

# APPLICANT INFORMATION DOCUMENT

|                        |            |                       |     |
|------------------------|------------|-----------------------|-----|
| TRIAGE & REFERRAL SITE | CASEWORKER | INTERVIEW DATE<br>/ / | HA# |
|------------------------|------------|-----------------------|-----|

|         |            |      |             |
|---------|------------|------|-------------|
| SURNAME | FIRST NAME | M.I. | MAIDEN NAME |
|---------|------------|------|-------------|

|       |                          |                      |            |                             |
|-------|--------------------------|----------------------|------------|-----------------------------|
| ALIAS | MALE ____<br>FEMALE ____ | DATE OF BIRTH<br>/ / | BIRTHPLACE | VETERAN<br>YES ____ NO ____ |
|-------|--------------------------|----------------------|------------|-----------------------------|

|                        |   |
|------------------------|---|
| ADMITTANCE DATE<br>/ / | USA CITIZENSHIP Y ____ N ____ ALIEN REGISTRATION NO. _____<br>UNDOCUMENTED Y ____ N ____ STATUS PENDING Y ____ N ____ STATUS VERIFIED Y ____ N ____ |
|------------------------|---|

**IDENTIFICATION PRESENTED**

Social Security Card \_\_\_\_\_

Driver License \_\_\_\_\_

State ID Card \_\_\_\_\_

Birth Certificate \_\_\_\_\_

Voter Registration Card \_\_\_\_\_

Alien Registration Card \_\_\_\_\_

Passport \_\_\_\_\_

DD214 \_\_\_\_\_

Statement of Service \_\_\_\_\_

Medicaid Card \_\_\_\_\_

PA ID Card \_\_\_\_\_

Other: (Specify) \_\_\_\_\_

Is Applicant able to communicate in English? Yes \_\_\_\_ No \_\_\_\_

If No, what language does Applicant speak? \_\_\_\_\_

Could you reside with a relative? Yes \_\_\_\_ No \_\_\_\_

Would you consider it? Yes \_\_\_\_ No \_\_\_\_

Explain:

## PERSON TO NOTIFY IN AN EMERGENCY

|                           |
|---------------------------|
| NAME                      |
| AREA CODE & TELEPHONE #   |
| RELATIONSHIP TO APPLICANT |

**ADDRESS: Include apt. # and Zip Code**

CASE EMERGENCY AT SCREENING YES \_\_\_\_ NO \_\_\_\_

911 CALLED? YES \_\_\_\_ NO \_\_\_\_

**DESCRIBE EMERGENCY AND ACTION TAKEN:**

\_\_\_\_\_

SCREENING WORKER: NAME/TITLE

SUPERVISORY REVIEW

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL ALERT:** For listing of medication taken, see section E. MEDICAL

Active Tuberculosis \_\_\_\_

Diabetic (Insulin Dependent) \_\_\_\_

Epilepsy \_\_\_\_ Heart Disease \_\_\_\_

Asthma \_\_\_\_ Allergies \_\_\_\_

Dialysis \_\_\_\_ Pregnant \_\_\_\_

Other \_\_\_\_\_

**NOTE:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SUPERVISOR'S SIGNATURE/DATE

**A. INDEPENDENT LIVING HISTORY**

1. How did you become homeless and have you ever been homeless before? \_\_\_\_\_
2. Where did you sleep prior to entering the shelter?  
HOSPITAL \_\_\_\_\_ JAIL/PRISON \_\_\_\_\_ STREET \_\_\_\_\_ FAMILY \_\_\_\_\_ FRIEND \_\_\_\_\_ DROP-IN CTR \_\_\_\_\_  
SHELTER \_\_\_\_\_ OWN RESIDENCE \_\_\_\_\_ OTHER/IDENTIFY \_\_\_\_\_
3. What and when was your last permanent address? \_\_\_\_\_
4. Did you own? Yes \_\_\_\_\_ No \_\_\_\_\_ or rent? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Did you have a lease? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Did you stay with family? Yes \_\_\_\_\_ No \_\_\_\_\_ or friend? Yes \_\_\_\_\_ No \_\_\_\_\_

| Name | Address | Telephone # | Relationship |
|------|---------|-------------|--------------|
|      |         |             |              |

**COMMENTS:****B. DOMESTIC VIOLENCE**

1. Are you here as a result of domestic violence? Yes \_\_\_\_\_ No \_\_\_\_\_ (Where applicable explain all answers below.)  
If Yes, how long have you been abused? \_\_\_\_\_
2. Do you have an Order of Protection? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Has it expired? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Where is the abuser now? \_\_\_\_\_
5. Have you ever received medical treatment Yes \_\_\_ No \_\_\_ and/or been hospitalized as a result of abuse? Yes \_\_\_ No \_\_\_
6. Have you been to the police to report this abuse? Yes \_\_\_ No \_\_\_ (If Yes, please explain below.)
7. Do you have any records? Yes \_\_\_ No \_\_\_ If Yes, where are they? \_\_\_\_\_

**COMMENTS:**

**C. FAMILY**

1. Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_

If married or separated:

Spouse: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_

2. Do you have any children? Yes \_\_\_ No \_\_\_

If Yes, how many? \_\_\_\_\_ (Complete 3a. and 3b. as applicable)

- 3a. List all
- ADULT**
- children (18 years and older), and indicate gender.

| Name  | M/F   | Address | Telephone # |
|-------|-------|---------|-------------|
| _____ | _____ | _____   | _____       |
| _____ | _____ | _____   | _____       |
| _____ | _____ | _____   | _____       |

- 3b. List all
- MINOR**
- children (under 18 years), and indicate gender.

| Name  | M/F   | Age /D.O.B. | In whose care? | Address/Telephone # |
|-------|-------|-------------|----------------|---------------------|
| _____ | _____ | _____       | _____          | _____               |
| _____ | _____ | _____       | _____          | _____               |
| _____ | _____ | _____       | _____          | _____               |

4. Do you have custody of your children? Yes \_\_\_ No \_\_\_

5. Are you seeking custody of your children? Yes \_\_\_ No \_\_\_

6. Are you known to the Agency for Children's Services? Yes \_\_\_ No \_\_\_

ACS worker's name \_\_\_\_\_ Telephone # \_\_\_\_\_

7. Explain your situation with ACS. Are you scheduled for child visits? Yes \_\_\_ No \_\_\_

**COMMENTS:**

**D. RESOURCES**

1. Do you have a source of income? Yes \_\_\_ No \_\_\_

| <u>TYPE</u>     | <u>CASE NUMBER</u> | <u>AMOUNT</u> | <u>LAST RECEIVED</u> | <u>PENDING</u> |
|-----------------|--------------------|---------------|----------------------|----------------|
| Wages           | ___ N/A ___        | _____         | _____                | _____          |
| PA              | _____              | _____         | _____                | _____          |
| SSI*            | _____              | _____         | _____                | _____          |
| Social Security | _____              | _____         | _____                | _____          |
| VA Pension      | _____              | _____         | _____                | _____          |
| Other Pension   | _____              | _____         | _____                | _____          |
| UIB             | _____              | _____         | _____                | _____          |
| Food Stamps     | _____              | _____         | _____                | _____          |
| Medicaid        | _____              | _____         | _____                | _____          |
| Other _____     | _____              | _____         | _____                | _____          |

\*Do you have a representative payee?

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE # \_\_\_\_\_

2. W.M.S. INFORMATION (See attached TAD)

COMMENTS:

**E. MEDICAL**

1. What if any medical problems or symptoms do you have?

- Epilepsy \_\_\_
- Tuberculosis \_\_\_
- Chronic Heart Disease \_\_\_
- High Blood Pressure \_\_\_
- Diabetes \_\_\_
- Asthma \_\_\_
- Hepatitis \_\_\_
- Lung Disease \_\_\_
- Cancer \_\_\_
- Kidney Disease \_\_\_
- Sexually Transmitted Disease \_\_\_
- Sickle Cell Anemia \_\_\_
- Physical Impairment \_\_\_ Type \_\_\_\_\_
- Other \_\_\_ please specify below:

\_\_\_\_\_

2. Are you taking any MEDICATION? Yes \_\_\_ No \_\_\_  
If Yes, please list:

|       |
|-------|
| _____ |
| _____ |
| _____ |
| _____ |
| _____ |
| _____ |
| _____ |
| _____ |
| _____ |
| _____ |

3. Have you been hospitalized in the last two years? Yes \_\_\_ No \_\_\_ If Yes, how many times? \_\_\_\_\_  
(If Yes, explain below why, when and where).

4. Does your illness or condition limit your ability to live independently and/or work? Yes \_\_\_ No \_\_\_  
(If Yes, explain how below.)

5. Are you currently under a Doctor's care? Yes \_\_\_ No \_\_\_

If Yes: Physician/Clinic name \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_

Next appointment date(s) \_\_\_\_\_

Verified: Yes \_\_\_ No \_\_\_

\_\_\_\_\_ Yes \_\_\_ No \_\_\_

\_\_\_\_\_ Yes \_\_\_ No \_\_\_

6. Have you been tested for TB within the last year? Yes \_\_\_ No \_\_\_ If Yes, results: Positive \_\_\_ Negative \_\_\_

Where were you tested? \_\_\_\_\_

7. Have you had Chicken Pox? Yes \_\_\_ No \_\_\_ Have you treated in your home a child with Chicken Pox? Yes \_\_\_ No \_\_\_

**COMMENTS:**

**F. MENTAL HEALTH**

1. Are you currently being treated for emotional problems?  
Yes \_\_\_ No \_\_\_ If Yes:

\_\_\_\_\_  
Therapist's name/Clinic

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone #

\_\_\_\_\_  
Last appointment date

2. Are you taking any MEDICATION? Yes \_\_\_ No \_\_\_  
If Yes, please list.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. In the past have you received mental health care? Yes \_\_\_ No \_\_\_ Were you hospitalized? Yes \_\_\_ No \_\_\_  
If you answer Yes to either question, explain below what happened. (When? Where? Why?)

4. Have you been hearing voices or seeing things that no one else hears or sees? Yes \_\_\_ No \_\_\_ If Yes, please explain.



**H. EMPLOYMENT**

1. Are you currently employed? Yes \_\_\_ No \_\_\_

a. If Yes:

\_\_\_\_\_  
Position\_\_\_\_\_  
Employer's name/Address\_\_\_\_\_  
Telephone #\_\_\_\_\_  
Schedule: Days/Hours\_\_\_\_\_  
Salary

How long have you been employed here? \_\_\_\_\_

Employment verified: Yes \_\_\_ No \_\_\_

Please describe the work you do .

b. If No, are you seeking employment? Yes \_\_\_ No \_\_\_ (explain)

If No, last job held.

\_\_\_\_\_  
Position\_\_\_\_\_  
Employer's name/Address\_\_\_\_\_  
Telephone #\_\_\_\_\_  
Dates of employment\_\_\_\_\_  
Salary

Why did you leave or lose that job? \_\_\_\_\_

2. What do you feel is the reason for your being currently unemployed? \_\_\_\_\_

(i.e., unskilled, age, disability, legal matter, mental illness, substance abuse, etc.)

3. What are your career plans or goals? (Explain either answer.) \_\_\_\_\_

**COMMENTS:****I. EDUCATION**

1. Are you currently enrolled in school (GED classes, college)? Yes \_\_\_ No \_\_\_

2. Are you currently enrolled in a job-training course? Yes \_\_\_ No \_\_\_

If you answered Yes to either 1 or 2, please answer the following:

\_\_\_\_\_  
School/Program\_\_\_\_\_  
Address\_\_\_\_\_  
Course of Study\_\_\_\_\_  
Schedule: Days/Hours

Verified? Yes \_\_\_ No \_\_\_

3. Highest grade completed? \_\_\_\_\_ Year \_\_\_\_\_ School \_\_\_\_\_

GED \_\_\_ Diploma \_\_\_ Associate \_\_\_ Bachelor \_\_\_ Graduate \_\_\_ Post Graduate \_\_\_ Other \_\_\_

4. Did you receive vocational training? Yes \_\_\_ No \_\_\_

Certificates/Licenses/Union cards, etc: \_\_\_\_\_

School: \_\_\_\_\_

Skills/Vocation: \_\_\_\_\_

5. Language Skills: \_\_\_\_\_

**COMMENTS:**

**J. LEGAL**

1. Do you have any current legal issues? Yes \_\_\_ No \_\_\_

2. Is there anything in your legal history that would prevent you from obtaining employment? Yes \_\_\_ No \_\_\_

If Yes:

Are you currently involved in any legal proceedings? Yes \_\_\_ No \_\_\_ If Yes specify: \_\_\_\_\_  
(Criminal, civil, child custody, Immigration, etc)

3. Do you have any outstanding warrants? Yes \_\_\_ No \_\_\_ If Yes, specify charge. \_\_\_\_\_

4. Were you ever convicted in a court of law? Yes \_\_\_ No \_\_\_ If Yes, explain below the type of offense(s) (felony or misdemeanor)

5. Were you ever in jail or prison? Yes \_\_\_ No \_\_\_ If Yes: Where? When? How long? \_\_\_\_\_

6. Are you currently on probation Yes \_\_\_ No \_\_\_ or parole? Yes \_\_\_ No \_\_\_ Date of completion \_\_\_\_\_

If Yes:

\_\_\_\_\_  
Probation/Parole Officer Telephone # Next Appointment

7. Do you need help with your legal problems? Yes \_\_\_ No \_\_\_ If Yes, explain:

**COMMENTS;**

**K. SUMMARY:** (Add addendum if necessary.)

1. Applicant's perception of his/her situation, goals and plans; reason(s) for homelessness and future plans.

2. Worker's Assessment: analyzed observations of applicant's perception of his/her situation, and referral recommendations.

\_\_\_\_\_  
Interviewer's Signature/Title

\_\_\_\_\_  
Date

**3. SUPERVISORY REVIEW/Follow-up:**

**ASSIGNMENT TO:** Mental Health \_\_\_ Substance Abuse \_\_\_ Employment \_\_\_ MICA \_\_\_ General \_\_\_

Pre-program \_\_\_ Medical CCP \_\_\_ Transitional housing \_\_\_

Transfer to another T&R/Assessment site (explain i.e. Domestic violence). \_\_\_\_\_

**DIVERTED TO:** Return to family \_\_\_ Return to apartment \_\_\_ Homeward Bound \_\_\_ Job Corps \_\_\_

**OTHER:** (Explain)

\_\_\_\_\_  
Supervisor's Signature/Title

\_\_\_\_\_  
Date