

Foundry Village Application

Foundry Village is operated by Mid Rogue Foundation as a 24-month clean and sober transitional housing program. There are 17 tiny homes at the Village and a communal space to be enjoyed by all that reside there. All Foundry Village participants:

- Have weekly appointments with the Navigator who helps support and set goals and work towards moving into other housing options.
- Participate in twice monthly house meetings where they work together in the shared living space.
- Receive training on how to care for their space by having weekly housing inspections and working with their Mobile Navigator.
- Perform weekly chores that are assigned by the Navigator.
Pay a Program Fee that consists of \$300 for rent and fee of \$50 for utilities a security deposit of \$250 due by the 1st of each month.
- Couples must fill out an application at the same time and come in together. Couples will have a discount on their program fees where the 2nd person pays rent of \$250 and utility fee of \$50. Only one security deposit is collected.
- Applicants must be 30 days clean and sober.

If you are selected to move into the village, you will be asked to provide the following documents:

- Copy of your ID or Driver's License
- Copy of your Social Security Card
- Paystubs or other Proof of Income
- Medication list (if applicable)
- Proof of Car Insurance and Registration (if applicable)

Drop off applications in the dropbox to the left of the main door to Foundry Village

or

Mail to the same location at
Mid Rogue Foundation
c/o Foundry Village
1020 SW Foundry St.
Grants Pass, OR 97526



Name: _____ Date: _____

ALIAS: _____

Physical Address: _____

Mailing Address: _____

(if different than above)

E-mail address:

Phone Number: _____ Message Number: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

US Military Veteran YES NO (circle one)

Generally, where did you stay last night

Such as Streets, Camp, RV, Car, Shelter, Friend or Family Member's House, Motel, Halfway House, Treatment Facility, Hospital, Jail, Rental, Etc.

Are you 30 days or more sober? Yes or No

How long have you stayed in your current place?

- ☐ One day or less
- ☐ Two days to One week
- ☐ More than a week, less than a month
- ☐ One to Three Months
- ☐ More than three months – less than a year
- ☐ One year or longer

How long have you been in Josephine County?

Please indicate the number of Months or Years _____

Demographics

1. How do you identify?
 - ☐ Male
 - ☐ Female
 - ☐ I prefer to self-describe: _____
 - ☐ I prefer not to say
2. Do you identify yourself as Hispanic, Latino or of Spanish origin?
 - ☐ Yes
 - ☐ No
3. Do you identify yourself as? *(Please check all that apply)*
 - ☐ American Indian or Alaskan Native
 - ☐ Asian or Asian American
 - ☐ Black or African American
 - ☐ Caucasian/White
 - ☐ Native Hawaiian or Other Pacific Islander
 - ☐ Other (please specify): _____
4. What is your Household Type?
 - ☐ Single
 - ☐ Couple with no children
5. Are you covered by Health Insurance?
 - ☐ Yes
 - Health Care Provider Name: _____
 - Insurance ID Number: _____
 - ☐ No
 - ☐ Don't know
 - ☐ I prefer not to say
6. Do you have a disabling Condition/Chronic Health Condition?
 - ☐ Yes
 - ☐ No
 - ☐ Don't Know
7. Do any of these conditions apply to you? *(Please check all that apply)*
 - ☐ Fleeing Domestic Violence
 - ☐ Mental Illness
 - ☐ HIV/AIDS
 - ☐ Other (please specify): _____
 - ☐ Current Alcohol use
 - ☐ Current Drug Use
 - ☐ Physically Disabled



Have you ever been convicted of a criminal offense or have any pending criminal charges against you?

*This refers only to felonies and misdemeanors; you do not need to include non-criminal traffic violations or municipal ordinance violations. Yes _____ No _____ If so, what charges?

Do you have a Parole/ Probation Officer? _____ Phone Number _____

Do you have any of the following: (Circle all that apply)

Active Restraining Order **Y** or **N**

Active Warrant **Y** or **N**

Are you a registered Sex Offender? **Y** or **N**

If you are a registered sex offender what level? _____

What is your household's monthly income from all sources

(Please check all that apply)

☐ Earned Income monthly amount: _____

☐ Social Security monthly amount: _____

☐ Pension/Retirement Income monthly amount: _____

☐ Other (please specify and amount): _____

Total monthly household income: \$ _____

Do you speak any language other than English?

☐ Yes, which languages? _____

☐ No



If accepted into the Foundry Village Program, what goals are you hoping to accomplish in the next year?

READ THE FOLLOWING, AND SIGN BELOW

By signing this form, I declare the above information to be true. I understand that if I receive services for which I am not entitled, due to intentionally giving false information I can be fined. I agree to a background check. I understand that completing an application does not guarantee being accepted into Foundry Village.

Applicant Print Name

Applicant Signature

Date

Applicant Print Name

Applicant Signature

Date

Homeless Management Information System (HMIS) Informed Consent & Release of Information Authorization

I, (print participant's name) _____, understand that (Service Provider) _____ collects information about me and/or my dependents listed below to enter it into a database system called Homeless Management Information System (HMIS). This database helps us to better understand homelessness, to improve service delivery to the homeless, and to evaluate the effectiveness of services provided to the homeless. Participation in data collection and release, although optional, is a critical component of our community's ability to provide the most effective services and housing possible. The information that is collected in the HMIS database is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with the standards set forth by federal, state, and local regulations governing confidentiality of client records. Every person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information.

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

The information gathered and prepared by this agency will be included in a HMIS database of the Oregon Community Continuum of Care (OCCC)'s participating agencies (*list available*), and only to the participating agencies who have entered into an HMIS Agency Participation Agreement and shall be used to:

- a. Produce a client profile at intake that will be shared by collaborating agencies
- b. Produce anonymous, aggregate-level reports regarding use of services
- c. Track individual program-level outcomes
- d. Identify unfilled service needs and plan for the provision of new services
- e. Allocate resources among agencies engaged in the provision of services

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

I authorize the participating agencies and their representatives to share basic information regarding my family members listed below and/or me. I understand that this information is for the purpose of assessing my/our needs for housing, utility assistance, housing counseling and/or other services.

THE INFORMATION MAY CONSIST OF THE FOLLOWING PPI (PROTECTED PERSONAL INFORMATION):

• Name	• Homeless History
• Date of Birth	• Family Composition
• Social Security Number	• Employment Status
• Gender	• Veteran Status
• Ethnicity and Race	• Disabling Condition
• Income and Non-Cash Benefits information	• Domestic Violence
• Housing information	

I UNDERSTAND THAT:

- Information I give concerning physical or mental health problems will not be shared with other participating agencies that have not completed an HMIS Agency Participation Agreement.
- The participating agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the client confidentiality policies used by the HMIS participating agencies.
- Staff members of the participating agencies who will see my information have signed agreements to maintain confidentiality regarding my information.
- I understand that participation in data collection is optional, and I may choose to not participate without it disqualifying me from receiving assistance.

Homeless Management Information System (HMIS) Informed Consent & Release of Information Authorization

- The release of my information does not guarantee that I will receive assistance, and my refusal to authorize the use of my informational again does not disqualify me from receiving assistance.
- I understand that I may withdraw my consent at any time.
- This authorization will remain in effect until I withdraw my consent in writing, and I may revoke authorization by signing a "Limited Visibility Request", but that cancellation will not be retroactive.
- If I revoke my authorization, all information about me already in the database will remain but will become invisible to all the participating agencies.
- My records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- Auditors or funders who have legal rights to review the work of this agency, including the U.S. Department of Housing and Urban Development may see my information.
- I understand that my personal information will not be made public and will only be used with strict confidentiality.
- This release is valid for seven (7) years from the date of my signature below.

Participating agencies: A list of the participating agencies within the Oregon Community Continuum of Care (OCCC) System may be viewed prior to signing this form. Information about the OCCC can be found at the website: oregonbos.org

List all Dependent children under 18 in household, if any (first and last names):

1.	2.
3.	4.
5.	6.

Please initial one of the following levels of consent:

_____ I understand that Protected Personal Information and other relevant information will be entered into the HMIS and shared between participating agencies.

_____ I understand that I can choose to limit Protected Personal Information to only the service provider agency listed on this document.

Participant Signature

Date

Agency Personnel Name (print)

Agency Personnel Signature

Date



Authorization to Release Information

Client Name: _____ **Service Point #:** _____

Address: _____

Telephone: _____ **Date of Birth:** _____

I, _____, authorize Mid Rogue Foundation to release/disclose the following information to:

Name: _____ *Organization:* _____

Relationship: _____

Address: _____

Telephone: _____ *Email:* _____

Information to be released/disclosed:

- ☐ Name, date of birth, and ID number
- ☐ Admission to program
- ☐ Program participation
- ☐ Financial documentation
- ☐ Program goals and objectives
- ☐ Progress and current status toward program goals and objectives
- ☐ Other _____

For the purpose of:

- ☐ Service coordination
- ☐ Emergency Contact
- ☐ Other _____

Client Signature: _____ **Date:** _____

Printed Name of Client: _____ **Time:** _____

I understand I can cancel permission to use and disclose my information at any time in writing. The only exception is when action has been taken in reliance on authorization. Unless revoked earlier, this consent will expire 90 days from the date of signing or shall remain in effect for the period reasonably needed to complete the requested services.