requested or may from time to time request. The client specifically consents to the release to any other member of the Network of case notes, substance use records, mental health records, domestic violence records, HIV status, and criminal records information. They also authorize each member of the Network to share this information electronically, orally or otherwise. They understand that a photocopy or digital copy of this authorization is as valid as the original.

**If this person is not 18 years of age, a parent or guardian verbally accept on their behalf.*

_____

Date Case Manager Signature

_____

Case Manager Name/Agency Printed

- COVID-19 HAN release allows for client to give verbal authorization to a case manager in person, by phone, or virtually. Client must be aware that this authorizes their information to be shared. For clients who do not wish to share their information to be shared, a Limited CAS release (boston.gov/limited-cas-release) should be used.
- COVID-19 HAN release is to be used to limit in person contact between clients and case managers per CDC instructions during the COVID-19 crisis.
- COVID-19 HAN release is only valid during the COVID-19 crisis. The Department of Neighborhood Development for the City of Boston will announce when this document should cease to be used.
- COVID-19 HAN releases signed, dated, and submitted during the crisis will be valid until the Department of Neighborhood Development announces cessation of use of the release at which point standard HAN releases signed by the clients will need to be obtained for clients who have used the COVID-19 HAN release.
- This authorization will expire after 24 months since last contact with any member of the Network.
- Client may withdraw this authorization at any time by informing any member of the Network in writing or verbally that they no longer want my information shared among them.
- Client understand that members of the Network will not deny service provision or payments based on whether they sign this authorization. However, the client understands coordination among the members of the Network for services that they have requested may be impacted by not doing so.
- By signing this form, the client allows Member organizations to share their information as may be necessary to provide services requested or may from time to time request. However, the client understands that their information may be redisclosed by the recipient and may no longer be protected by the Member's privacy policies or by applicable state or federal law or regulation.
- Additional agencies may join the Network and will have access and permission to share their information. The list of agencies in the Network is attached. An updated list of agencies is posted online at boston.gov/han-providers. The list may also be requested at any time from any member agency.

Boston Homeless Assistance Network (HAN) Providers

Below is a list of the member agencies of the Boston Homeless Assistance Network. Additional agencies may join the network at any time. An updated list of agencies is posted online at boston.gov/han-providers and may also be requested from any of the participating agencies.

Bay Cove	Eliot Community Human Services	Middlesex Human Services
Boston Housing Authority	Ecumenical Social Action Committee	New England Center and Home for Veterans
Boston Healthcare for the Homeless	HEARTH	Pine Street Inn
Boston Medical Center	Home for Little Wanderers	Project Place
Boston EMS	Home Start	St. Francis House
Boston Public Health Commission	Justice Resource Institute	US Department of Veteran Affairs
Boston Rescue Mission	Metro Housing| Boston	Volunteers of America
Bridge Over Troubled Waters	Massachusetts Housing and Shelter Alliance	Women's Lunch Place

OFFICE OF WORKFORCE DEVELOPMENT / EDIC

CDBG FY2020

A Division of BOSTON PLANNING & DEVELOPMENT AGENCY

BENEFICIARY INCOME VERIFICATION FORM

DATE	LAST NAME	FIRST NAME	Middle Initial	GENDER ☐ MALE ☐ FEMALE

ADDRESS	CITY	ZIP CODE

TELEPHONE NUMBER	DATE OF BIRTH	I.D. # (*If applicable*)

NEIGHBORHOODS (*Check zip code you live in*)

- ☐ **ALLSTON/BRIGHTON** - *02134, 02135, 02146*
- ☐ **CHARLESTOWN** - *02129*
- ☐ **CHINATOWN / DOWNTOWN** - *02109, 02110, 02111, 02114*
- ☐ **EAST BOSTON** - *02128*
- ☐ **FENWAY** - *02115, 02215*
- ☐ **HYDE PARK** - *02136*
- ☐ **JAMAICA PLAIN** - *02130*
- ☐ **MATTAPAN** - *02126*
- ☐ **NORTH or SOUTH DORCHESTER** - *02122, 02124, 02125*
- ☐ **NORTH END** - *02113*
- ☐ **ROSLINDALE** - *02131*
- ☐ **ROXBURY** - *02119, 02120, 02121*
- ☐ **SOUTH BOSTON** - *02127*
- ☐ **SOUTH END / BACKBAY** - *02118, 02108, 02116*
- ☐ **WEST ROXBURY** - *02132, 02167*

RACE/ETHNICITY/ MULTI-RACE

- ☐ **WHITE (Non-Latino)**
- ☐ **BLACK (Non- Latino)**
- ☐ **HISPANIC**
- ☐ **AMER. INDIAN / ALASK. NATIVE**
- ☐ **ASIAN**
- ☐ **HAITIAN**
- ☐ **CAPE VERDEAN**
- ☐ **OTHER:** _____
- ☐ **HAWAIIAN/PACIFIC ISLANDER**
- ☐ **AFRICAN AMER & WHITE**
- ☐ **ASIAN & WHITE**
- ☐ **AMER. INDIAN & WHITE**
- ☐ **AMER. INDIAN/ALASKAN & WHITE**
- ☐ **AMER. INDIAN/ALASKAN & BLACK**

PARTICIPANT CHARACTERISTICS
(*Check off all that apply*)

- ☐ **TAFDC RECIPIENT**
- ☐ **VETERAN STATUS**
- ☐ **DISABLED**
- ☐ **REFUGEE/ENTRANT**
- ☐ **FEMALE-HEADED HOUSEHOLD**
- ☐ **BHA RESIDENT**

Mark the HOUSEHOLD SIZE box and select ONE of the three income options going across ON THE SAME LINE.

*Example: a **3-person** household with an annual income of **$17,000** would be marked on the third row, as **Extremely-Low Income**.*

☒ *3 Persons* ☒ *$0 to $27,900* ☐ *$27,901 to $46,550* ☐ *$46,551 to $70,350*

HOUSEHOLD SIZE (*Including You*)	*Extremely-Low Income* (*30% of Median*)	*Very-Low Income*	*Low Income*
☐ *1 Person*	☐ *$0 to $21,700*	☐ *$21,701 to $36,200*	☐ *$36,201 to $54,750*
☐ *2 Persons*	☐ *$0 to $24,800*	☐ *$24,801 to $41,400*	☐ *$41,401 to $62,550*
☐ *3 Persons*	☐ *$0 to $27,900*	☐ *$27,901 to $46,550*	☐ *$46,551 to $70,350*
☐ *4 Persons*	☐ *$0 to $31,000*	☐ *$31,001 to $51,700*	☐ *$51,701 to $78,150*
☐ *5 Persons*	☐ *$0 to $33,500*	☐ *$33,501 to $55,850*	☐ *$55,851 to $84,450*
☐ *6 Persons*	☐ *$0 to $36,000*	☐ *$36,001 to $60,000*	☐ *$60,001 to $90,700*
☐ *7 Persons*	☐ *$0 to $38,450*	☐ *$38,451to $64,150*	☐ *$64,151 to $96,950*
☐ *8 Persons or more*	☐ *$0 to $40,950*	☐ *$40,951 to $68,250*	☐ *$68,251 to $103,200*

***Mark the source(s) of Income Documentation:**

- ☐ **TAFDC**
- ☐ **SSI/SSDI**
- ☐ **FOOD STAMP**
- ☐ **REFUGEE ASSISTANCE**
- ☐ **BPS SCHOOL DATA**
- ☐ **CHILD SUPPORT**
- ☐ **ALIMONY**
- ☐ **SECTION 8**
- ☐ **UNEMPLOYMENT INSURANCE**
- ☐ **PAYCHECK / W-2**
- ☐ **PUBLIC HOUSING:** _____ (name of development)
- ☐ **OTHER:** _____

I hereby confirm that the information that I have provided on this form is true and accurate to the best of my knowledge.

☐ I , _____ . affirm that I have reviewed with client, _____, the above information and have recorded their answers accurate and honestly.

PROGRAM INTERVIEWER SIGNATURE: _____ **DATE:** __

**Information collected in this form is confidential and only used to verify that CDBG funds benefit eligible Boston residents.*

Department of Transitional Assistance

Permission to Share Information Form (PSI)

Organizations must keep the signed PSI form on file and make the form available to DTA upon request.

Section 1: DTA Client or Applicant

Client/Applicant Name

DTA Agency ID or Last Four Digits of SSN

Date of Birth

Section 2: Information to be Shared (check one or both)

☐ I allow DTA to share information about my TAFDC, EAEDC and/or SNAP case with the **SNAP Outreach Partner** organization named in Section 3.

☐ I allow DTA and the **SNAP Path to Work Provider** named in Section 3 to share information about my TAFDC, EAEDC and/or SNAP case to determine my eligibility for the SNAP Path to Work program and to share information about my participation and progress in the SNAP Path to Work program.

By signing below, I also give permission for DTA to get records about my employment status from other state agencies, federal agencies and from Equifax Workforce Solutions.

Section 3: SNAP Outreach Partner/SNAP Path to Work Provider

Interseminarian Project Place, Inc.
Name of Organization

617-542-3740
Phone Number

1145 Washington Street Boston, MA 02118
Address of Organization

_____
Organization ID

Section 4: Right to Change Your Mind:

You may change your mind and stop sharing this information. To stop it, you must:

- call 1-877-382-2363 during regular business hours and speak to a DTA Representative; or
- send a written request to: DTA Document Processing Center, P.O. Box 4406, Taunton, MA 02780 or fax to (617) 887-8765

Section 5: Signature

Complete at the time of the remote intake

☐ I , _____ . affirm that I have reviewed with client, _____, the above information and have recorded their answers accurate and honestly.

*****WE MUST OBTAIN A SIGNATURE FROM CLIENTS via Postal Mail, Docusign or Adobe Fill and Sign*****

I understand that when I sign below, I am giving permission to DTA and the organization named in Section 3 to share information about my case.

Client/Applicant Signature

Date

This form is **valid for two years** from the date of the applicant/client signature, unless revoked (see Section 4).

This institution is an equal opportunity provider.
Esta institución es un proveedor que ofrece igualdad de oportunidades.