DIO/BH Admission Application

Transitional Shelter Program

Thank you for your interest in our transitional shelter program. Please complete the application below to begin the admission process.

Client Privacy Statement

At DIO/BH, we are committed to protecting your privacy. We collect personal information directly from you for the following reasons, as outlined in our Notice of Privacy Practices:

Legal Requirements: We may be required to collect certain personal information by law or by organizations that provide funding for our program.

Program Operations: The personal information we collect is essential for running our programs effectively, improving services for homeless individuals, and understanding the needs of those experiencing homelessness.

Appropriate Information: We only collect information that we deem appropriate for these purposes.

The collection and use of all personal information are guided by strict standards of confidentiality.

Application Form

Personal Information:

Full Name: _____

Date of Birth: _____

Social Security Number (SSN): _____

Do you have a current ID? (Yes/No) _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email Address: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____

Background Information

Are you currently homeless? (Yes/No) _____

If yes, please explain your current situation:

_____

Previous Address: _____

Recall Person for Emergency: _____Telephone:_____

Do you have current insurance? (Yes/No) _____

Any past or current charges or felonies? (Yes/No) _____ If yes, please explain:

_____

Are you on probation or parole? (Yes/No) _____

What current income do you receive? (e.g., SSA, SSI, etc.):

_____

Any health conditions we should be aware of?

_____

Do you have a vehicle? (Yes/No) _____

Program Needs:

What specific services are you seeking from our transitional shelter program?

_____

Additional Information:

Please provide any other information that may be relevant to your application:

_____

Signature

By signing below, I acknowledge that I have read and understood the Client Privacy Statement and consent to the collection and use of my personal information as described.

Signature: _____

Date: _____

Thank you for completing your application. We will review your information and contact you regarding the next steps in the admission process. If you have any questions, please feel free to reach out to us.

Client Privacy Statement We collect personal information directly from you for the reasons that are discussed in our Notice of Privacy Practices. We may be required to collect some personal information by law or by organizations that give us money to operate this program. Other personal information that we collect is important to run our programs, to improve services for homeless persons, and to better understand the needs of homeless persons. We only collect information that we consider to be appropriate. The collection and use of all personal information is guided by strict standards of confidentiality. A copy of our Notice of Privacy Practices is available to all Clients upon request.

Burfoot House: Program for Homeless Women
916 Centerville Turnpike South
Chesapeake, VA 23322
INTAKE CHECKLIST 2025

1. **_____Online Screening application**

2. **_____Release of Information Authorization**

3. **_____Medication Information**

4. **_____Program Fee Notification**

5. **_____Non-Disclosure Form**

6. **_____Acknowledgement Form**

7. **_____Dollar Bank Account#**

8. **Copy of _____Drivers License _____Soical Security Card**

   _____Birth Certificate _____Health Insurance Card

   _____Current Photo

9. **_____Mental Health Screening Form**

10. **_____Drug/Alcohol Screening – 90 days verified clean**

11. **_____Background Check Completed**

12. **_____Car information make/model License Plate:_____**

13. **_____Personal Property Items**

14. **_____Date of 30-Day review**

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RELEASE OF INFORMATION AUTHORIZATION

_____ _____ _____
Print Full Name Date of Birth SS# (last 4 digits)

I hereby authorize the Burfoot House: Program for Homeless Women and staff to share information contained in my file and receive information from agencies and/or individuals listed below on an as needed basis to assist me with needed services and funds.

AARP
ACCESS
Barret Haven
CAST
Catholic Charities
Christian Psychotherapy Associates
Chesapeake Regional Hospital Transitional Care Program
Chesapeake Integrated Behavioral Health
Chesapeake Care Clinic
Dept. of Health, Hampton Roads
Doctor's Office _____
Emergency Services
Independence Center
Family (except _____)
For Kids
Ghent Area Ministries
HER Shelter
HMIS
JCOC
Keim Center
Legal Aid
Mobile Mental Health
NEST
Next Step
Norfolk Redevelopment & House
Office to End Homelessness
Oxford House
Planning Council
Probation & Parole Officer
Salvation Army
Samaritan House
Second Chances
Social Security Administration
Social Services
St. Columba Ecumenical Ministries
STOP Organization
TACT
Union Mission
UP Center
Virginia Employment Commission
Virginia Supportive Housing
YWCA
Dollar Bank
Other: _____

The following basic information about me may be shared/disclosed: name, age, birth date, gender, race, address, length of stay, social security number, area of need, the reason for need, medical information, treatment information, services provided, financial information, history and progress notes, homelessness information, recommendations, etc.

_____ **I Do Not Wish my information to be shared with the Circled Agencies and/or Individuals identified above.**

I understand information allowed by this authorization will be transmitted confidential via written, verbal, audio, electronically or fax only to individuals responsible for assisting me in obtaining the services and support I requested. I understand I have the right to withdraw this authorization at any time in writing

except where action has already been taken. I understand this authorization is valid for one year from today's date.

Client Signature_____ Date _____

Staff Signature_____ Date_____

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MEDICATION INFORMATION

Client: _____

___ Yes ___ No Do you have **allergies** to food, any medication, prescriptions, and over-the-counter?

If yes, please list: _____

_____

List below medications you are currently taking and prescribing physician

Date Prescribed	Name of Medication and number of refills	Prescribed Dosage	When Taken	Prescribing Physician

I agree that these medications are prescribed to me by a physician and I will not share medicines with others at the Burfoot House. Each client will have access each morning to her prescribed daily medications and the remaining prescription(s) will be kept secured in a locked cabinet.

Emergency Contact:

First Name: _____ Last Name: _____

Relation to contact: _____

Contact Phone #: Cell:_____Land:_____

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

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MANDATED NON-REFUNDABLE PROGRAM FEE AND SAVINGS AGREEMENT

While you are a client at the Burfoot House program, your goal will be to become financially stable so that you can move/transition into a place of your own. To do this, you will need to have a savings/financial plan. Your assigned mentor will meet with you and help guide you in making a budget so that you will be able to pay off past debts and save for future security deposits, rent, etc.

NON-REFUNDABLE MANDATED PROGRAM FEE of $400.00 & SAVINGS POLICY REQUIREMENTS:

1. Each client will be required to pay a NON-REFUNDABLE Program Fee of $400 each month due by the 5th of each month.

2. Fifty percent (50 %) of my income will be saved for my transition to permanent housing. This percentage may ONLY vary based on a reviewed complete budget established with my Mentor and approved by the Executive Director.

3. Any income received must be reported to my Mentor. Immediately after receiving my paycheck, I will provide my mentor and Financial Coach with a copy of my pay stub or a copy of the earnings statement.

Signed Agreement:

I, _____, agree to establish a savings plan, report ALL income, and abide by these and other Burfoot House rules as long as I am a client of the Burfoot House located in Chesapeake, VA. If I fail to comply, I am subject to immediate eviction from the Burfoot House.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

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NON-DISCLOSURE FORM

As part of the Burfoot House, my duties include work assignments and responsibilities in which I may acquire personal knowledge of and access to information concerning Burfoot House clients and volunteers. I may have access to written information, both hard copy and electronic, and will be privy to oral information of Burfoot House clients and volunteers.

I understand that all information is for official use only (FOUO) and shall not be disclosed to other individuals without an official release or legitimate need to know. I also understand that unauthorized disclosure of FOUO information is protected by the Privacy Act (5 U.S.C. 552a, as amended). As such, I understand that I must coordinate with Burfoot House leadership to release information to those individuals outside Burfoot House for any purpose.

Further, I understand that unauthorized disclosure may result in administrative actions up to and including:

- Client removal from the Burfoot House and/or
- Volunteer service terminated.

_____ _____

Client Signature Date

_____

Print Name

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ACKNOWLEDGEMENT FORM

Client: _____

____ I agree that I will open a Dollar Bank savings account upon acceptance into the program and before entering Burfoot House.

____ I acknowledge I have read and agree to adhere to ALL the rules, policies, and procedures set forth herein and provided to me in The Burfoot House Client Handbook.

____ I understand there is a video and audio monitoring at the Burfoot house and van to promote and ensure safety.

____ I agree that I will not take pictures or audio recordings at the Burfoot House for the client privacy.

____ I give my permission to the Burfoot House staff and leadership team to use photographs they take during my residency for its program promotion.

_____ _____
Client Signature Date

_____ _____
Executive/Office Manager Signature Date

(A copy of the signed documentation shall be retained in the client's folder)

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PROGRAM FEE NOTIFICATION

Client:_____

Each Burfoot House client will pay a monthly program fee of $400 monthly. Income is from ALL sources. Only the Executive Director can grant a hardship waiver (fees owed will be charged to the client's account for future payment). Program fees will be prorated for the first month if necessary and are due to the Executive Director by the first of each month but no later than the close of business on the fifth of each month.

A $10.00 late will be assessed with the payments made after the 1st. Habitual lateness could result in additional late fees being assessed. Fees will be adjusted for clients who begin working after moving into Burfoot House. Program fees are charged to help offset program and operational costs and to establish a positive credit referral for Burfoot House clients.

Monthly Income:_____ Job location and telephone number:_____

Other Income Source Information:

Month	Monthly Program Fee Amount $400	Payment Date	Payment Due	Late Fees	Money order Number
1.					
2.					
3.					

Client Signature_____ Date:_____

Executive/Office Manager Signature_____ Date:_____