



Date of Application: _____ Date of Admittance: _____ Unit Number: _____
 Have you been in this program before? Yes No -- Have you filled out a FCC application before? Yes No When: _____

Required data entry fields for all clients
Answer this section for all persons in household (use additional sheets for larger families)

Full Name	SSN	Highest Grade Level Attained	Gender	Relationship to Head of Household	Date of Birth mm/dd/yyyy	Primary Race	Secondary Race (If applicable)
Person 1: (HEAD OF HOUSEHOLD) <u>Full Name</u> HMIS # _____	<u>SSN Data Quality</u> <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or partial SSN reported	<input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> No schooling completed <input type="checkbox"/> Grade Completed: _____ <input type="checkbox"/> College	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other (If Other) Specify: _____	<input type="checkbox"/> Self (Head of household)	/ / <u>DOB Data Quality</u> <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White
Person 2: (CHILD) <u>Full Name</u> HMIS # _____	<u>SSN Data Quality</u> <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or partial SSN reported	<input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> No schooling completed <input type="checkbox"/> Grade Completed: _____ <input type="checkbox"/> College	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other (If Other) Specify: _____	<input type="checkbox"/> Head of Household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member (other relation to head of household) <input type="checkbox"/> Other: non-relation member	/ / <u>DOB Data Quality</u> <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White
Person 3: (CHILD) <u>Full Name</u> HMIS # _____	<u>SSN Data Quality</u> <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or partial SSN reported	<input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> No schooling completed <input type="checkbox"/> Grade Completed: _____ <input type="checkbox"/> College	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other (If Other) Specify: _____	<input type="checkbox"/> Head of Household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member (other relation to head of household) <input type="checkbox"/> Other: non-relation member	/ / <u>DOB Data Quality</u> <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White

**Telephone number: _____

Required data entry fields for all clients
Answer this section for all persons in household (use additional sheets for larger families)

Full Name	SSN	Highest Grade Level Attained	Gender	Relationship to Head of Household	Date of Birth mm/dd/yyyy	Primary Race	Secondary Race (If applicable)
Person 4: (CHILD) <u>Full Name</u> HMIS # _____	<u>SSN Data Quality</u> <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or partial SSN reported	<input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> No schooling completed <input type="checkbox"/> Grade Completed: _____ <input type="checkbox"/> College	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other (If Other) Specify: _____	<input type="checkbox"/> Head of Household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member (other relation to head of household) <input type="checkbox"/> Other: non-relation member	/ / <u>DOB Data Quality</u> <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White
Person 5: (CHILD) <u>Full Name</u> HMIS # _____	<u>SSN Data Quality</u> <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or partial SSN reported	<input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> No schooling completed <input type="checkbox"/> Grade Completed: _____ <input type="checkbox"/> College	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other (If Other) Specify: _____	<input type="checkbox"/> Head of Household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member (other relation to head of household) <input type="checkbox"/> Other: non-relation member	/ / <u>DOB Data Quality</u> <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White
Person 6: (CHILD) <u>Full Name</u> HMIS # _____	<u>SSN Data Quality</u> <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or partial SSN reported	<input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> No schooling completed <input type="checkbox"/> Grade Completed: _____ <input type="checkbox"/> College	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other (If Other) Specify: _____	<input type="checkbox"/> Head of Household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member (other relation to head of household) <input type="checkbox"/> Other: non-relation member	/ / <u>DOB Data Quality</u> <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White

Name <i>(Please Answer for Each Person in HH)</i>	Martial Status	Ethnicity	Active Duty US Military Veteran	Currently Covered by Health Insurance?	<i>(If Client has Health Insurance)</i> Select All Type(s) That Apply
Person 1: (HEAD OF HOUSEHOLD)	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/Latino	(Answer for adults 18+ only) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults
Person 2: (CHILD)		<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/Latino	(Answer for adults 18+ only) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults
Person 3: (CHILD)		<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/Latino	(Answer for adults 18+ only) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults

Name <i>(Please Answer for Each Person in HH)</i>	Ethnicity	Active Duty US Military Veteran	Currently Covered by Health Insurance?	(If Client has Health Insurance) Select All Type(s) That Apply
Person 4: (CHILD)	<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/Latino	(Answer for adults 18+ only) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults
Person 5: (CHILD)	<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/Latino	(Answer for adults 18+ only) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults
Person 6: (CHILD)	<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/Latino	(Answer for adults 18+ only) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults

Name (Please Answer for All Persons in HH)	If client has a disabling condition, please answer the following sub-assessment questions:						
	Does the client have a disabling condition?	Disability Type (Select all that apply)	Disability Determination	If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?	Documentation of Disability and Severity on File	Currently Receiving Services/Treatment for this disability	Long Term (Yes/No)
Person 1: (HEAD OF HOUSEHOLD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 2: (CHILD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 3: (CHILD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name (Please Answer for All Persons in HH)	If client has a disabling condition, please answer the following sub-assessment questions:						
	Does the client have a disabling condition?	Disability Type (Select all that apply)	Disability Determination	If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?	Documentation of Disability and Severity on File	Currently Receiving Services/Treatment for this disability	Long Term (Yes/No)
Person 4: (CHILD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 5: (CHILD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 6: (CHILD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

****Answer the following questions for HEAD OF HOUSEHOLD and ADULTS (18+) only!
(Print additional pages where needed)****

Housing/Homeless Information

- Category 1 – Homeless
- Category 2 – At imminent risk of losing housing
- Category 3 – Homeless only under other federal statutes
- Category 4 – Fleeing domestic violence
- At-risk of homelessness
- Stably housed
- Client doesn't know
- Client refused

Zip Code of Last Permanent Address _____

Residence Prior to Project Entry

- Client doesn't know
 - Emergency Shelter, including hotel or motel paid for with emergency shelter voucher
 - Foster care home or foster care group home
 - Hospital or other non-psychiatric medical facility
 - Hotel or motel paid for without emergency shelter voucher
 - Jail, prison or juvenile detention facility
 - Long-term care facility or nursing home
 - Other
 - Owned by client, no ongoing housing subsidy
 - Owned by client, with ongoing housing subsidy
 - Permanent supportive housing for formerly homeless persons (e.g., COC project; HUD legacy programs; HOPWA PH)
 - Place not meant for human habitation (e.g., a vehicle, an abandoned building, bus/train/subway station, airport, or anywhere outside)
 - Psychiatric hospital or other psychiatric facility
 - Client refused
 - Rental by client, no ongoing housing subsidy
 - Rental by client, with other ongoing housing subsidy
 - Rental by client, with VASH subsidy
 - Rental by client, with GPD TIP subsidy
 - Residential project or halfway house with no homeless criteria
 - Safe Haven
 - Staying or living in a family member's room, apartment, or house
 - Staying or living in a friend's room, apartment, or house
 - Substance abuse treatment facility or detox center
 - Transitional Housing for homeless persons (including homeless youth)
- (If Other) Specify _____

Length of Stay in Previous Place

- One day or less
- Two days to one week
- More than one week, but less than one month
- One to three months
- More than three months, but less than one year
- One year or longer
- Client doesn't know
- Client refused

****Answer the following questions of ALL HOUSEHOLD MEMBERS!**

1. Is client entering from the streets, shelter or safe haven?

- Yes No Client doesn't know Client refused

1a. Approximate Date Homelessness Started _____ / _____ / _____

2. Regardless of where they stayed last night -- Number of times the client has been homeless on the streets, in ES, or SH in the past three years including today.

- Never In 3 Years 1 Time 2 Times
 3 Times 4 or More Times Client doesn't know Client refused

2a. Total number of months homeless on the street, in ES or SH in the past three years.

- One Month (This Time is the First Month)
 2 – 12 Months > **Must specify # of months:** _____
 More Than 12 Months Client Doesn't Know Client Refused

****Answer the following questions for HEAD OF HOUSEHOLD and ADULTS (18+) only!**

Domestic Violence

*Domestic Violence Victim/Survivor should be indicated as "Yes" if the person has experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has taken place **within the individual's or family's primary nighttime residence.***

Domestic violence victim/survivor?

- Yes Client doesn't know
 No Client refused

(If yes) When Experience Occurred

- Within the past three months One year ago or more
 Three to six months ago (excluding six months exactly) Client doesn't know
 Six months to one year ago (excluding one year exactly) Client refused

*Currently fleeing should be indicated as "Yes" if the Person is fleeing, or is attempting to flee, the domestic violence situation **or** is afraid to return to their primary nighttime residence.*

- (If yes) Are you currently fleeing?** Yes No Client Doesn't Know Client Refused

Overview of domestic violence

Income and Non-Cash Benefit Information

Employment Information for Head of Household

Employed (Head of Household) ? Yes No

Total Monthly Income \$ _____

Currently receiving income from any source? Yes No Client doesn't know Client refused
(If Yes, select all income types you receive and amount(s) below)

MONTHLY INCOME sub-assessment

X	Source of Income (Monthly)	Amount from Source
	Alimony or Other Spousal Support	\$.00
	Child Support	\$.00
	Earned Income (<i>Employment</i>)	\$.00
	Pension or Retirement Income From a Former Job	\$.00
	Private Disability Insurance	\$.00
	Retirement Income from Social Security	\$.00
	SSDI (<i>Social Security Disability Income</i>)	\$.00
	SSI (<i>Social Security Income</i>)	\$.00
	TANF (<i>Temporary Assistance for Needy Families or FIP grant</i>)	\$.00
	Unemployment Insurance	\$.00
	VA Service-Connected Disability Compensation	\$.00
	VA Non-Service-Connected Disability Pension	\$.00
	Workers Compensation	\$.00
	Other (<i>Please Specify</i>) _____	\$.00
	No Financial Resources	\$.00
	Total Monthly Income Reported	\$.00

Currently receiving any non-cash benefits? Yes No Client doesn't know Client refused
(If Yes, select all non-cash benefit types you receive and amount(s) below)

NON-CASH BENEFIT sub-assessment

X	Source of Non-Cash Benefit (Monthly)	Amount (if applicable)
	Supplemental Nutrition Assistance Program (<i>Food Stamps</i>)	\$.00
	Special Supplemental Nutrition Program for WIC	\$.00
	TANF Child Care Services	\$.00
	TANF Transportation Services	\$.00
	Other TANF Funded-Services	\$.00
	Section 8, Public Housing or rental assistance	\$.00
	Other Source	\$.00
	Temporary Rental Assistance	\$.00

BUDGET

EXPENSES	
	Amount
Car Payment	
Car Insurance	
Health Insurance	
Child Care	
Lunch Money	
Gas	
Cell Phone	
Cigarettes	

Diapers	
Credit Cards	
Medical Bills	
Utility Debts	
Rental Debts	
Court Debts	
Other Expenses	
Monthly Expenses:	Total

Are you pregnant? Yes No

Do you currently have custody of your dependent children? Yes No

Court ordered custody ___ Physical custody ___ Any children not in your custody? Yes No

TELEPHONE NUMBER(S) WHERE YOU CAN BE REACHED:

Telephone # _____ Emergency Contact Name & Telephone# _____

What city do you currently live in? _____ How long at this residence? _____

Male/husband: Are you employed? Yes No - If yes, how long? _____ Income: \$ _____

Start Date: _____

If no, how long since you last worked? _____

Highest education completed? _____

Do you have a prior criminal record? Yes No

Female/wife: Are you employed? Yes No - If yes, how long? _____ Income: \$ _____

Start Date: _____

If no, how long since you last worked? _____

Highest education completed? _____

Do you have a prior criminal record? Yes No

Have you applied for? Section 8 _____, Hickory Housing _____, WPCOG _____

Have you stayed in prior shelters? Yes No Do you have your own transportation? Yes No

Where did you sleep last night? (friends, family, shelter, hotel, car, other): _____

Primary reason for homelessness? (eviction, domestic violence, unemployment, disability, released from prison, etc.)

Briefly explain: _____

List the schools and/or daycare where your children attend: _____

Do you home-school your children? Yes No

Driver's License Number: _____ Issuing state for ID _____

Do you know anyone who has been or is currently in our program? Yes No – if yes, who? _____

Are you or your spouse taking any prescription drugs? Yes No – If yes, what?

DO YOU OR YOUR SPOUSE CURRENTLY:

Have a dependency on drugs (marijuana, cocaine, heroin, alcohol) or prescription drugs such as valium, Xanax?

You: Yes No ----- Spouse: Yes No

If yes, please explain _____

Been treated for dependency? Yes No

Hospitalized with mental illness or physical ailment? Yes No

Diagnosis _____

Involved with therapy? Date, location, therapist _____

Had Hepatitis A, B or C; TB; HIV-AIDS? Yes No _____

Are you or your spouse an ex-offender? Yes No

Explain _____

Are you or your spouse on probation? Yes No

Do you have any court cases pending? Yes No

Have you or your spouse ever been investigated by DSS? Yes No

I hereby certify that the information given in this application is correct. I understand that I may be asked to leave immediately if any false statements are given on this form. I certify I have read the rules, regulations and guidelines for this program.

Applicant's signature

Date

If married, co-applicant's signature

Date

VERIFICATIONS

I give Family Care Center permission to use photographs of my family for the purpose of fundraising or promotion of the agency. I understand there is no form of compensation, either expressed or implied, for the use of these photographs. I understand our names will not be used with any photograph.

I hereby give my consent and authorization to Family Care Center to request, receive and to share information and professional records (medical, psychological, educational, court, criminal background and credit) about myself and other members of my family with various respected agencies interested in helping me and my family.

I understand that if the time of my stay has expired or I am in violation of FCC rules, I will be directed to leave the premises and if I do not comply in an orderly fashion, I will be escorted off the premises by a law enforcement officer and/or charged with trespassing. I understand my personal property must be removed within the time allowed or I could be charged a storage fee or the property may be removed.

I understand that when entering the program, a \$200 deposit is required with \$100 being non-refundable. If the unit is left in clean condition and there is no damage, overage of utilities and keys are returned, \$100 will be refunded after 30 days from exit date.

Applicant's signature Date

If married, co-applicant's signature Date

Signature of FCC Staff Member Date

DRUG TEST AUTHORIZATION PERMISSION FORM

I/we acknowledge that I have been advised that I may be required to submit to a drug screen test as part of the Guest Requirements and Rules of Family Care Center. Such drug test may be required as part of the company's random drug testing program. I further understand that the Family Care Center of Catawba Valley, Inc. prohibits the presence of illegal substances in the systems of its guests while in the program and/or while residing on the Family Care Center property. A confirmed positive test is a violation of the Family Care Center's Guest Requirements and Rules policy and will result in an immediate discharge. Additionally, a refusal to test, failure to submit adequate urine for test, or adulterated sample, constitutes a positive test and will result in an immediate discharge.

I further understand that the data resulting from said test will be held in confidence except as otherwise necessary to carry out the terms and objectives of this policy. **I understand that I will be responsible for the cost of the test.**

I understand that it is my responsibility prior to the drug testing to inform the laboratory and/or Family Care Center of any medication, prescribed or non-prescribed, that I may be taking and/or have taken within the last 60 days prior to the testing.

I consent to the release of the results of any drug test to authorized representatives of the Family Care Center for appropriate review. I release Family Care Center and its officers, employees and any person affiliated with the testing from any claims, losses, damages or other liabilities due to any acts, omissions or negligence arising from or related to such testing.

I acknowledge that the drug and alcohol policy of Family Care Center is to have a drug free environment. I consent freely and voluntarily to a drug test under the circumstances described above along with all the terms and conditions of the Family Care Center. I also understand that although I may not agree with the drug and alcohol policy of Family Care Center, failure to acknowledge the policy with my signature below may be grounds for immediate discharge from the Family Care Center program. A photocopy of this authorization shall be deemed an original and shall be accepted as such by every person.

Applicant's Signature Date

If married, co-applicant's signature Date

Agency Representative Date

Guest Requirements and Rules

1. **Adults must be employed, enrolled in school or verifiably disabled. Children must be enrolled in school or working if age 16+. Any change in your employment must be discussed immediately with the Social Worker. You must print out and give to FCC a copy of your Credit Report-use the computer in the Resource Room.**
2. **No more than 30% of a guest's countable income (with a cap of \$200) will be charged for program fees, cleaning or damage expenses.**
If the apartment is cleaned according to the House Cleaning Chart, keys returned on original key ring, and there are no damages or overages, \$100 will be returned to the guest upon exiting the program after 30 days.
3. Up to 30% of your weekly income should be deposited into your escrow (savings) account while you are at Family Care Center.
4. **Weekly contact with the Social Worker in person is mandatory.**
5. Guests are not allowed to socialize with other guests; work on your family's progress toward becoming self-sufficient. Guests are to display their parking pass in car window at all times – security patrol will check nightly.
6. **ABSOLUTELY NO alcohol, drugs, violence or weapons will be permitted on the Family Care Center property. Candles, incense, kerosene heaters, toaster ovens, electric fans, outdoor grills and children's pools are not allowed. Random drug screening may be required while in the program at your expense. Should any prohibited items be found in your unit, they will be confiscated and returned to you at the time of discharge. Any illegal items found will be turned over to law enforcement.**
7. Children are to be properly supervised at all times by parents/guardians.
8. You must report to management any loitering in the parking lot, playground, or outside the apartments after 9 p.m.
9. Security patrol services will report to management any loitering and any suspicions of illegal or unlawful activity.
10. **No smoking** in any of the units. All Family Care Center offices and units have been designated as “**smoke free**”. There is to be no smoking in any units, hallways, or offices for the safety of the residents, staff and volunteers; and for the upkeep of the unit. Smoking is permitted outside the units. No cigarette butts are to be thrown in the grass or in the inside trash cans. Please safely dispose of cigarette butts.
11. **No pets** of any kind are allowed.
12. **No visitors.** You may have someone pick you up or drop you off, but no visitors are allowed in the units. This includes relatives and boy/girlfriends.
13. No duplicate keys are to be made of either the apartment unit, chapel or the mailbox. **All keys must remain on the original Family Care Center key ring given at admittance. Key replacement fees will be charged for lost keys.**
14. **Excessive utility bills will be the responsibility of the guest, up to 30% of countable income over \$60. No car washing allowed on Family Care property.**
15. Family Care Center staff will be entering the units **without notice**, for general maintenance, inventory and inspections, etc. Please remember you are a guest of Family Care Center and the apartment unit is a shelter for you and your family while you are working the program. You are our guest and not protected by tenant/landlord law of the state of NC.
16. **Unannounced Weekly Inspections:** Unannounced weekly inspections will be performed by the staff. Units will need to be kept clean. Remember you are here temporarily and the units are fully furnished, no additional furniture is to be brought into the unit; only bring the minimum belongings to keep down the clutter. No food of any kind is to be left out in the apartment. **Unfavorable inspections can result in a discharge.**

17. Do not move furniture in the unit. If you have a special request, contact the office. No furniture or clutter is to be placed outside of unit. Sidewalks should remain clear at all times. Guests are expected to keep grass areas outside of units clean. No personal furniture is allowed to be brought into the unit unless approved by the social worker.
18. Guests are prohibited from ordering cable or internet while residing at Family Care Center.
19. **Sheets are to be kept on the beds.** Under no circumstances is anyone allowed to sleep on our mattresses without a fitted sheet. If needed, sheets will be provided by the office. Bed pillows and not sofa pillows must be used for sleeping.
20. No stickers or pictures are to be hung on the walls or furniture.
21. Guests are expected to spend the nights in the apartment unit. If you plan to be away, please inform the Social Worker. If we see that you are not sleeping in the unit at night, we will assume you have another place to stay, our program is no longer needed and you will be discharged.
22. Mutual respect of Family Care Center staff and guests is required.
23. I give Family Care Center staff permission, in the case of an accident and I am incapacitated, to seek medical attention for any member of my family.
24. I agree not to hold the Family Care Center accountable for any accident or injury while a guest on the Family Care Center property.
25. Parents are not to home-school children while in this program. Both parents are expected to find gainful employment.
26. Proper clothing attire is expected of all guests while in this program.
27. Families may be asked to do in-kind services such as cleaning, weeding, other tasks by the Director or Social Worker.
28. Family Care Center reserves the right to discharge any guest for failure to comply with program guidelines.

I have read the Guest Requirements and Rules and understand and agree to follow each rule with the understanding that failure to follow the above rules could result in discharge from the Family Care Center program.

Applicant's Signature

Agency Representative

Applicant's Signature

Date

PHILOSOPHY STATEMENT

Family Care Center embraces Judeo-Christian values, which in essence supports the notion that all human beings possess an innate dignity which comes from being children of God. This notion of dignity is reinforced by certain activities that we engage in, such as work. Human industry elevates the sense of self-worth by utilizing God-given gifts to provide for ourselves the basic necessities of life – that is, housing, food, clothing, hygiene, and other health measures.

Families who, for whatever reasons, can't provide for their own basic needs can look to non-profit organizations, public, and private, in order to meet these on a temporary basis. This is meant to serve as a bridge leading from temporary dependence to permanent independence. Family Care Center rejects dependence as a way of life and we will endeavor to move families to independence through temporary housing, case management, education, and job opportunities. Family Care Center will only commit its resources to the use of families who also share this philosophy of life.

***The following sheets should only be filled out for additional adults in the family (anyone over the age of 18 that is not the head of the household)**

ADDITIONAL ADULT FAMILY MEMBER

FULL NAME (Adult over 18): _____ (HMIS # _____)

SSN	Highest Grade Level Attained	Gender	Relationship to Head of Household	Date of Birth mm/dd/yyyy	Primary Race	Secondary Race (If applicable)
<input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or partial SSN reported SSN Data Quality	<input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> No schooling completed <input type="checkbox"/> Grade Completed: _____ <input type="checkbox"/> College	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other (If Other) Specify: _____ -	<input type="checkbox"/> Head of Household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member (other relation to head of household) <input type="checkbox"/> Other: non-relation member	/ / DOB Data Quality <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White

Ethnicity	Active Duty US Military Veteran	Are you pregnant?	Currently Covered by Health Insurance?	(If Client has Health Insurance) Select All Type(s) That Apply
<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/Latino	(Answer for adults 18+ only) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults

Revised 11/2/17

Does the client have a disabling condition?	Disability Type (Select all that apply)	Disability Determination	If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?	Documentation of Disability and Severity on File	Currently Receiving Services/ Treatment for this disability	Long Term (Yes/No)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Domestic Violence

Domestic Violence Victim/Survivor should be indicated as “Yes” if the person has experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has taken place **within the individual’s or family’s primary nighttime residence**.

Domestic violence victim/survivor?

- Yes Client doesn't know
 No Client refused

(If yes) When Experience Occurred

- Within the past three months One year ago or more
 Three to six months ago (excluding six months exactly) Client doesn't know
 Six months to one year ago (excluding one year exactly) Client refused

Income and Non-Cash Benefit Information

Employment Information

Employed? Yes No **Total Monthly Income** \$ _____

Currently receiving income from any source? Yes No Client doesn't know Client refused
 (If Yes, select all income types you receive and amount(s) below)

MONTHLY INCOME sub-assessment

X	Source of Income (Monthly)	Amount from Source
	Alimony or Other Spousal Support	\$.00
	Child Support	\$.00
	Earned Income (<i>Employment</i>)	\$.00
	Pension or Retirement Income From a Former Job	\$.00
	Private Disability Insurance	\$.00
	Retirement Income from Social Security	\$.00
	SSDI (<i>Social Security Disability Income</i>)	\$.00
	SSI (<i>Social Security Income</i>)	\$.00
	TANF (<i>Temporary Assistance for Needy Families or FIP</i>) grant)	\$.00
	Unemployment Insurance	\$.00
	VA Service-Connected Disability Compensation	\$.00
	VA Non-Service-Connected Disability Pension	\$.00
	Workers Compensation	\$.00
	Other (<i>Please Specify</i>) _____	\$.00
	No Financial Resources	\$.00
	Total Monthly Income Reported	\$.00