

**New Creations Inn
Residential Application**

Today's Date

Applicant's Information

Name: _____ Age: _____
 Last First Middle

Driver's License Number: _____ DOB: _____

SSN: _____ Marital Status: _____

Contact Information

Current Address: _____

City: _____ State: _____ Zip Code: _____

Current Living Situation (i.e. family, friends, shelter): _____

Current Phone Number: _____

Message Number: _____ May we leave a confidential voicemail? _____

References:

Please provide two references for us to contact. References may be friends, family members, employers, etc..

Name: _____

Address: _____

Telephone: _____ Relationship to you: _____

Name: _____

Address: _____

Telephone: _____ Relationship to you: _____

Work History

Employment (proof is required)

Currently Employed: Yes No

How Many Hours Worked Last Week: _____

Type of Work: Permanent Temporary Seasonal Contract Based

If not employed, are you looking for work: Yes No

Are you unable to work: Yes No If yes, please explain:

Please list current or last employer

Current or Previous Employer: _____

Address _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Supervisor's Name: _____

Position and Duties: _____

Dates Employed _____

Reason for Leaving: _____

Income From Work & Other Sources (All)

Received Income From Work Last Month: Yes No

Amount of Income Received From Employment Last Month: \$ _____

Received Income From Other Sources: Yes No (Proof is Required)

1) Unemployment:	\$ _____	9) Retirement from Social Security:	\$ _____
2) Supplemental Security Income:	\$ _____	10) Veteran's Pension:	\$ _____
3) Social Security Disability Income:	\$ _____	11) Pension from Former Job:	\$ _____
4) Veteran's Disability Payment:	\$ _____	12) Child Support:	\$ _____
5) Private Disability Insurance:	\$ _____	13) Alimony/Other Spousal Support:	\$ _____
6) Worker's Compensation:	\$ _____	14) Aid to the Needy and Disabled	\$ _____
7) Temporary Assist for Needy Families:	\$ _____	15) Old Age Pension (OAP)	\$ _____
8) General Assistance:	\$ _____	16) Other Sources: Describe _____	\$ _____

Non-Cash Benefits (Proof is Required)

	Eligible	Application Submitted	Currently Receiving	Past Recipient	Not Receiving
Food Stamps Amount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid Health Insurance Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicare Health Insurance Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State Children's Health Insurance Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women Infants Children, WIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veteran's VA Medical Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TANF Child Care Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TANF Transportation Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TANF Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rental Assistance, Section 8, Housing Vouchers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Benefit sources? _____

Total Monthly Cash Income: _____

Total Monthly Expenses: _____

Source	Amount
_____	_____
_____	_____
_____	_____
_____	_____

Education

Highest level of Education completed _____

High School Diploma Yes No Year Graduated _____ Location _____

GED Certificate Yes No

Are you currently in school Yes No

Vocational or Apprenticeship Certificate: Yes No

Special Training or Skills: _____

Domestic Violence

Have you ever been involved in a domestic violence incident? _____

If so how recent: _____

Describe incident:

Military Background

Served/Serving U.S. Military (*veteran*) Yes No

Branch Served _____

Dates Served: _____

Type of Discharge Received: _____

Health Information

General Health (*choose one*): Excellent Very Good Good Fair Poor

Currently Pregnant? Yes No Don't Know

If yes, what is the due date: ____/____/_____(MM/DD/YYYY)

Physical or Developmental Disability (please describe):

Your medical provider and Doctor's name _____

Medical Insurance Provider and Insurance Number _____

Mental Health Diagnosis (please include current history, current symptoms and treatment plan)

Mental Health Provider and Doctor's name: _____

Other Care Providers: _____

How long have you been in treatment: _____

Prescriptions Medications

Please list all of you prescription medications and what they are used for:

Substance Use History

A. Alcohol

1. When was the last time you had something alcoholic to drink? _____
2. How much do you drink at one time? _____
3. How many times did you drink last month? _____
4. Is there a history of alcoholism in your family? _____
5. Has drinking ever caused any problems for you? _____
6. Have you ever been through an alcohol treatment program? Yes No
If yes, when and where? _____

B. Drugs

1. Have you ever used street drugs? Yes No
If yes, which drugs have you used? _____
2. When was the last time you used drugs?

3. Have you ever been through a drug treatment program? Yes No
If yes, when and where? _____

Legal Background

Have you ever been arrested? Yes No What county? _____

Have you ever been convicted? Yes No

Are you currently on probation\parole Yes No What county? _____

Name and telephone number of Officer _____

If you answered **yes** to any of the above, please give **the date and circumstances for each**. Please note that answering **yes** to any of the previous questions will not necessarily disqualify you from New Creations Inn program.

Are you currently incarcerated? ____ yes ____ no What facility? _____
Name and telephone number of case manager: _____

Spiritual Life (Please answer questions thoughtfully on a separate piece of paper)

1. What challenges or roadblocks do you seem to continually struggle with?
2. **Why** do you want to be part of this program?

Have you read the New Creations Inn Program Manual? ____ yes ____ no

Please attach a letter explaining why you want to be in the Transitional Housing Program and what goals you want to achieve during the program.

I certify that this application is accurate and complete to the best of my knowledge. I hereby release the above references and caregivers from confidentiality with the staff of New Creations Inn for the purpose of discussing my relationship with the references and caregivers, any previous therapy/treatment, and any items disclosed in this application. I also release the staff of New Creations Inn from confidentiality for the same purpose with the above named organizations and/or persons. I understand that New Creations Inn adheres to the posted privacy statement, which explains the rights to my information.

Name

Date