

- Emergency shelter or motel (with voucher)
- Motel (without voucher)
- Foster care
- Hospital (non-psychiatric)
- Jail/prison/incarceration
- Nursing home
- Owned by client
- Place not meant for habitation: _____
- Psychiatric facility
- Rental (no subsidy)
- Rental (with subsidy: _____)
- Staying with family
- Staying with friends
- Other: _____

Length of time at above address:

- 1 day or less
- 2 days to 1 week
- Over 1 week but less than 1 month
- 1 to 3 months
- Over 3 months but less than 1 year
- 1 year or longer

Category:

- Homeless
- Imminent risk of losing housing
- Homeless under federal statutes
- Fleeing domestic violence
- At risk of losing housing

Address prior to now:

Last Permanent Address:

Income and Benefits

Any cash income in the past 30 days: Yes No (Attach proof for each member)

Income Source	HH Member Receiving	Last 30 Days Income Total
Earned income		
Unemployment		
SSI		
SSD		
VA disability (service)		
Private disability		
SS retirement		
Pension		
Child support		
Alimony		
TANF/PA		
Other: _____		

Monthly Total: _____

Any non-cash benefits in the past 30 days: Yes No

Non-Cash Source	HH Member Receiving
SNAP (Monthly Amt: _____)	
WIC	
Section 8/rental assistance	
Other: _____	

Liquid Assets (e.g., checking/savings accounts): Yes No

If yes:

Source	Amount	HH Member Receiving

Health and Social Concerns

Health insurance: (check one) Yes No

If yes, complete this section

Insurance see codes below	HH member receiving

A. Private B. Medicare C. Medicaid/Fidelis D. Employment based E. Military F. Child Health Plus G. Cobra

Health Conditions:

Condition	Yes/No	Long-Term (Y/N)	Receiving Treatment (Y/N)	Referral Needed (Y/N)
Physical disability				
Developmental disability				
Chronic health condition				
Mental health concerns/issues				
Substance use/abuse				

Would you like a referral to services? [] Yes [] No

Domestic Violence History:

Question	Answer
Have you experienced domestic violence?	[<input type="checkbox"/>] Yes [<input type="checkbox"/>] No
If yes, when?	
- Currently fleeing	[<input type="checkbox"/>] Yes [<input type="checkbox"/>] No
- Within 3 months	[<input type="checkbox"/>] Yes [<input type="checkbox"/>] No
- 3-6 months ago	[<input type="checkbox"/>] Yes [<input type="checkbox"/>] No
- 6 months to 1 year ago	[<input type="checkbox"/>] Yes [<input type="checkbox"/>] No
- 1+ years ago	[<input type="checkbox"/>] Yes [<input type="checkbox"/>] No
Would you like a referral to services?	[<input type="checkbox"/>] Yes [<input type="checkbox"/>] No

Certification and Signatures

Applicant Signature: _____

Date: _____

Staff Certification: [] Case Manager confirms eligibility for financial assistance.

Staff Signature: _____

Date: _____