**Section 1 Applicant Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Income Source/Amount Per Month

* Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* SSI/SSDI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* SS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Day Labor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Welfare: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* VA Benefits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Child Support: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Unemployment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Scrap/Recycling: \_\_\_\_\_\_\_\_\_\_\_\_\_
* Hustling/Panhandling: \_\_\_\_\_\_\_\_\_
* Food Stamps: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2 Educational Information**

Did you have a high school diploma or GED?

* No
* Yes

What was the last grade you completed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any college credits/degrees?

* No
* Yes How many hours/degree held? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently working on a degree/certificate?

* No
* Yes What program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 3 Needs (Check all that apply)**

* Need assistance with applying for Food Stamps
* Need assistance with clothing
* Need assistance with mental or medical care
* Need assistance with getting prescription
* Need assistance with getting personal grooming items
* Need assistance with transportation to appointments
* Need assistance with basic household items (dishes, pots/pans, blankets, cleaning supplies, etc)

**Section 4 Medical Health**

Which of the following medical conditions have you been **diagnosed** with? (Check all that apply)

* Kidney/Renal Disease
* Liver Disease/Cirrhosis/Hepatitis C
* Heart Disease, Arrhythmia
* HIV/AIDS CD4 Count: \_\_\_\_\_\_\_\_\_ Viral Load: \_\_\_\_\_\_\_\_\_ Current Weight: \_\_\_\_\_\_\_\_\_\_\_ As of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Emphysema
* Asthma
* Cancer
* Diabetes
* TB
* Vision Impairment
* Hearing Impairment
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving treatment for the illness or illnesses?

* Yes
* No Why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, are you receiving medication as part of the treatment?

* No
* Yes Please list all medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you taking your medications as prescribed by your healthcare provider?

* Yes
* No Why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 5 Substance Abuse History**

Have you ever abused alcohol?

* Yes
* No

If yes, how often and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you last use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever abused drugs (illegal or prescription)?

* Yes
* No

If yes, which drug(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you last use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received treatment (outpatient or inpatient)?

* Yes
* No

If yes, are you currently receiving any form of treatment?

* Yes If yes, where and how long have you been receiving treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

Have you ever attended NA/AA/CA/GA meetings?

* Yes
* No

If yes, are you currently attending any of the above mentioned meetings?

* Yes If yes, where and how long have you been attending the meetings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

**Section 6 Mental Health**

Have you been diagnosed with a mental illness?

* Yes If yes, what is your diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

If yes, are you currently receiving treatment for the mental illness?

* Yes
* No

If no, explain why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If yes, are you receiving medication as part of the treatment?

* Yes
* No

If yes, please list all medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you taking your medications as prescribed by your healthcare provider?

* Yes
* No

If no, explain why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Section 6 Current Mental Health State**

Are you currently or have you recently experienced any of the following? (check all that apply)

* Prolonged or unexplained sadness
* Loss of interest in activities once thought pleasurable
* Problems resting or sleeping
* Frequent irritability
* Anger issues, difficulty controlling temper
* Feelings of helplessness, nothing helps ease the feelings
* Constant worry, negative anticipation
* General nervousness that is not normal for your
* Sudden panic/sweating/shaking
* Thoughts of suicide \*
* Thoughts of homicide (harming someone) \*\*

\*Contact a mental health professional

\*\*Contact authorities

**Section 6 Criminal/Legal Issues**

Have you ever been convicted of a crime?

* Yes
* No

If yes, what crime? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_To\_\_\_\_\_\_\_\_\_\_\_\_

Last date of incarceration

what crime? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_To\_\_\_\_\_\_\_\_\_\_\_\_

what crime? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_To\_\_\_\_\_\_\_\_\_\_\_\_

what crime? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_To\_\_\_\_\_\_\_\_\_\_\_

Are you currently on probation or parole?

* Yes
* No

If yes, name of your PO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any pending or unresolved charges?

* Yes
* No

If yes, what are the charges? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Client Date

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

Signature of staff completing form Date