CATHOLIC CHARITIES
Diocese of Wilmington

Documentation Needs for Program Participation

Photo ID for all adults

Social Security Cards for all household members over 6 months of age

Proof of US Citizenship [any of the following]
- Birth Certificate
- Passport
- Native American tribal card
- Certificate of naturalization
- Certificate of citizenship

Proof of Qualified [Legal] Alien Status

Proof of Delaware residency [any of the following]
- Current driver's license
- Current non-driver ID card
- Mortgage statement/lease/utility bill/cable bill/bank statement with DE address
- Federal or State government correspondence with DE address

Fixed Income [any of the following]
- Social Security, SSI, or Veterans Assistance award letter, or bank statement showing direct deposit amount
- Proof of Pension

Employment Income [any of the following]
- Paystubs for last 3 months, or year-to-date paystub
- Proof of tax records for self-employed

Proof of Unemployment Compensation or Child Support [12 month printout]

Proof of Temporary Assistance for Needy Families [TANF] or General Assistance [GA]
- copy of check, food stamp [SNAP] award letter

Current natural gas, propane, and/or electric bill with current address and account number

Proof of home ownership
- Deed/mortgage

Proof of renter status
- Complete current signed lease with address, utilities, and signature pages
- If subsidized, complete current rent recertification with amount you pay

Landlord verification form if no formal lease, completed, signed, and dated

Basic Needs Intake and Consent Forms - complete these forms, included here

Catholic Charities Basic Needs Intake Form

Section 1 - Completed by Client

First Name:	MI:	Last Name:		Date:
Street Address:	Apt. #:	City:	State:	ZIP:

Phone #:	Email:	Total Household Members:	Do you rent or own your home?

PLEASE COMPLETE THIS SECTION FOR ALL HOUSEHOLD MEMBERS

Household Member Name	Relationship	Annual Income	Income Source*	Date of Birth	Social Security Number	M/F	Race**	Hispanic Y / N	Veteran Y / N	Disability Y / N	Citizen Y / N
	SELF										

* Income Source: [for each household member] Employment, Unemplyment Comp, TANF, Pension, SSA, SSI, SSD, Family Support, No Income, Veteran's Admin, Other

** Race: [for each household member] White, Black/African American, Asain, AM Indian/Alaskan, Native Hawaiian/Other Pac Islander, AM Indian/Alaskan Native & White
AM Indian/Alaskan Native & Black, Asian & White, Black & White, Other, No Response

Section 2 - Completed by Catholic Charities Case Manager

Client Meeting Site: Main Office/Mobile Office	Case Manager:	AMI %:

Utility	Arrearage Amount	Shut Off Notice Date	Main Heat Y N	Account Number
Electric				
Gas				
Water				
Oil				

You may submit proof of ID, income and other required documentation by taking a picture with your smart phone and sending it via email to basicneeds@ccwilm.org

Client Services to bill: Intake ☐ Budget Counseling ☐ Energy Counseling ☐ DESEU Program Referral ☐
Energy Advocacy ☐ LIHEAP Referral ☐ Other Energy Program Referral ☐ Energy Workshop ☐

Thrift Services Voucher ☐ Food Program Referral ☐ Diaper Bank Referral ☐ SNAP Education ☐

Section 3 - Completed by Catholic Charities Case Staff

Data Entry Staff: Date:

Release of Information

Delaware Community Management Information System
Release of Information

Date: _____

Name: _____

Agency Name: CATHOLIC CHARITIES

Background Information:
The Delaware Community Management Information System (DE-CMIS) is a computer system that is used to collect and share information on homelessness persons in Delaware. The information gathered by DE-CMIS helps agencies plan and deliver services that help people who are homeless or at-risk for homelessness. By sharing information with each other, DE-CMIS agencies are able to streamline service delivery by tracking services and referrals provided to the person they serve. The agency named above participates in DE-CMIS.

Consent Information:

- This agency will never give information about a person to anyone outside of this system without the person's written consent or as required by law through a court order.

- In accordance with federal and state law medical information such as mental health conditions, HIV status and substance abuse treatment will not be shared.

Only agency staff members who have signed the USER POLICY, CODE OF ETHICS AND RESPONSIBILITY STATEMENT will be allowed to log in to the DE-CMIS system.

- I have a right to see my DE-CMIS record, ask for changes and to have a copy of my record from this agency upon written request. I have the right to refuse my information from being shared by checking "refuse to share information" at the bottom of this form.

- I have the right to withdraw my consent by informing the agency in writing. I understand that withdrawing my consent will not change information that has already been given out or actions already taken.

With this written consent, the agencies that are part of DE-CMIS may share and update basic and service information about me and other members of my household, such as:

BASIC

CATHOLIC CHARITIES, INC.

I, _____
(Name of client)

authorize _____
(Name or general designation of program making disclosure)

to disclose to _____
(Name of person or organization to which disclosure is to be made)

the following information:_____
(Nature of information, as limited as possible)

_____

The purpose of the disclosure authorized herein is to: _____
(Purpose of disclosure, as specific as possible)

_____

I understand that my records are protected under the Federal Regulations governing confidentiality in accordance with The Health Insurance Portability and Accountability Act of 1996, 45CFR, 160 & 164 and for Alcohol and Drug Abuse Patient Records 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. Further, I understand that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. I also understand that I may revoke this consent at any time in writing except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse 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 prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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.

Client Signature: _____ Effective Date: _____

Witness: _____ Effective Date: _____

Parent / Guardian Signature: _____ Effective Date: _____

Please save this document with your last name followed by the letters [BN] and email it to basicneeds@ccwilm.org