

Tri County Alliance for the Homeless (TCAH)
Supportive Housing Program

Application

Instructions: If you would like to complete the computerized version of this form, tab from field to field and enter text or numerical information in the shaded areas or click on the appropriate check box to insert an "x". You should then print the completed form for mailing.

Last Name:	First Name:	MI:
Address:	City:	
State:	Zip:	Phone:
Date of Birth:	Social Security No.:	Service Point Client ID#

Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender	<input type="checkbox"/> Other
Race:	<input type="checkbox"/> Asian	<input type="checkbox"/> Black African American	<input type="checkbox"/> White	<input type="checkbox"/> African American & White
	<input type="checkbox"/> American Indian	<input type="checkbox"/> Native Hawaiian / Pacific Islander	<input type="checkbox"/> Other	<input type="checkbox"/> Other Multi Racial
U.S. Citizen:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
City of Birth:	State of Birth:			
Primary Language Spoken:	Speaks English: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

Are you homeless? Yes No

Date of present homelessness:

Extent of Homelessness:

- | | |
|--|--|
| <input type="checkbox"/> First Time | <input type="checkbox"/> 1-2 Times in the Past |
| <input type="checkbox"/> 4 or More Times in the Past 3 Years | <input type="checkbox"/> 2 Years or More |

Homeless Reason: (Mark "P" for Primary Reason and "S" for Secondary Reason. Choose only one of each.)

Medical Condition	Substance Abuse
Criminal Activity	Mortgage Foreclosure
Utility Shutoff	Loss of Transportation
Health / Safety	Substandard Housing
Loss of Job	Release from Institution
Mental Health	No Affordable Housing
Domestic Violence Situation	Loss of Public Assistance
Loss of Child Care	Eviction
	Underemployment / Low Income

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Current Living Situation:

- | | |
|--|--|
| <input type="checkbox"/> Decline to Answer | <input type="checkbox"/> Living with Family |
| <input type="checkbox"/> Domestic Violence Situation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Don't Know | <input type="checkbox"/> Own House / Apartment |
| <input type="checkbox"/> Emergency Shelter | <input type="checkbox"/> Permanent Housing (formerly homeless) |
| <input type="checkbox"/> Foster Care / Group Home | <input type="checkbox"/> Place Not Meant for Human Habitation |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Psychiatric Hospital / Facility |
| <input type="checkbox"/> Hotel / Motel (w/o emergency shelter) | <input type="checkbox"/> Rental House / Apartment |
| <input type="checkbox"/> Jail, Prison, Juvenile Facility | <input type="checkbox"/> Subsidized Housing |
| <input type="checkbox"/> Living w/Friends | <input type="checkbox"/> Transitional Housing for the Homeless |

Reason for Leaving Prior Residence:

- | | | | |
|---|---|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Current Residence | <input type="checkbox"/> Building Condemned | <input type="checkbox"/> Evicted | <input type="checkbox"/> Moved |
| <input type="checkbox"/> Unable to Pay Rent | <input type="checkbox"/> Family / Friend Conflict | <input type="checkbox"/> Fire | <input type="checkbox"/> Overcrowding |
| <input type="checkbox"/> Other: | | | |

Disability Status:

<i>Disability</i>	<i>Start Date</i>	<i>End Date</i>	<i>Disability</i>	<i>Start Date</i>	<i>End Date</i>
Alcohol Abuse			Physical / Mobility Limits		
Developmental			HIV / AIDS		
Drug Abuse			Hearing Impaired		
Physical / Medical			Vision Impaired		
Seriously Mentally Ill			Dual Diagnosis (Mental Health & Addictions)		
Other:					

Employment:

Are you unemployed? Yes No *(If "Yes", explain.)*

Current Employment:

Date began employment:

Employer's Name:

Supervisor's Name:

Address:

City:

State:

Zip:

Phone:

FAX :

Employment Level:

- | | | |
|------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Full Time | <input type="checkbox"/> Retired | <input type="checkbox"/> Seasonal Work |
| <input type="checkbox"/> Part Time | | <input type="checkbox"/> Volunteer Work |

Type of Work:

Hours per Week:

Hourly Wage / Salary?

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Cashier | <input type="checkbox"/> Retail Sales | <input type="checkbox"/> Teacher |
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Nurses Aid | <input type="checkbox"/> Technical |
| <input type="checkbox"/> Management | <input type="checkbox"/> Clerical | <input type="checkbox"/> Wait Person / Hostess |
| <input type="checkbox"/> Manual Labor | <input type="checkbox"/> Medical Professional | <input type="checkbox"/> Other (Specify): |

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Income: *Please provide amount and start and end dates if known*

<i>Source</i>	<i>Last 30 Day Amount</i>	<i>Last 90 Day Amount</i>	<i>Start Date</i>	<i>End Date</i>
Alimony or Other Spousal Support				
Annuities / Dividends from Investments				
Child Support				
Contributions from Other People				
Food Stamps				
Medicaid				
Medicare				
Pension (from former job)				
Private Disability Insurance				
Railroad Retirement				
Rental Income				
Retirement Disability				
Savings (Personal)				
SCHIP (State Children Health Insurance Program)				
Section 8, Public Housing, Rental Assistance				
Self Employment Wages				
Social Security Retirement				
SSDI				
SSI				
State Disability				
TCA (for families with children under 18)				
TDAP (for disabled adults)				
Unemployment Benefits				
Veteran's Pension				
Veteran's Disability				
WIC (Nutrition Program Special Supplement)				
Worker's Compensation				

Other Resources: *Please provide start and end dates if known.*

<i>Type</i>	<i>Start Date</i>	<i>End Date</i>	<i>Type</i>	<i>Start Date</i>	<i>End Date</i>
Case Management			Primary Health Care		
Food Stamps			Subsidized Day Care		
Housing/Rent Assistance			Substance Abuse Treatment		
Income Support			Transportation		
Job Training			Veteran Services		
Mental Health Service			Welfare to Work		

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Mental Health:

Are you currently in treatment for mental health? Yes No

Treatment Start Date:

Treatment End Date:

If yes, list diagnosis.

Where are you currently being treated?

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

If yes, please list location and date.

<i>Location</i>	<i>Treatment Start Date</i>	<i>Treatment End Date</i>

Are you currently on medication? Yes No

Do you take them as prescribed? Yes No

<i>Please list any current medications:</i>	<i>Dosage</i>	<i>Frequency</i>
1.		
2.		
3.		
4.		
5.		

Medical Information:

Do you have medical insurance? Yes No *If yes, Type?*

Have you been diagnosed with HIV or AIDS? Yes No Decline to Answer

Medical History:

Current Medical Issues:

Name of Primary Care Provider:

Address:

Phone:

<i>Please list any current medications:</i>	<i>Dosage</i>	<i>Frequency</i>
1.		
2.		
3.		
4.		
5.		

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Additional Comments to Support Application

Emergency Contact: (Relative or friend's name and number who we can contact in the case of any emergency.)

Name:

Phone:

Referral Source: Must be completed.

Referring Party:	Date:
Agency:	
Type of Program:	
Agency Address:	
Agency Phone:	FAX:

Client's Statement:

All information that I have provided on this application is complete, truthful, and I have answered all questions to the best of my ability.

Client's Signature

Date

Referral Checklist: (*Documentation below must be attached for completion of referral process.*)

- Documentation of Homelessness (Letter from referring agency stating homeless status of the client, or, if applicable, a letter from the Shelter.)
- Documentation of Disability (Letter from a doctor or other qualified professional that states this person has a disability.)
- Current Entitlements (Proof of any current entitlements being received, i.e. pay stubs, award letters, bank statements)
- Dually executed Consent to Release Information

As the information contained in this application contains protected health information, please mail this form to:

Program Coordinator
Tri County Alliance for the Homeless
Somerset County Health Department
7920 Crisfield Highway
Westover, MD 21871

Phone: (443) 523-1810