



\*YOUR NAME: \_\_\_\_\_

\*NAME of AGENCY/PERSON who referred you: \_\_\_\_\_

\*If not referred—how did you find out about our program? \_\_\_\_\_

\*HAVE YOU applied for or been in our program before? \_\_\_\_\_ IF SO, when: \_\_\_\_\_

*\*\*\*It is VERY IMPORTANT that we have some way to contact you—and hear back from YOU promptly when housing is or becomes available. If we cannot reach you, or do not hear back from you within 72 hours of leaving you a message, you will lose your housing and go to bottom of the list.*

CONTACT INFORMATION: \_\_\_\_\_ PHONE #(S): \_\_\_\_\_

\*Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
*(Month) (Day) (Year)*

\*Ethnicity:  Hispanic/Latino (1)  Not Hispanic/Latino

\*Race: (Check all that apply)  American Indian or Alaska Native  Asian  Black or African-American  
 Native Hawaiian/Pacific Islander  White  Don't know

\*Gender:  Female  Male \*Veteran Status:  No  Yes

\*Where did you stay last night: \_\_\_\_\_ How long have you been there? \_\_\_\_\_

\*Zip Code of Last Permanent Address: (where you last lived for 6 mos or more): \_\_\_\_\_

\*If ZIP not known—Address: \_\_\_\_\_  
*(number) (street) (city) (state)*

First time homeless? (circle one:   Y     N  ) Number of times homeless? \_\_\_\_\_

\*INCOME SOURCE: \_\_\_\_\_ AVERAGE MONTHLY INCOME: \$ \_\_\_\_\_

\*Total income received last month: \$ \_\_\_\_\_ Any changes expected in income: \_\_\_\_\_

\*If Employed--Employer's Name/Address: \_\_\_\_\_

Physical Disability:  No  Yes  Don't know Developmental Disability:  No  Yes  Don't know

Please Explain Disabilities and Special Needs: \_\_\_\_\_

Health Status:  Excellent  Very Good  Good  Fair  Poor

Pregnant:  No  Yes  Don't know  Not Applicable If yes, due date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Children:  No  Yes Are Children in YOUR Custody:  No  Yes\* \*If YES, please provide

Names and Ages of Children: \_\_\_\_\_

Nearest Relative's Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list all prescription medications you are currently taking, (or should be taking) and any prescription medications currently in your possession: \_\_\_\_\_

Please write a *brief* health history and description of your current *physical* and *mental* health and/health issues and challenges: \_\_\_\_\_  
*(Please use the back of this sheet if necessary)*

Name of your Therapist(s) or Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Worker(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Are you now or have you ever been a substance abuser? \_\_\_\_\_ When? \_\_\_\_\_ What? \_\_\_\_\_

Are you now or have you ever been in recovery? \_\_\_\_\_ If so, how many times? \_\_\_\_\_ When? \_\_\_\_\_  
\_\_\_\_\_ Where? \_\_\_\_\_

Current length of time in sobriety and/or drug free \_\_\_\_\_

Have you ever been in an abusive relationship? \_\_\_\_\_ Please describe: \_\_\_\_\_

---

Please explain your criminal history? \_\_\_\_\_

*(Please use the back of this sheet if necessary)*

What in your opinion has contributed to you being in your present state (homeless)?

---

Please write a brief Personal History: \_\_\_\_\_

*(Please attach a separate page or use the back of this sheet.)*

What do you expect a transitional program to do for you, and how will you use this program to your best advantage? \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*The information contained in this application is true, accurate and correct to the best of my knowledge.*

APPLICATION MUST BE COMPETELY FILLED OUT FOR YOU TO BE ELIGIBLE FOR THE PROGRAM.