Supportive Services Application

Client Information:

Full Name: _____

SSN:_____ **Date of Birth:** _____

Cell Phone:_____Work Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How many children do you have? _____ Currently Pregnant?_____

Do you have a Primary Care Physician?_____ OB/GYN?_____

Do the children have a pediatrician?_____ Last Check up?_____

Did you experience Domestic Violence? ☐ Yes ☐No

Employment Information:

Are you currently working? ☐ No ☐ Yes ☐ Full time -or- ☐ Part time

Current Employer:_____ Position:_____ Since (date):_____

Previous Employer: _____ Position:_____ How long_____

Highest Level of Education Completed: _____

Getting to know *You*

What do you like to do in your spare time? _____

What would you like to achieve within the next year?_____

Identification: (Check **All** the documents in your possession)

_____ Driver's License	_____ Social Security Card	_____ Marriage Certificate
_____ Passport	_____ Your Birth Certificate	_____ Divorce Decree
_____ Military ID	_____ Kids Birth Certificates	_____ Custody Papers
_____ DMV Issued ID	_____ Insurance Card	_____ Immunization Records

Last Name_____

Supportive Services You are Seeking from A Stepping Stone: (Check All that Apply)

- ☐ Transitional Housing Referral
- ☐ Career Mentoring
- ☐ Job Search Assistance
- ☐ Resume Writing Skills
- ☐ Interview Practice
- ☐ Counseling
- ☐ Creating a Budget
- ☐ College Application Assistance
- ☐ Financial Assistance
- ☐ Other: _____

Housing Experience

Current Address_____
How long have you lived here?_____
Are you currently Homeless? ☐ Yes or ☐ No
Type of Living Situation: (Check One)

- ☐ Owned house/townhouse
- ☐ Rental House/Apartment
- ☐ Transitional Housing for Homeless
- ☐ Hotel/Motel
- ☐ Domestic Violence Situation
- ☐ Living w/ Family
- ☐ Living w/Friends
- ☐ Permanent Housing for Formerly Homeless
- ☐ Subsidized Housing
- ☐ Psychiatric Hospital or Facility
- ☐ Hospital
- ☐ Emergency Shelter
- ☐ Substance Abuse Treatment Center

Prior Housing Information:
Location of Last Residence_____ How long?_____
List Other State(s) within the last 5 years: _____

Reason for seeking Housing services: (Check One)

- ☐ Separation
- ☐ Dispute with Family/Friends
- ☐ Divorce
- ☐ Evicted
- ☐ Housing plans fell through
- ☐ Moved to seek work
- ☐ Unemployment
- ☐ Addiction
- ☐ Change in family situation ☐
- ☐ Dispute with Spouse
- ☐ Domestic Violence
- ☐ Family/Personal Illness
- ☐ Unable to pay rent
- ☐ Physical/Mental Disability
- ☐ Released from Substance Abuse Treatment
- ☐ Other:_____

Date in need of housing: _____

Last Name_____

Check all that apply:

☐ Have friends in the area ☐ Applying from out of town
☐ Have family support

Types of housing you have lived in:

☐ Subsidized apartment or house ☐ Apartment rental
☐ House rental ☐ Relative's home
☐ House mortgage ☐ Other _____

Have you pursued other housing possibilities? ☐ Yes ☐ No

If Yes, please list:

_____

List your other housing options if you are not admitted into this program:

_____

Do you have reliable transportation? ☐ **Yes** ☐ **No**

Type of transportation: _____

Emergency Contact Information:

Contact Name: _____

Contact Address: _____

City:_____ State: _____

Phone:_____Relationship: _____

Monthly Income: List dollar amount next to source. Put "0" if it does not apply to you.

☐ No Financial Resources – or-

Income from Current Employment	$
Alimony or Other Spousal Support	
Child Support	
Food Stamps	
SSI	
SSDI	
Unemployment Insurance	
Other TANF-Funded Service	
Private Disability Insurance	
Supplemental Nutrition – WIC	
TANF Transportation Services	
Medicaid Rental Income	
Pension From a Former Job	
Section 8, Public Housing	
TANF Child Care Service	
Worker's Compensation	
Earned Income:	
General Assistance:	
Other:	
TOTAL	**$**

Agency Name and Contact of Benefits:

_____

Date benefits started: _____

Do you have a disability of long duration? ☐ Yes ☐ No

Disability Type:

☐ Alcohol Abuse	☐ Developmental
☐ Drug Abuse	☐ Physical/Medical
☐ Mental Illness	☐ Physical/Mobility Limits
☐ HIV/AIDS	☐ Hearing Impaired
☐ Vision Impaired	☐ Dual Diagnosis
☐ Other	☐ Other: ADHD
	☐ Other: Cognitive

Education:

Are you currently a student? ☐ No ☐ Yes Where?_____

Do you have any certificates or degrees: _____

_____

Have you ever had a vocational assessment (where, when, etc): _____

_____

What job skills or experience do you have: _____

_____

Barriers to employment: _____

_____

Employment goals: _____

_____

Current Employer: _____

Name of Supervisor: _____

How long have you been employed: _____

Phone: _____ Hourly rate: _____

Hours: _____ Full-time or Part-time Employment Verification? ☐ Yes ☐ No

Previous Employer: _____

Name of Supervisor: _____

How long were you employed: _____

Phone: _____ Hourly rate: _____

Hours: _____ Full-time or Part-time Employment Verification? ☐ Yes ☐ No

Last Name_____

Legal Information:

Have you ever been arrested? ☐ Yes ☐ No

If Yes, explain _____

_____

Have you even been convicted of any legal charges? ☐ Yes ☐ No

If Yes, explain _____

_____

Have you ever been incarcerated? ☐ Yes ☐ No

_____

_____

Have you been convicted of a Felony? ☐ Yes ☐ No

List charge(s): _____

Are you currently on Probation/Parole? ☐ Yes ☐ No

Probation/Parole Officer: _____

Do you have any outstanding warrants? ☐ Yes ☐ No

If Yes, explain: _____

_____

Do you have any pending court dates? ☐ Yes ☐ No

If Yes, explain(when, where, why)

_____

_____

Children:

How many children do you have? _____

Are all of the children with you in your physical custody? ☐ Yes ☐ No

Do you have a custody order? ☐ Yes ☐ No

Are all of the children with you legally in your custody? ☐ Yes ☐ No

If No, explain: _____

Are there other children not in your care? ☐ Yes ☐ No

If Yes, explain: _____

Has a child(ren) been reported to Child Protective Services? ☐ Yes ☐ No

If Yes, explain: _____

Are child(rens) immunizations up-to-date? ☐ Yes ☐ No

Have any of your children received any of the following care:

☐ Attended a day care center ☐ Professional baby sitter in their home
☐ Other ☐ Professional baby sitter in your home

If Other, explain:_____

Do any of your child(ren) have special needs? ☐ Yes ☐ No

If Yes, explain: _____

Are any of your child(ren) receiving special education services? ☐ Yes ☐ No

If Yes, explain: _____

Do you feel any of child(ren) need additional school help? ☐ Yes ☐ No

If Yes, explain: _____

Are any of child(ren) receiving counseling services? ☐ Yes ☐ No

If Yes, explain and name of provider: _____

Last Name_____

Child # :

Name: _____ _____ _____ _____
(first) (mi) (last) (suffix)

SSN:_____ Date of Birth: _____

Gender: ☐ Female ☐ Male Primary Race:_____

Name & Grade of school: _____

Does child have a disability of long duration? ☐ Yes ☐ No

Disability Type: _____
(Examples: Alcohol Abuse, Drug Abuse, Mental Illness, Alzheimer/Dementia, HIV/AIDS, Vision Impairment, Learning, Speech, Developmental, Physical, Medical, Mobility Limits, Hearing Impaired, ADHD, Cognitive, Dual Diagnosis, Mental Handicap/Injury)

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Please Print as many as you need to complete information on each child

Last Name_____

How did you hear about A Stepping Stone?

_____

_____

Name of Referral:

_____

What are you doing or have done to change your current situation?

_____

_____

Please List 3 Personal References **with Name, phone number and email address**:

1. _____
2. _____
3. _____

I certify that the information given in response to the questions on this document is true. I understand that any false information given is grounds for dismissal. A background check will be completed and References will be called prior to program entry.

Signature: _____

Date: _____

Case Manager's Signature: _____ Date: _____