

Partners in Recovery Community Housing Application

Type of Housing: **Select**

Direct Care Clinic:

I. Recipient of Care

Recipient of Care:	CIS ID #:	DOB:	SSN:	
Priority Population: <input type="checkbox"/> Yes <input type="checkbox"/> No				Category of Priority Population: Select
ACT Team <input type="checkbox"/> Yes <input type="checkbox"/> No	Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No	Title XIX: <input type="checkbox"/> Yes <input type="checkbox"/> No		COT: <input type="checkbox"/> Yes <input type="checkbox"/> No
Current Setting:		City: Select		AZ Zip
Recipients Current Address:				

II. Living Environment

If recipient lived independently at some time over the last three years, what was the most reason for leaving *(please check all that apply)*:

<input type="checkbox"/> Voluntary	<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Inpatient Substance Abuse	<input type="checkbox"/> Eviction
<input type="checkbox"/> Jail/Prison		<input type="checkbox"/> Other:	

Is the recipient interested in moving from current environment? Yes No If yes, Geographical Preference: Select
If yes, Living Environment: Select

Does the recipient have a pet? Yes No If yes, does the pet meet the Americans Disability Act? Yes No

Does the recipient have a co-occurring/substance abuse? Yes No Provider Agency:

Does the recipient have legal issues? Yes No Type: Select Sex Offender: Yes No Level: Select

Does the recipient have a Probation Officer Parole Officer If yes,
NAME:
ADDRESS: PHONE:

Does the recipient have a legal guardian? Yes No If yes,
NAME:
AGENCY: PHONE:

Current Sources of Income: *(please check all that apply)*

<input type="checkbox"/> SSI \$	<input type="checkbox"/> SSDI \$	<input type="checkbox"/> Social Security \$	<input type="checkbox"/> GA \$
<input type="checkbox"/> VA \$	<input type="checkbox"/> AFDC/TANF \$	<input type="checkbox"/> Unemployment Benefits \$	<input type="checkbox"/> Employment \$

Sources of financial assistance applied for or will apply for:

Does the recipient own any of the following household items? *(please check all that apply)*

<input type="checkbox"/> Bed	<input type="checkbox"/> Dresser	<input type="checkbox"/> Night Stand	<input type="checkbox"/> Coffee/End Table	<input type="checkbox"/> Sofa	<input type="checkbox"/> Other e.g. language/medical/etc :
<input type="checkbox"/> Dining Table	<input type="checkbox"/> Pots/Pans	<input type="checkbox"/> Dishes	<input type="checkbox"/> Storage Containers	<input type="checkbox"/> Utensils	
<input type="checkbox"/> Towels	<input type="checkbox"/> Sheets	<input type="checkbox"/> Blankets	<input type="checkbox"/> Cups/Glasses	<input type="checkbox"/> Pillows	
<input type="checkbox"/> Bath Mats	<input type="checkbox"/> Shower Curtain	<input type="checkbox"/> Lamps	<input type="checkbox"/> Cleaning Supplies	<input type="checkbox"/> Comforter	

Describe type of housing needed: Select

Does the recipient have any barriers and what type of assistance is needed? *(please check all that apply)*

BARRIERS

<input type="checkbox"/> Has friends at current location	<input type="checkbox"/> Does not know where else to live
<input type="checkbox"/> Sense of community at current	<input type="checkbox"/> Cannot afford to live independently
<input type="checkbox"/> Fear of the unknown	<input type="checkbox"/> Cannot afford to move
<input type="checkbox"/> Wants a roommate	<input type="checkbox"/> Poor credit history
<input type="checkbox"/> Poor ADL/ILS	<input type="checkbox"/> Poor rental history
<input type="checkbox"/> Medical Issues	<input type="checkbox"/> Criminal background
<input type="checkbox"/> Substance Abuse Issues	<input type="checkbox"/> Other

TYPE OF ASSISTANCE NEEDED

<input type="checkbox"/> Ongoing rental subsidy
<input type="checkbox"/> One-time only assistance
<input type="checkbox"/> Fix up/Rehab
<input type="checkbox"/> Credit/rental history repair
<input type="checkbox"/> Don't Know
<input type="checkbox"/> Other

Please explain all that apply:

Has the recipient applied for other housing? Yes No If yes, Housing Type: Select

III. Signatures

Case Manager:	Print Name:	Date:
Clinical Coordinator	Print Name:	Date: