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Meadville, PA 16335

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# Transitional Living Program Application

Transitional Living Program

Date:

Source of Referral:

Contact Information for Referral Source:

**Applicant Information:**

Applicant Name:

(First) (Middle) (Last)

Date of Birth: / / Age: Gender:

Current Address:

Contact Information:

(Phone) (Email)

(Additional Means of Contact)

**Emergency Contacts:**

(Name) (Relationship) (Phone) (City/State)

(Name) (Relationship) (Phone) (City/State)

Are you a veteran? Y or N

**Education/Employment:**

Education highest grade completed: Are you currently participating in any education program? Y or N

If yes, name of the program:

Current employment if applicable:

Employer’s Phone:

**Sources of Income:**

Do you receive any of the following sources of income?

Employment Social Security

Child Support SSI/SSD

Veterans Pension DPW/TANF

Any other sources of income

**Screening/Eligibility Please Indicate Yes or No for the Following Questions:**

Are you 18 years of age and older and currently homeless or at imminent risk of becoming homeless? Y or N

How long have you been homeless?

Is there another place you could temporarily stay? If yes how long?

Do you have a relationship with your family? Please describe.

Are you working with another agency to find housing?

Y or N

Are you willing and able to work towards independent living?

Y or N

Do you have a housing preference, living alone/with others?

Do you have current or pending charges for any crime? (an answer of yes does not exclude applicant/referral from housing)

Y or N

If you answered yes above please describe the nature of the offense(s):

Have you ever had charges/adjudication related in any way to sexual misconduct (sexual abuse, assault, indecent exposure)?

Y or N

Do you have a history of alcohol or substance abuse/or are you in recovery?

Y or N

If you are currently seeking treatment, what type and where? Who is your counselor/sponsor?

How many attempts to sobriety have you had?

Are you pregnant or the parent of any minor child(ren) with intact parental rights?

Y or N How many children live full-time with you?

If you are pregnant, when is your due date?

Do you have a documented diagnosis of serious mental illness (SMI-Bi-Polar, Major Depression, Schizophrenia, Anxiety, Phobias)?

Y or N

If yes, please describe:

Do you have current, or a history of suicidal and/or homicidal ideation and/or attempts?

Y or N

If yes, please explain:

If yes, how many in patient stays have you had within the past five years?

Do you have any allergies?

Y or N

If yes, please explain:

**Applicant/Referral Self-Assessment:**

Activities of Daily Living

On a scale of 1-5, (1=poor to 5=excellent) how would you rate yourself/referral at the following:

Wake up on your own Household chores

Cleanliness/hygiene Laundry

Being on time Following through on tasks

Getting to work/school Managing Money

Setting and following through with goals

Setting and attending medical/counseling appointments

Social Skills

On a scale of 1-5, (1=poor to 5=excellent) how do you get along with:

Peers Peers residing with you

Co-workers Bosses

Teachers Counselors

Police Friend/Family/Provider Emergency Contacts

Strengths

My personal strengths are:

Needs

Do you need assistance with the following (mark all that apply):

Obtaining photo ID Obtaining medical/dental/health insurance

Employment skills/job training Job placement

Obtaining cash assistance if eligible Budgeting Finances

Maintaining Sobriety Complying with medication schedule

Job/school attendance Complying with probation requirements

Family relationships Peer relationships

Social Skills Parenting skills

Cleaning/organizational skills Laundry

Transportation Meal preparation

Balancing time between responsibilities and recreation

AA support groups Faith based support

Finding medical/dental provider Shopping

Addressing mental health concerns Locating community resources

If you checked yes to obtaining medical/dental or health insurance please describe current needs, problems or circumstances:

Additional comments/concerns about you or your living situation:

**References**

Please include three references that are **not related to you** and their contact information (teachers, employers, peers, caseworkers, etc.):

1.

(Name) (Relationship) (Contact# or email)

2.

(Name) (Relationship) (Contact# or email)

3.

(Name) (Relationship) (Contact# or email)

I understand that I am applying for the Transitional Living Program and will be expected to work cooperatively with my coordinator to develop goals and complete them in a timely manner. It is expected that through this program I finish my GED, find employment and locate permanent housing.

I verify that the information provided is accurate and I understand it is being considered for my acceptance in the Child to Family Connections Transitional Living Program. I understand that this is just the first step in the application process. Final acceptance into the program is based solely on the decision of the selection committee.

(Applicant Signature) (Date)

(Witness Signature) **\*This must be signed\*** (Date)

**Return Application To:**

**Child to Family Connections**

**13388 Dunham Road**

**Meadville, PA 16335**

**Fax: 814-336-3020**

**Phone: 814-336-3307**

**Email: cfcadmin@childtofamilyconnections.org**