



Casa Pacifica Housing Application

General Information

Name		US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address		City	Zip
Email		Phone Number	
Age	Date of Birth	Place of Birth	Cell Number
Emergency Contact Name		Relationship of Contact	Contact Phone Number
In Foster Care Now? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did You Exit Foster Care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Exited Foster Care	County of Foster Care
Name of Social Worker		Social Workers Phone Number	

Employment History

Most Recent Employer – Company Name		Are you still Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Company Phone Number
Address		City	Zip
Supervisors Name		Supervisors Phone Number	Dates of Employment
Position Held	Salary	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	How many Hours Per Week
Brief Job Description:			
Reason for Leaving			May We Contact Employer <input type="checkbox"/> Yes <input type="checkbox"/> No

Company Name		Are you still Employed <input type="checkbox"/> Yes <input type="checkbox"/> No		Company Phone Number	
Address			City		Zip
Supervisors Name			Supervisors Phone Number		Dates of Employment
Position Held		Salary	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		How many Hours Per Week
Brief Job Description:					
Reason for Leaving					May We Contact Employer <input type="checkbox"/> Yes <input type="checkbox"/> No
What are your career goals?					

Education Information

Did you Graduate High School <input type="checkbox"/> Yes <input type="checkbox"/> No		High School Diploma <input type="checkbox"/> Yes <input type="checkbox"/> No		GED <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Completed
Are You Currently Attending School? <input type="checkbox"/> Yes <input type="checkbox"/> No		School Attending				Date Started
Class Schedule						
What are your educational goals?						

Community Life Functioning

Do you have medical insurance <input type="checkbox"/> Yes <input type="checkbox"/> No		Insurance Company Name		Insurance #		Do you have a primary Dr. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Doctors Name					Doctors Phone Number		
Have you been diagnosed with a serious illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe below:							
Are you experiences a medical condition/physical symptoms you attribute to mental, emotional, or stress-related conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe below:							

Personal Wellbeing

Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much per week?	Do you currently use illegal drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever used illegal drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you received mental health treatment before? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dates	How long?
List of current medication		How long?	Medication for <input type="checkbox"/> Mental Condition <input type="checkbox"/> Health Reasons
List of current medication		How long?	Medication for <input type="checkbox"/> Mental Condition <input type="checkbox"/> Health Reasons
List of current medication		How long?	Medication for <input type="checkbox"/> Mental Condition <input type="checkbox"/> Health Reasons
Have you ever attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe circumstances below:			

Financial History

Do you have a Bank Account? <input type="checkbox"/> Yes <input type="checkbox"/> No	Balance of Checking	Balance of Savings	Do you have a Credit Card? <input type="checkbox"/> Yes <input type="checkbox"/> No	Balance owed
Do you owe anyone money? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much total?	Have you ever developed a personal budget? <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like to learn? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Other

Do you have a Drivers License? <input type="checkbox"/> Yes <input type="checkbox"/> No	Drivers License #:	Do you have a California ID? <input type="checkbox"/> Yes <input type="checkbox"/> No	California ID #:
Do you own a car? <input type="checkbox"/> Yes <input type="checkbox"/> No	Year / Make / Model of Car		License # of Car:
Do you have car insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Car Insurance Provides Name		
Car Insurance Policy Number	Have you ever been on probation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently on Probation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Probation Officer		Probation Officer Phone Number	

References

Name	Relationship	Address	Phone
Name	Relationship	Address	Phone
Name	Relationship	Address	Phone

**In Order For Your Application To Be Considered
The Following Questions Must Be Completed**

Please briefly state why you are interested in living in CITY's Transitional Housing Program?

Please briefly state your current living situation?

Please describe what qualities would make you a good candidate for CITY's Transitional Housing Program?

Please describe some obstacles you have faced in the past and how you have overcome them:

What are some challenges you think you may face if you are accepted into CITY's Transitional Housing Program?

Applicants Signature

Date

For Transitional Services Staff Use Only

Date Received _____

- CITY Participant Intake Needed Schedule Interview Interview Date: _____
- Accepted Date Letter Sent: _____
- Declined Date Letter Sent: _____
- Incomplete Application Date Letter Sent: _____

Housing Option:

- Stepping Stone Community Nest The Shire

Date: _____ Signature _____