TRANSITIONAL HOUSING PROGRAM
SYBIL H. SMITH FAMILY VILLAGE

REFERRAL AND APPLICATION FORM

Date Applied: ________________ ***Date received*** ____________________ ***office use only***

Name:____
First *Middle* *Last*

Date of Birth: ________ Age: ______ Soc. Sec. # _____________Medicaid #_____________

Referring Agency: _________________________

Address of Agency: ____

Referring Person:________________________________Title:__________________________

Agency Phone: _____________ Fax Number: _______________

E-Mail: ____

If referring agency is a shelter, how long has applicant resided in your facility? _____________

REASONS FOR REFERRAL

State why you believe this applicant to be appropriate for the transitional housing program:

____

____

Provide a brief narrative of your agency's involvement with this family:

____

____

____

What, if any, problems have you observed with adult family members while at your agency?

____

____

Have the family members been in compliance with the rules of your agency? Yes____ No_____
If no, please explain:

____

____

(SHS/FV Form 001 – Rev. 01/29/07)

APPLICANT INFORMATION

1. Present Address: ____________________________________ Phone: ________________
2. Marital Status: ______________Spouse/Ex-spouse Name _________________________

Significant Other: ________________________

3. Emergency Contact Name: ____

Address: _______________________Phone:_________ Relationship:________________

4. Do you own a car? ______ If so, do you have current insurance on the car? ____________
Do you have a valid, current driver's license? _____ Driver's Lic. #___________________
Do you have any outstanding traffic tickets? Amount $ _______
Do you have any outstanding warrants? _________

5. Please list last three addresses, starting with most recent:

	Address	City/State/Zip Code	How long lived there	Monthly Rent
a.				
b.				
c.				

6. Highest grade completed in school: _______ Did you graduate? ______ When? ________
If not, do you have a GED? ________ Date earned GED _________
Do you have a copy of your GED Certificate? ________

What colleges/jr. colleges/trade schools have you attended? When?
____

7. List last three places of employment, starting with most recent:

	Employer	Address	Dates worked there	Position	Gross Monthly Pay
a.					
b.					
c.					

8. Please list all current sources of income and amount:

	Source	Monthly Amount
a.	Employment income	$_______________
b.	TANF	$_______________
c.	Food stamps	$_______________
d.	Fuel assistance	$_______________
e.	Unemployment compensation	$_______________
f.	Child support	$_______________
g.	Alimony	$ _______________
h.	Social Security	$_______________
i.	SSI / Disability	$_______________
j.	Medicare/Medicaid	$ _______________
k.	Veterans' Benefits	$ _______________
l.	Relatives/Friends	$ _______________

m. Other: ______________________________ $ ________________

9. Have you applied for public housing and/or Section 8 housing?: ____ If yes, list date of application: __________ What is status (do you have a Voucher)? _______________
Have you ever resided in public housing and/or Section 8 housing? ________________
Where?_________________________ When? ___________________

Have you ever been evicted from private or public housing or Section 8? _____________
If so, why were you evicted? ____

10. Explain any criminal history of you and/or any family members: ________________________
____
____
____

11. Are you currently involved in any legal action?:_____ If yes, attorney? __________________
Please explain and list case number and case name, if known:
____
____

12. Have you ever used alcohol or drugs? _________ If yes, when? ________________________

Have you ever been treated for substance abuse? _____

If yes, list place of treatment: ____

List dates of treatment: ____

Did you successfully complete or graduate from the treatment program? ________________

Are you in recovery? _________ If so, how long have you been in recovery? _____________

Do you currently have a sponsor? ____ Name & Phone No. of Sponsor: _______________

13. Do you currently have, or have you had at any time in the past, a DHR social worker? If so, please list: Name of Worker __________________________ Phone No.: ______________

How did you or your family become involved with DHR? (Child Protective Services, TANF, JOBS, Foster Care?)
____
____
____
____

MEDICAL HISTORY

Weight: ____________ Height: _____________

Do you or have you ever had problems with (please check yes or no):

Condition	Yes	No	Condition	Yes	No
Heart Problems	____	____	Ear/Hearing Problems	____	____
Blood Pressure	____	____	Cancer	____	____
Kidney/Urinary	____	____	Bones/Joints	____	____
Stomach/Digestive	____	____	Nerves/Anxiety	____	____
Anemia	____	____	Central Nervous System	____	____
Stroke	____	____	Head Injury	____	____
Diabetes	____	____	Back Injury	____	____
Asthma/Allergies	____	____	Skin	____	____
Seizures	____	____	Frequent Headaches	____	____
Lungs/TB	____	____	Vaginal Infections	____	____
HIV / AIDS	____	____	Teeth / Mouth	____	____
Venereal Disease	____	____	Dyslexia	____	____
Eyes	____	____	ADHD	____	____
Personality Disorder	____	____	Depression	____	____
Hormonal Imbalance	____	____	Other _____________________		

If you answered "yes" to any of the above, please list the condition and explain details below, including dates of injury/illness, treatment received, medications, doctor name and phone number, if you were hospitalized and where hospitalized:

____

____

____

Are you currently taking any medications? If so, please provide details:

Name of Medication	Daily Dosage	Condition	Dr.'s Name

Are you pregnant? ____ If so, what is due date? _____________________

PLEASE PROVIDE FULL INFORMATION FOR EACH MINOR CHILD IN THE FAMILY.
Make copies as needed.

Child's Full Name_______________________________ Date of Birth ________ Age ___________

Social Security Number_______________________Medicaid No. _______________Sex ______

Will this child be residing with mother at The Village? ______

If not, why not? ____

Current School/Daycare Attending ________________________________ Grade ____________

Prior School/Daycare Attended ____

Has child repeated a grade or been held back a grade for any reason?_____________________

How many days of school did child miss last year? ____ Why? __________________________

What special needs or problems does this child have?__________________________________

Has child been prescribed any medications? ____ If so, please list medication and diagnosis:

____Is child currently taking medication(s) as

prescribed? If not, why not?____

Child's Full Name_______________________________ Date of Birth __________ Age ________

Social Security Number_______________________Medicaid No. _______________Sex ______

Will this child be residing with mother at The Village? ______

If not, why not? ____

Current School/Daycare Attending __________________________________Grade _________

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What special needs or problems does this child have?__________________________________

Has child been prescribed any medications? ____ If so, please list medication and diagnosis:

____Is child currently taking medication(s) as

prescribed? If not, why not?____

PLEASE READ THE STATEMENT BELOW WHICH DEFINES A "HOMELESS" PERSON AND CHECK THE REASON YOU ARE CONSIDERED HOMELESS:

According to the U.S. Department of Housing and Urban Development Supportive Housing Program: Implementing Regulations, 24CFR, Part 583 (19960), homeless persons are those who are:

_____Sleeping in places not meant for human habitation, such as cars, parks, sidewalks, and abandoned buildings.
_____Sleeping in emergency shelters.
_____Living in transitional or supportive housing for homeless persons but whom originally came from streets or emergency shelters.
_____Being evicted within the week from private dwelling units and no subsequent residences have been identified and they lack the resources and support networks needed to obtain access to housing. *(NOTE: This situation requires a letter or other document substantiating that eviction is cause of homelessness—please attach to this Application).*
_____Being discharged within the week from institutions in which they have been residents for more than 30 consecutive days and no subsequent residences have been identified and they lack the resources and support networks needed to obtain access to housing.
_____ Homeless as a result of home being destroyed, or damaged and unfit for human habitation, by Hurricane Katrina or Hurricane Rita.

Additional Comments/Details:
____
____
____

I certify that I have read the specific criteria for consideration as a resident of the Sybil H. Smith Family Village, and that I meet these criteria. I have checked the homeless situation above which best applies to me.

I affirm that the foregoing information is true and complete to the best of my knowledge, information and belief. I understand that this form is only an application for consideration as a participant in the Sybil H. Smith Family Village Transitional Housing Program, and that the submission of this application does not reserve housing nor in any way guarantee acceptance into the program. I authorize verification of all information and references given.

Date:__________________________

____
Signature

Referring Agency Representative, please sign below:

I certify that I have read the specific criteria for the Applicant to be considered as a participant in the Sybil H. Smith Family Village Transitional Housing Program, and that to the best of my knowledge, understanding and belief, the Applicant, __________________, does meet these criteria.

Date: ___________________________

____

Agency Representative