Alliance for Housing and Healing

Application for Assistance

☐ CHOISS ☐ Group Home ☐ Housing Case Management

Last Name: _____ **First Name:** _____ MI_____ Also known as:_____

Social Security Number: _____-_____-_____ **Birth Date:** _____/_____/_____ **Mother's Maiden Name:**_____

Current Address: _____ City: _____ State: _____ Zip: _____

Move in Date:_____/_____/_____ **Birthplace** (City/State or Country): _____ **May we send mail to your home address?** ☐ **YES** ☐ **NO**

Phone #: (_____) _____-_____ Cell #: (_____) _____-_____ Other #: (_____) _____-_____ Email:_____

May we say we are calling from this agency? ☐ **YES** ☐ **NO** **May we leave a message?** ☐ **YES** ☐ **NO** **May we email?** ☐ **YES** ☐ **NO**

Mailing Address: _____ ***Apt. #:*** _____

*City:*_____ *State:*_____ *Zip:*_____ **May we send mail to your mailing address?** ☐ **YES** ☐ **NO**

Race *(check one)* ☐ Asian ☐ Asian/White ☐ Black/African American ☐ Black/African American and white ☐ Native American/Alaska Native ☐ White
☐ Native American/Alaska Native and Black ☐ Native American/Alaska Native and White ☐ Native Hawaiian or Other Pacific Islander ☐ Other multi-racial

Hispanic *(check one)* ☐ Hispanic ☐ Non-Hispanic **Language** ☐ English ☐ Spanish ☐ Other _____

Gender ☐ Male ☐ Female ☐ Transgender **Veteran** ☐ Yes ☐ No **Marital Status:**_____ **History of Domestic Violence** ☐ Yes ☐ No

PRIOR HOUSING Utilization
☐ Non-Housing (street, car, etc.)
# of episodes of homelessness past year _____
☐ Own Home
☐ Rental Housing
☐ Subsidized housing
Specify:_____
☐ Emergency Shelter
☐ Transitional Living
☐ Substance Abuse Facility
☐ Psychiatric Facility
☐ Hospice
☐ Jail/Prison
☐ Hospital
☐ Domestic Violence
☐ W/ Friends or Family
Other living situation_____

Current HOUSING Utilization
☐ Non-Housing (street, car, etc.)
# of episodes of homelessness past year _____
☐ Own Home
☐ Rental Housing
☐ Subsidized housing
Specify:_____
☐ Emergency Shelter
☐ Transitional Living
☐ Substance Abuse Facility
☐ Psychiatric Facility
☐ Hospice
☐ Jail/Prison
☐ Hospital
☐ Domestic Violence
☐ W/ Friends or Family
Other living situation_____

HOUSEHOLD information (list all other residents)

	Name	Relationship to Client	Gender	HIV Status	Date of Birth	Place of Birth
1.						
2.						
3.						
4.						

INCOME ☐ NO INCOME ☐ PENDING BENEFITS
☐ SSI $_____ /mo.
☐ SSDI $_____ /mo.
☐ SDI $_____ /mo.
☐ GR $_____ /mo.
☐ CalWorks $_____ /mo.
☐ Food Stamps $_____ /mo.

☐ Wages/Employment Income $_____ /mo.
☐ Unemployment Insurance $_____ /mo.
☐ VA Benefits $_____ /mo.
☐ Other Income 1 $_____ /mo.
☐ Other Income 2 $_____ /mo.
Total Income $_____ /mo.

MEDICAL INSURANCE ☐ Medi-Cal ☐ Medicare ☐ ADAP ☐ Private Insurance ☐ VA Insurance ☐ No medical insurance

SECOND DX
Mental Illness: ☐ No ☐ Yes Type:_____
Physical Disability: ☐ No ☐ Yes Type:_____
Alcohol or Drug abuse: ☐ No ☐ Yes Drug Type:_____

Is client sober? ☐ No ☐ Yes Length of Sobriety: _____
Ambulatory: ☐ No ☐ Yes
Describe ambulatory issue_____

I attest that all of the above information is true and correct to the best of my knowledge. I understand that all of the information I have supplied above is confidential and for the sole use of THE SERRA PROJECT and/or Aid For AIDS.

Client Signature:_____ Date_____

REFERRING AGENCY
Provider Name:_____ Date_____

Agency: _____ Telephone: _____ Email: _____