

Transitional Housing UNIVERSAL APPLICATION

Please check the program to which you are applying (you can check more than one):			
PROGRAM	CONTACT	FAX #	EMAIL
Vita Nova Village	AMANDA MEYERS	561.689.0806	AMEYERS@VITANOVAINC.ORG
Villages of Hope	THERESA PEAK	561.557.8949	THERESAP@VILLAGESOFHOPE.NET
Pond Lake	KEHAN RAHMING	561.383.9820	KEHANRAHMING@HELPHOMESAFE.ORG

YOUTH INFORMATION

Name: _____ Social Security #: _____

Present Address _____ apt # _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone Number: _____

Social Media: **Check** ✓ all that apply



Please list usernames: _____

Date of Birth: _____ Age: _____ Gender: _____

Ethnicity: _____ US Citizen? _____ Primary Language: _____

If you are female: are you pregnant?: _____

If you are a male: do you have a baby on the way?: _____

Do you have any children?: _____ If so, how many? _____ ages? _____

Are your children living with you? _____

SCHOOL INFORMATION

School or Program name: _____ Grade?: _____

Do you want to go to college? _____ If so, where?: _____

What would you like to study?: _____

If you are not in school:

Last grade completed: _____ School Name: _____

Why did you stop attending school?: _____

Do you plan on going back to school?: _____ If so, where?: _____

What is your plan for returning to school?

Please list 3 steps that will help you achieve this goal:

Step 1: _____ Step 2: _____ Step 3: _____

EMPLOYMENT INFORMATION

Where do you work?: _____ How long?: _____

List 3 Previous Employer(s)

Employer Name	Start Date	End Date

If you are not working where have you been looking for a job? _____

What do you want to do as a career?: _____

LEGAL HISTORY

Have you ever been arrested?: _____

What have you learned from that experience?: _____

JUST A LITTLE MORE...

1. Please describe how you would handle a conflict with a room mate?: _____

2. Why do you want to be in supportive housing?: _____

3. List what you believe we can help you accomplish in supportive housing?

a. _____

b. _____

c. _____

6. Would you be willing to meet with a therapist monthly? _____

7. Are you willing to take random drug tests for the first 30-days? _____

IF NOT, then would you be willing to participate in drug use sessions with a therapist? _____

8. Please let us know any debt you have (*examples*: Old cell phones, past landlord)

TO BE FILLED OUT BY REFERRAL (ADVOCATE, CASE MANAGER, GUARDIAN)

Referral Source (organization/person): _____ Phone: _____

Case Manager: _____ Phone: _____

Email: _____

Reason for referral: _____ Current living situation: _____

Former foster youth? _____ How long in foster care? _____

Income Source:

- EMPLOYED
- PESS
- AFTERCARE
- EXTENDED FOSTERCARE
- SOCIAL SECURITY
- OTHER: _____

Involvement In	Yes/No	Date	NOTES:
Fire Setting			
Violent/Assault			Weapons?
Property Destruction			
Gang Affiliation			
Sexual Offense			
Charges Pending			Felony/Misdemeanor
Substance Use			Can pass drug test today?
Suicide Thoughts			
Suicide Attempts			
Baker Act			Last admission to hospital?

CASE MANAGER / THERAPIST SECTION

Is there a current diagnosis:

Axis I _____
 Axis II _____
 Axis III _____
 Axis IV _____
 Axis V (GAF) _____

Current Medication	Dosage	Reason

Past Medication	Dosage	Reason

Medical Issues / Allergies: _____

Current Therapist: _____ Phone: _____

Agency Name: _____

Person Completing Form: _____ Phone: _____

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

Program Applicant Name: _____

DOB: _____

Information to be released by or exchanged with the following:

Referral source such as case manager, foster parent, GAL, mentor, program staff, etc.
Vita Nova, Villages of Hope, Pond Place

Other: _____

The following information may be released and exchanged:

- | | |
|--|---|
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Educational -Tests & Reports |
| <input type="checkbox"/> Court/Agency Documents | <input type="checkbox"/> Chemical Recovery History |
| <input type="checkbox"/> Family System Evaluation | <input type="checkbox"/> Therapist Orders |
| <input type="checkbox"/> Nursing Notes | <input type="checkbox"/> School Attendance |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Dates of Hospitalization |
| <input type="checkbox"/> Mental Status | <input type="checkbox"/> Diagnoses |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Psychosocial Report |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Crisis Intervention Reports |
| <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Medical Records |
| <input type="checkbox"/> School Records | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Treatment Team reports |
| <input type="checkbox"/> Progress Notes | |

Verbal Exchange

Other (specify): _____

APPLICANT NAME: _____

SIGNATURE: _____

DATE: _____