HHA
Palm Beach County

NONPROFIT MEMBERSHIP APPLICATION

After completing these forms, please scan and email to gdevine@pbcgov.org.

Membership Year: _____

(NOTE: There is an alternate membership application for individuals.)

NAME (Organization, Business, or Governmental Entity):

_____

(Exactly as you would like it listed on membership list)

PHYSICAL ADDRESS:_____

(Please list physical address of primary service/business location)

City:_____ **State**:_____**Zip**:_____

MAILING ADDRESS:_____

(If different from physical address)

City:_____**State**:_____**Zip**:_____

MAIN PHONE NUMBER:_____ **FAX:**_____

WEBSITE:_____

(This will be the site listed on our Website with a link)

Name of Highest Level Executive:_____

Title of Highest Level Executive:_____

Is your organization:

501 (c) 3:	Yes_____	No_____	Pending_____
Inter/Faith Based:	Yes_____	No_____	
Government:	Yes_____	No_____	
Business:	Yes_____	No_____	

____ Other, please specify_____

Organization's Mission/Business Purpose:_____

_____

What part(s) of the 10 year Plan to End Homelessness in Palm Beach County <u>is</u> <u>your organization/business going to lead or proactively assist in developing?</u>

_____ Homeless Prevention

_____ One Stop/Customer Service Center

_____ Housing/Shelter

Other: _____

Organization's Designated Representative:_____

(The person who will be responsible for casting the organization's vote)

Title:_____ **Email:**_____

Organization's Designated Alternative:_____

Title:_____**Email:**_____

- Please provide a copy of your 501c3
- *If you provide direct service to homeless individuals and/or families please complete the forms for Direct Services. Thank you.*

Authorized Signature: _____

Date: _____

FOR-PROFIT/BUSINESS MEMBERSHIP APPLICATION

After completing these forms, please scan and email to gdevine@pbcgov.org.

Membership Year: _____

(NOTE: There is an alternate membership application for individuals.)

Company's name:_____

Headquarters Address: _____

How would you describe your business:_____

(i.e., faith based, developer)

In what part of Palm Beach County does your business have a physical presence?

(check all the apply)

_____Western ____ Central _____North _____South

Will your company:

(check all that apply)

_____Attend monthly meetings or sub- committee meetings to support the efforts of the HHA

_____Sponsor/host an event to benefit HHA

_____Be an advocate to help our homeless neighbors

_____Provide an in-kind service needed by HHA

_____Provide volunteers to assist with HHA's bi-annual homeless census and events

_____Other, please specify:_____

Name of Highest Level Executive:_____

Title of Highest Level Executive:_____

Organization's Designated Representative:_____

(The person who will be responsible for casting the organization's vote)

Title:_____ **Email:**_____

Authorized Signature: _____

Date: _____

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DIRECT SERVICES

To be completed by organizations which provide a direct service to our homeless neighbors in Palm Beach County

This information will be used to help connect people in need of services with the proper agencies, and ensure that up-to-date and accurate information about services currently available in the Palm Beach County homeless system of care is available and maintained for planning and grant writing purposes.

The following questions are specific to a program offered by your organization. (Please complete ONE FOR EACH PROGRAM within your organization.)

Program Name:_____

Physical Street Address (of program):_____

City:_____**State:**_____**Zip code:**_____

Program Contact Person:_____

Program Contact Person's Email:_____

Phone:(____)_____ **Fax:** (____)_____

General Program Description:_____

_____

Intake/Application Process:
_____ Referral from a provider
_____ Walk-in
_____ Call for appointment
_____ Other: _____

Operating hours:_____
Program Fees:_____

Handicap Accessible: _____Yes _____No

Languages:_____(i.e., Spanish, Chinese, etc., speaking staff; interpreter)

Population group served by this program (select only one):

_____Only Single Males (18 years and older)

_____Only Single Females (18 years and older)

_____Only Single Males and Females (no children)

_____Families with Children

_____Mixed Populations (Families and Individuals)

_____Only Unaccompanied Young Males (younger than 18)

_____Only Unaccompanied Young Females (younger than 18)

_____Only Unaccompanied Youth (Males and Females)

_____ Other: Be specific (include age groups)_____

Sub-population group(s) served by this program (check all that apply):

_____Chronically Homeless

_____Veterans

_____Victims of Domestic Violence

_____Youth aging out of Foster Care

_____Unaccompanied Youth

_____Ex-Offenders

_____Persons with Serious and Persistent Mental Illness

_____Persons with Chronic Substance Abuse

_____Physically Disabled

_____Developmentally Disabled

_____Persons with HIV/AIDS

_____Other, please specify:_____

Indicate if this program is serving:

_____Only Domestic Violence Victims

_____Only Veterans

_____Only Persons with HIV/AIDS

Indicate if program can serve pregnant women: ____Yes____ No

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SERVICES THIS PROGRAM PROVIDES

Shelter/Housing

Type	Limitations/Length of Service(Days/Months)	Cost/Amount of Assistance	Other Eligibility
Emergency			
Transitional			
Permanent Supportive			
Boarding House			
Rental Subsidy			

____Other Housing (please describe):_____

Transportation Assistance:

____Direct Assistance (transport)

____Auto Repair Assistance

____Bus Passes, if yes type of pass_____

____Travel Assistance (to reunite with out of-area support systems)

Prevention Services:

____Clothing

____Utility Assistance

____Holiday Assistance

____Back to School Supplies

____Rental/Mortgage Assistance

____Other:_____

Food:

____Food Boxes/Groceries

____Serve Prepared Meals at Our Location (excluding resident meals)

____Grocery Gift Cards

____Take Meals to Parks, Camps, etc.

____Other:_____

Outreach:

____Medical

____Street Outreach

____Take clothing to camps, parks, etc.

____Spiritual

____Other:_____

Other Services provided by this program (check all that apply):

____Advocacy
____Life Skills Training
____Legal Assistance
____Case Management
____Employment:
_____*Job Readiness Evaluation*
_____*Job Training*
_____*Job Placement*
_____*Job Readiness Skills*
_____*Job Coaching*
_____*Supported/Bonded*
____Parenting
____Child Care
____Education
_____Healthcare:
_____*Physical*
_____*Hearing Testing*
_____*Medication*
_____*HIV/AIDS Prevention*
_____*Eye Care*
_____*Dental*
_____Mental Health Treatment:
_____*Acute Care*
_____*Residential*
_____*Outpatient*
Substance Abuse Treatment:
_____*Detox*
_____*Residential*
_____*Outpatient*

Other (please describe):_____

Eligibility Criteria :

_____
_____
_____
_____

(i.e. must be working; have mental illness; families with no males over 13 years old; income guidelines, etc.)

Operating hours:_____
Program Fees:_____

Handicap Accessible: _____Yes _____No

Languages:_____

(i.e., Spanish, Chinese, etc., speaking staff; interpreter)

Any Additional Information:

_____
_____
_____
_____
_____

Authorized Signature: _____Date: _____