CASE NO. _____

ADVOCATES FOR HOMELESS FAMILIES, INC.
APPLICATION FOR SERVICES

_____
CASE NUMBER

_____ _____ /_____ /_____
REFERRED BY TODAY'S DATE

_____**Transitional Housing** _____ **Rapid Rehousing** _____ **Homeless Prevention**

_____ _____/_____/_____ _____
NAME **DATE OF BIRTH** **RACE**

_____ _____/_____/_____ _____
SPOUSE'S NAME **DATE OF BIRTH** **RACE**

_____ _____
SOCIAL SECURITY NUMBER **SPOUSE'S SOCIAL SECURITY NUMBER**

MARITAL STATUS:

❑ Married ❑ Divorced ❑ Separated ❑ Never Married

GENDER (check one):

❑ Female ❑ Male ❑ Transgender ❑ Questioning ❑ Non-Binary ❑ Decline to Provide

EMERGENCY CONTACT(s):

_____

_____ (_____)_____
RELATIONSHIP **PHONE**

_____ _____ _____ _____
CARS(s) **MAKE** **MODEL** **YEAR**

CHILDREN'S NAME(s) - GENDER, D.O.B., AGE, S.S.N., RACE, LIVING WITH YOU? (Yes/No)

_____

_____

_____

_____

_____

_____

HOW MANY CHILDREN ARE LIVING WITH YOU? _____

FOR THOSE CHILDREN NOT LIVING WITH YOU, WHERE AND WITH WHOME ARE THEY CURRENTLY RESIDING?:

_____

CHILDRENS FATHERS NAME(s): ADDRESS: PHONE:

_____

_____

_____

Have you or any other member of your household been charged with a criminal offense?: _____

If yes, please list the names of the person, the charge, the date of the offense, and the outcome of the charge:

_____

_____

Are you or any member of your household currently on probation?: _____

If yes, please give the name and phone number of your probation officer, length of probation, and start date of probation:

_____

Would you and all adult members of your household be willing to submit to a criminal background check?: _____Yes _____No

HOUSING

In what type of housing are you currently residing?: ❑ Shelter ❑ Public Housing ❑ Section 8
❑ Subsidized ❑ Market Rate ❑ Friends ❑ Relatives ❑ Car ❑ Motel ❑ Other

How long have you been living at your current address?: _____ **Do you pay rent?:** _____
If yes, how much do you pay?: $_____ (weekly) (monthly)

Where were you living before your current address?: _____

How long did you reside at this address?: _____ **Where you renting?:** _____

How much did you pay?: $_____ (weekly) (monthly)

Have you ever been evicted?: _____ **If yes, when, where, and why?:** _____

_____

Do you have any outstanding utility bills (electric, gas, phone, cable, water)?: _____

If so, how much are they?: $_____ Electric (Company Name: _____)

$_____ Gas (Company Name: _____) $_____ Cable (Company Name: _____)

$_____ Phone (Company Name: _____) $_____ Water (Company Name: _____)

Have you ever found yourself homeless before?: ❑ Yes ❑ No If yes, when were you homeless, how long were you homeless, and where did you stay (in a shelter, with family, with friends, on the street)?:

_____

_____

PHYSICAL/MENTAL HEALTH

Do you have a chronic illness? (such as asthma, allergies, diabetes, epilepsy, high blood pressure, heart condition, etc.): ❑ Yes ❑ No

LIST ALL CHRONIC ILLNESSES:

Type of chronic illness:_____

Name of medical professional treating this illness: _____

Name and dosage of prescription drug: _____

Are you taking medications as prescribed? ❑ Yes ❑ No

Is the condition currently manageable? ❑ Yes ❑ No

What are your symptoms? _____

Date of last OB/GYN exam?: _____ Month _____ Year

If you are over 40 years old, have you ever had a mammogram?: ____Yes ____ No ____ Not Applicable

If yes, when was your last mammogram?: _____ Month _____ Year

Have you had a dental exam in the last year?: _____ Month _____ Year

Have you had an eye exam in the last year?: _____ Month _____ Year

During your last pregnancy, did you receive prenatal care?: ____Yes ____ No ____ Not Applicable

Were there any complications or problems with your last pregnancy?: ____Yes ____ No

If yes, please explain: _____

_____

What is your current method of birth control: _____

_____

Have you ever been diagnosed with a mental illness (such as depression, bi-polar or affective disorder, schizophrenia, etc.)?: ____Yes ____ No

If yes, are you currently receiving psychotherapy, medication, or any other treatment for this diagnosis?:

____Yes ____ No Please explain: _____

_____

Do you currently have difficulties with emotions (for example: prolonged or extreme sadness; low self esteem; very shy; extreme or inappropriate anger, etc.)?**:** ____Yes ____ No Please explain: _____

_____ Name of medication/dosage: _____

Do you have any physical disabilities?: ____Yes ____ No Please explain: _____

_____

Do you currently have health insurance/medical assistance?: ____Yes ____ No Type: _____

If yes, who is coveredd in addition to you?: ____Spouse ____ Children

Does this include Prescription drug Plan?: ____Yes ____ No

Do you currently have Dental Insurance?: ____Yes ____ No

If yes, who is covered in addition to you?: ____Spouse ____ Children

Do you have a regular family doctor?: ____Yes ____ No If yes, Dr.'s name: _____

Date of last appointment with a doctor?: _____ Month _____ Year

Was the appointment for a physical exam?: ____Yes ____ No If no, for what reason did you see the doctor? _____

CHILDREN'S HEALTH *(make one copy for each child)*

____ ______ ____/____/____

CHILD'S NAME AGE DATE OF BIRTH

Does your child have any health or behavioral problems (such as asthma, allergies, diabetes, frequent ear aches, etc.)?:

❑ Yes ❑ No If yes, what are they?: ____

____

____

____ ______ ____/____/____

CHILD'S NAME AGE DATE OF BIRTH

Does your child have any health or behavioral problems (such as asthma, allergies, diabetes, frequent ear aches, etc.)?:

❑ Yes ❑ No If yes, what are they?: ____

____

____

____ ______ ____/____/____

CHILD'S NAME AGE DATE OF BIRTH

Does your child have any health or behavioral problems (such as asthma, allergies, diabetes, frequent ear aches, etc.)?:

❑ Yes ❑ No If yes, what are they?: ____

____

____

Health Insurance *(check all that apply):*

❑ Medicare ❑ Medical Assistance *(MA)* ❑ Primary Adult Care ❑ VA Health Care

❑ Private Health Insurance ❑ Maryland Children's Health Program *(MCHP)* ❑ None

❑ Decline to provide ❑ Don't Know

Head of Household - Source and Amount of Income *(please check all that apply and provide the monthly (30 day) total for each):*

❑ Earned Income $________________ ❑ Alimony $________________

Child Support: Write the name of each child receiving child support and the amount. If none, write none and zero for the amount:

Child 1: ______________________________________ Amount: ________________

(First and Last Name)

Child 2: ______________________________________ Amount: ________________

(First and Last Name)

Child 3: ______________________________________ Amount: ________________

(First and Last Name)

❑ Temporary Assistance for Needy Families *(TANF)* $_____

❑ Social Security Disability Insurance *(SSDI)* $_____

❑ Temporary Case Assistance *(TCA)* $_____ ❑ Supplemental Security Income *(SSI)* $_____

❑ Veterans Affairs Disability $_____ ❑ Veterans / Military Pension $_____

❑ Unemployment Insurance $_____ ❑ Temporary Disability *(TDAP)* $_____

❑ Worker's Compensation $_____ ❑ Social Security *(Retirement)* $_____

❑ Other _____ $_____

Total Monthly Income *(calculate the total sum of the above income amounts)***:** $_____ ❑ Zero Income

Head of Household - Non-Cash Benefits *(please check all that apply and provide the amount for each benefit):*

❑ SNAP - Supplemental Nutrition Assistance Program/Food Stamps $_____

❑ WIC *(Women, Infants & Children)* $_____

❑ LIHEAP *(Low-Income Home Energy Assistance Program)* $_____

❑ Childcare Voucher $_____ ❑ Affordable Care Act Subsidy $_____

❑ HUD-VASH *(Veterans Supportive Housing)* $_____ ❑ Housing Subsidy $_____

❑ What type of housing subsidy? $_____ ❑ Other _____ $_____

Total Non-Cash Benefits *(calculate the total sum of the above benefits amounts)*: $_____ ❑ Do not receive Non-Cash Benefits

Household/Family Member - Source & Amount of Income *(for each source that applies, provide the monthly (30 day) total):*

Earned Income: $_____ Alimony: $_____ Child Support: $_____

Veterans / Military Pension: $_____ Social Security (Retirement): $_____

Temporary Case Assistance: $_____ Social Security Disability Insurance (SSDI): $_____

VA Disability: $_____ Unemployment Insurance: $_____

Supplemental Security Income (SSI): _____ Worker's Compensation: $_____

Temporary Disability: $_____ Temporary Assistance for Needy Families (TANF): $_____

Other: _____: $_____ Zero Income ❑

Total Monthly Income *(place the sum of all the income amounts from above)*: $_____

Total Annual Income *(calculate estimate of annual income (TMI x 12 months)))*: $_____

Household/Family Member - Non-Cash Benefits *(please check all that apply and provide the amount for each benefit):*

❑ Zero Non-Cash Benefits Affordable Care Act Subsidy: $_____

Supplemental Nutrition Assistance Program (SNAP, Food Stamps): $_____

Women, Infant, and Children (WIC): $_____ Childcare Voucher: $_____

LIHEAP (Low-Income Home Energy Assistance Program): $_____

Total Non-Cash Benefits *(place the sum of all the non-cash benefit amounts from above)*: $_____

Housing Subsidy: $_____ Housing Subsidy Type? _____

DOMESTIC VIOLENCE - Have you been a victim of domestic violence *(check one):*

❑ Yes ❑ No ❑ Don't Know ❑ Decline to Provide

If 'Yes' - When did the experience(s) occur?

❑ Within the past 3 *(three)* months ❑ 3 *(three)* to 6 *(six)* months

❑ 6 *(six)* months to 1 *(one)* year ❑ Don't know

Are you currently fleeing domestic violence? ❑ Yes ❑ No ❑ Decline to Provide

SUBSTANCE USE HISTORY

Do you have a history of abusing drugs and/or alcohol?: ❑ Yes ❑ No

If yes, what substance(s)?: _____

When was the last time you used this substance?: _____ Month _____ Year

Are you currently drug and alcohol free?: ❑ Yes ❑ No

Have you ever participated in in-patient treatment?: ❑ Yes ❑ No

If yes, when and where: _____

What are you doing to stay clean and sober?: _____

_____ Do you have a sponsor?: ❑ Yes ❑ No

EDUCATION

What level of education have you completed?: ❑ LESS THAN HIGH SCHOOL Last grade completed: _____

❑ G.E.D. Year: _____

❑ HIGH SCHOOL GRADUATE Year: _____

❑ VOCATIONAL/TECHNICAL CERTIFICATE Year: _____

❑ SOME COLLEGE How many credits?: _____

List course study: _____ Year(s) of attendance: _____

❑ COLLEGE GRADUATE Year: _____ Degree: _____

Have you been diagnosed as having a learing disability?: ❑ Yes ❑ No

When and by whom were you evaluated?: _____

Are you currently involved in an educational program?: ❑ Yes ❑ No

If yes, please list school or program: _____

EMPLOYMENT

Are you currently employed: ❑ Yes ❑ No Start date of current position: _____

Current employer: _____ Position: _____

Income: $_____ Hourly/Weekly/Bi-Weekly/Monthly/Annually *(circle one)*

How many hours per week do you work?: ❑ Less than 20 ❑ 20-30 ❑ 30+

What days of the week do you work *(circle all that apply)*?: M T W Th F S S

May we contact your current employer?: ❑ Yes ❑ No Phone: (_____)_____

How are your children cared for while you are at work?: _____