

HOMEAGAIN

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Cover Sheet APPLICATION FOR TRANSITIONAL PROGRAM

Notice to the applicant: The application contains 14 pages. Please make sure all pages are fully completed before submitting.

Applicant, please complete the following information:

Application submitted to (circle one):

Carolyn Burdett, LCSW – Women’s Division

Jonathan Penn, M.Ed. – Men’s Division

Via (circle one): Fax Mail Delivery

Date: _____

STATEMENT OF CONFIDENTIALITY:

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(For Internal Use Only)

Application Received by: _____ Date: _____

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APPLICATION FOR TRANSITIONAL PROGRAM

Please complete this form as completely and honestly as possible. All information will be kept confidential within our agency and is necessary to determine whether our program is appropriate for you and you are appropriate for our program.

Application to: (check one)

- Family INRICH Transitional – serving families in a variety of compositions
 Men's Transitional Veteran's Transitional

I. General Information

Name _____ Date _____

Date of Birth _____ Age _____ Social Security Number _____

Gender: _____ Female _____ Male _____ Transgender

Current Address _____

Current telephone number _____ Email _____

How long have you lived there? _____

Previous Permanent Address: _____

Explain why you are homeless. _____

Are you a citizen of the United States? Yes No

If not, please check the appropriate box below. Are you:

- A Lawful Permanent Resident
 An alien authorized to work until _____

Note: Applicants may be required to show proof of citizenship or proper permanent resident or alien documentation during the application process.

Are you a veteran? Yes No

Ethnic Group (please circle the appropriate answer).

African-American Asian Hispanic White Other: _____

Marital status (please circle the appropriate answer).

Married Single Separated Divorced Widowed

Emergency Contact(s)

Name _____ Relationship to you _____

Address _____

Phone Number(s) _____

Name _____ Relationship to you _____

Address _____

Phone Number(s) _____

Children (If not applicable, please go to the Personal Development section).

Child's Name	Date of Birth	Social Security Number	Gender	Age

Do you have legal custody of the above named children? Yes No

If no, please explain and give name(s) and phone number(s) of their custodian(s).

Have any of your children or children under your care been reported to Child Protective Services (CPS)? Yes No

Have your children ever been placed in foster care? Yes No

If yes, please explain.

If accepted into the Women's Transitional Program, please indicate which children would live with you. (Generally, no more than three children will be accepted into the program.)

1. _____
2. _____
3. _____

II. Personal Development

Name three personal strengths:

1. _____
2. _____
3. _____

Name three areas that you could improve upon:

1. _____
2. _____
3. _____

List three goals you have for yourself:

1. _____
2. _____
3. _____

Please write a brief paragraph discussing why you should be considered for transitional housing and what you hope to accomplish while in the program. (You may attach a separate sheet of paper.)

III. Health

Please provide the names of your past and present health care providers, including psychiatrists, psychologists, counselors, social workers and others.

Name	Type of Provider	Agency	Dates of Service

Are you currently taking any prescribed medications? (including methadone) Yes No
 If yes, please complete the information below.

Medication	Condition prescribed for	Length of time on this medication

Mental Health

Have you in the past, or are you currently receiving help for mental health problems?

Yes No

If you are currently receiving help, please state the name of the program(s) and when you started receiving treatment there:

Have you ever been hospitalized for mental health problems? Yes No

If yes, please state the name(s) of the facility(ies), when you were hospitalized, and the length(s) of stay.

Substance Abuse

Do you have a problem with alcohol addiction, drug addiction or both? Yes No

If yes, please briefly tell us about it.

Briefly describe when you began using drugs/alcohol and why.

What was your drug of choice? _____

What drugs have you used in the past? _____

Have you in the past, or are you currently receiving treatment for alcohol or substance abuse problems? Yes No

If yes, is/was treatment: Inpatient Outpatient

Please indicate the name of the program(s) _____

Who is/was your therapist / doctor _____

How long have you been clean from drug use? (Please state last date of use and how many months and/or years clean.) _____

Does your family or friends tell you that you have a problem with alcohol or drugs?
Yes No

Have you experienced problems at your work or in your personal life because of drugs or alcohol abuse? Yes No
If yes, please briefly tell us about it. _____

Did you use drugs while you were pregnant? Yes No N/A

If yes, which drugs did you use? _____

Physical and Verbal Abuse

Have you ever been physically and/or verbally abused? Yes No
If yes, please briefly tell us about it (include length of time of the abuse).

Have you ever physically or verbally abused someone else? Yes No
If yes, please briefly tell us about it.

Have you ever been counseled for domestic violence and/or anger management?
Yes No If yes, please briefly tell us about it.

Have you, or your children, experienced other traumatic events such as sexual abuse, incest, serious injury and/or violence? Yes No If yes, please briefly tell us about it.

Physical Health

Do you have a primary care physician? Yes No

If yes, please give the following information about the physician:

Name _____ Telephone _____

When was the last time you saw a doctor? _____

Do you have insurance? Yes No

Do you have any medical problems and/or needs? Yes No

If yes, please explain.

Do you have any physical limitations that require special accommodations? Yes No

If yes, please explain.

Does your child(ren) have any medical problems and/or needs? Yes No

If yes, please explain.

Are you pregnant? Yes No N/A If yes, how many months _____

Have you been hospitalized for physical problems? Yes No

If yes, please explain.

Have you had a TB test or chest x-ray? Yes No

If yes, please provide dates. _____

IV. Education

Please complete the following table:

Education Level	Attended (yes or no)	Graduated (yes or no)	Highest level/grade completed	Dates attended
High school				
GED				
College				

Have you received vocational or any other type of training? Yes No

If yes, please explain.

Do you have any further educational goals? Yes No

If yes, please explain.

Were you in any kind of special education class? Yes No

If yes, please explain.

V. Employment

Are you currently employed? Yes No

If yes, are you employed: Full time? Part-Time?

How long have you been employed? _____

Where? _____ Your job title: _____

Have you ever had a vocational assessment? Yes No

If yes, please state when and where: _____

VI. Financial

Do you have debt in the following areas? Please fill in the amount of debt:

Area of Debt	Yes or No	Amount
School Loans		
Medical Bills		
Car Loans		
Traffic Violation Debt		
Other Legal Fines		
Housing / Rent		
Utilities		
Joint Debt		
Credit Card		
Other		
TOTAL DEBT		

Please indicate all sources of income in the chart below:

Sources of income	Amount
Earnings from employment	
Unemployment benefits	
Child Support	
Workman's compensation	
Temporary Assistance to Needy Families (TANF)	
Supplemental Security Income (SSI)	
Supplemental Security Disability Income (SSDI)	
Social Security Retirement or Survivor's Benefits	
Veteran's Benefits (disability or pension)	
Other retirement or pensions	
Financial assistance from relatives or friends	
Other sources of income	
TOTAL INCOME	

Do you pay child support? Yes No
If yes, please explain.

Have you ever filed for bankruptcy? Yes No
If yes, please explain.

VII. Legal

Please list all crimes for which you have been convicted.

<u>FELONY</u>	<u>DATE</u>	<u>MISDEMEANOR</u>	<u>DATE</u>

Are you currently on parole or probation? Yes No
If yes, please explain and give your officer's name and phone number.

Do you have any outstanding warrants for your arrest? Yes No
If yes, please explain.

Do you have a valid driver's license? Yes No

Do you have photo I.D.? Yes No

Did anyone assist you in completing this form? Yes No

Name of person assisting you with completing this form: _____

Phone Number: _____

Agency: _____

I certify that the answers given herein are true and complete to the best of my knowledge.

Signature _____

Date _____

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APPLICATION FOR TRANSITIONAL PROGRAM
Referral Information Form

Name of Person referred _____

Referring Agency _____

Agency Representative _____ Phone _____

Date of Referral _____

Please give your observations about the person whom you are referring on the following areas. If you prefer, you may attach a letter of recommendation, but please address each area listed below.

Level of Motivation: _____

Expressed goals and objectives: _____

Ability to work in groups: _____

Social Skills: _____

Parenting Skills: _____

Areas of Concern: _____

Other Observations: _____

