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)** **Full Name** HMIS #_____	_____ **SSN Data Quality** □ Full SSN Reported □ Approximate or partial SSN reported	☐ GED ☐ High School Diploma ☐ No schooling completed ☐ **Grade Completed:_____** ☐ College	□ Female □ Male ☐ Other *(If Other)* Specify: _____	□ Self (Head of household)	/ / **DOB Data Quality** □ Full DOB reported □ Approximate or partial DOB	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White
Person 2: **(CHILD)** **Full Name** HMIS #_____	_____ **SSN Data Quality** □ Full SSN Reported □ Approximate or partial SSN reported	☐ GED ☐ High School Diploma ☐ No schooling completed ☐ **Grade Completed:_____** ☐ College	□ Female □ Male ☐ Other *(If Other)* Specify: _____	□ Head of Household's child □ Head of household's spouse or partner □ Head of household's other relation member (other relation to head of household) □ Other: non-relation member	/ / **DOB Data Quality** □ Full DOB reported □ Approximate or partial DOB	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White
Person 3: **(CHILD)** **Full Name** HMIS #_____	_____ **SSN Data Quality** □ Full SSN Reported □ Approximate or partial SSN reported	☐ GED ☐ High School Diploma ☐ No schooling completed ☐ **Grade Completed:_____** ☐ College	□ Female □ Male ☐ Other *(If Other)* Specify: _____	□ Head of Household's child □ Head of household's spouse or partner □ Head of household's other relation member (other relation to head of household) □ Other: non-relation member	/ / **DOB Data Quality** □ Full DOB reported □ Approximate or partial DOB	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ 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)** **Full Name** HMIS #_____	_____ **SSN Data Quality** □ Full SSN Reported □ Approximate or partial SSN reported	☐ GED ☐ High School Diploma ☐ No schooling completed ☐ **Grade Completed:_____** ☐ College	□ Female □ Male ☐ Other *(If Other)* Specify: _____	□ Head of Household's child □ Head of household's spouse or partner □ Head of household's other relation member (other relation to head of household) □ Other: non-relation member	/ / **DOB Data Quality** □ Full DOB reported □ Approximate or partial DOB	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander ☐ White
Person 5: **(CHILD)** **Full Name** *HMIS #*_____	_____ **SSN Data Quality** □ Full SSN Reported □ Approximate or partial SSN reported	☐ GED ☐ High School Diploma ☐ No schooling completed ☐ **Grade Completed:_____** ☐ College	□ Female □ Male ☐ Other *(If Other)* Specify: _____	□ Head of Household's child □ Head of household's spouse or partner □ Head of household's other relation member (other relation to head of household) □ Other: non-relation member	/ / **DOB Data Quality** □ Full DOB reported □ Approximate or partial DOB	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White
Person 6: **(CHILD)** **Full Name** HMIS #_____	_____ **SSN Data Quality** □ Full SSN Reported □ Approximate or partial SSN reported	☐ GED ☐ High School Diploma ☐ No schooling completed ☐ **Grade Completed:_____** ☐ College	□ Female □ Male ☐ Other *(If Other)* Specify: _____	□ Head of Household's child □ Head of household's spouse or partner □ Head of household's other relation member (other relation to head of household) □ Other: non-relation member	/ / **DOB Data Quality** □ Full DOB reported □ Approximate or partial DOB	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White

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

Name *(Please Answer for Each Person in HH)*	**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)**	□ Non- Hispanic/ Non-Latino □ Hispanic/Latino	(Answer for adults 18+ only) □ Yes □ No	□ Yes □ No	□ MEDICAID □ MEDICARE □ State Children's Health Insurance Program □ Veteran Administration (VA) Medical Services □ Employer Provided Health Insurance □ Health Insurance Obtained through COBRA □ Private Pay Health Insurance □ State Health Insurance for Adults
Person 5: **(CHILD)**	□ Non- Hispanic/ Non-Latino □ Hispanic/Latino	(Answer for adults 18+ only) □ Yes □ No	□ Yes □ No	□ MEDICAID □ MEDICARE □ State Children's Health Insurance Program □ Veteran Administration (VA) Medical Services □ Employer Provided Health Insurance □ Health Insurance Obtained through COBRA □ Private Pay Health Insurance □ State Health Insurance for Adults
Person 6: **(CHILD)**	□ Non- Hispanic/ Non-Latino □ Hispanic/Latino	(Answer for adults 18+ only) □ Yes □ No	□ Yes □ No	□ MEDICAID □ MEDICARE □ State Children's Health Insurance Program □ Veteran Administration (VA) Medical Services □ Employer Provided Health Insurance □ Health Insurance Obtained through COBRA □ Private Pay Health Insurance □ 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**)	□ Yes □ No	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
Person 2: **(CHILD)**	□ Yes □ No	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
Person 3: **(CHILD)**	□ Yes □ No	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ 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)**	□ Yes □ No	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
Person 5: **(CHILD)**	□ Yes □ No	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
Person 6: **(CHILD)**	□ Yes □ No	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ 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 Started _____/_____/_____

Follow-up questions:

1. *"Did you stay anywhere other than on the streets, in ES, or SH for less than 7 days (if not an institution)."* ***or***

2. *Were you in jail/hospital/other Institution less 90 days (if break is an institution)".*

If 1 or 2 is yes, continue back to the next break in homelessness.

If the date of becoming homeless is greater 365 days from project entry then skip question 2 & 2a below.

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 Months □ 3 Months □ 4 Months □ 5 Months
□ 6 Months □ 7 Months □ 8 Months □ 9 Months □ 10 Months □ 11 Months □ 12 Months
□ More Than 12 Months □ Client Doesn't Know □ Client Refused

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

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
□ No
□ Client doesn't know
□ Client refused

***(If yes)* When Experience Occurred**

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

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 (*Employment*)	$ .00
	Pension or Retirement Income From a Former Job	$ .00
	Private Disability Insurance	$ .00
	Retirement Income from Social Security	$ .00
	SSDI *(Social Security Disability Income)*	$ .00
	SSI (*Social Security Income*)	$ .00
	TANF *(Temporary Assistance for Needy Families or FIP) grant*)	$ .00
	Unemployment Insurance	$ .00
	VA Service-Connected Disability Compensation	$ .00
	VA Non-Service-Connected Disability Pension	$ .00
	Workers Compensation	$ .00
	Other *(Please Specify)* _____	$ .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 *(Food Stamps)*	$ .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

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?_____

Marital Status: □ Married □ Single □ Divorced □ Separated

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

How long have you been homeless? _____

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 may 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

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	Active Duty US Military Veteran	Relationship to Head of Household	Date of Birth mm/dd/yyyy	Primary Race	Secondary Race (If applicable)
_____ SSN Data Quality □ Full SSN Reported □ Approximate or partial SSN reported	☐ GED ☐ High School Diploma ☐ No schooling completed ☐ **Grade Completed:_____** ☐ College	(Answer for adults 18+ only) □ Yes □ No □ Client doesn't know	□ Head of Household's child □ Head of household's spouse or partner □ Head of household's other relation member (other relation to head of household) □ Other: non-relation member	/ / DOB Data Quality □ Full DOB reported □ Approximate or partial DOB	□ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Ethnicity	Gender	Are you pregnant?	Currently Covered by Health Insurance?	*(If Client has Health Insurance)* Select All Type(s) That Apply
□ Non- Hispanic/ Non-Latino □ Hispanic/Latino	□ Female □ Male ☐ Other *(If Other)* Specify: _____	☐ Yes ☐ No	□ Yes □ No	□ MEDICAID □ MEDICARE □ State Children's Health Insurance Program □ Veteran Administration (VA) Medical Services □ Employer Provided Health Insurance □ Health Insurance Obtained through COBRA □ Private Pay Health Insurance

				□ State Health Insurance for Adults

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
Same as Head of Household: □ Yes □ No
If "No" please explain:_____

Length of Stay in Previous Place
Same as Head of Household: □ Yes □ No
If "No" please answer:_____

1. Is client entering from the streets, shelter or safe haven?
□ Yes □ No □ Client doesn't know □ Client refused

1a. If Yes, Approximate Date 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 Months □ 3 Months □ 4 Months □ 5 Months
□ 6 Months □ 7 Months □ 8 Months □ 9 Months □ 10 Months □ 11 Months □ 12 Months
□ More Than 12 Months □ Client Doesn't Know □ Client Refused

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)*
□ Yes □ No	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ 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
- □ No
- □ Client doesn't know
- □ Client refused

***(If yes)* When Experience Occurred**

- □ Within the past three months
- □ Three to six months ago (excluding six months exactly)
- □ Six months to one year ago (excluding one year exactly)
- □ One year ago or more
- □ Client doesn't know
- □ 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 (*Employment*)	$ .00
	Pension or Retirement Income From a Former Job	$ .00
	Private Disability Insurance	$ .00
	Retirement Income from Social Security	$ .00
	SSDI *(Social Security Disability Income)*	$ .00
	SSI (*Social Security Income*)	$ .00
	TANF *(Temporary Assistance for Needy Families or FIP) grant*)	$ .00
	Unemployment Insurance	$ .00
	VA Service-Connected Disability Compensation	$ .00
	VA Non-Service-Connected Disability Pension	$ .00
	Workers Compensation	$ .00
	Other *(Please Specify)* _____	$ .00
	No Financial Resources	$ .00
	Total Monthly Income Reported	**$ .00**

Guest Requirements and Rules

1. Able adults are expected to acquire gainful employment within the first 30 days of entrance into the shelter. Adults who receive disability payments for themselves or their children are not expected to gain employment. Children must be enrolled in school or working if age 16+. No home schooling is allowed. 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-for your budgeting purposes.

2. **No more than 30% of a guest's countable income (with a cap of $200) will be charged for housing or services 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, up to $100 will be returned to the guest upon exiting the program, after 30 days have passed.

3. Up to 30% of your weekly income should be deposited into your escrow (savings) account while you are in the program at Family Care Center.

4. **Weekly contact with the Social Worker in person is requested.**

5. Guests are not allowed to socialize with other guests.
   Guests are to display their parking pass in car window at all.

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. **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.

9. **No pets** of any kind are allowed unless animal is a service animal.

10. **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.

11. 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.**

12. **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.

13. 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. You are our guest and not protected by tenant/landlord law of the state of NC.

14. **Weekly Inspections:** 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.

15. 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.

16. Guests are prohibited from ordering cable or internet while residing at Family Care Center.

17. **Sheets and mattress protectors are to be kept on the beds**. Under no circumstances is anyone allowed to sleep on our mattresses without a mattress protector and fitted sheet. If needed, sheets will be provided by the office. Bed pillows and not sofa pillows must be used for sleeping.

18. No stickers or pictures are to be hung on the walls or furniture.

19. 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.

20. Mutual respect of Family Care Center staff and guests is required.

21. 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.

22. I agree not to hold the Family Care Center accountable for any accident or injury while a guest on the Family Care Center property.

23. Proper clothing attire is expected of all guests while in this program.

24. Family Care Center reserves the right to discharge any guest for failure to comply with program guidelines including failure to remove a firearm, and for violence of any kind.

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