# Mercy Center for Women Application for Housing

Name: SS#:

Date of Birth: Age:

Phone #: Alt. Phone #:

Current Address:

How long have you been at this address? Discharge date:

Interview Dates: #1:

#2:

Arrival:

Referred By (agency):

Marital Status: Maiden Name:

Natural Disaster Domestic Violence Release from Hospital Building condemned/renovated Family Dispute Release from DA treatment Overcrowding Runaway/Abandoned Release from Jail

Evicted Release from MH In Transition Other

**Ethnic Group:** Black Asian

White Native American Bi Racial

Hispanic None Hispanic

Children **coming** to Mercy Center

# Children

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Birth date | Age | Sex | SS # |
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Fathers Name/ Age/ Relationship:

Any special needs or concerns:

Children **not** currently in your custody

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| --- | --- | --- | --- | --- |
| Name | Birth date | Age | Sex | SS # |
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Fathers Name/ Age/ Relationship:

Any special needs or concerns:

Are you Pregnant? Yes No Due Date: Attending Physician:

**Involvement with Office of Children & Youth**

Yes No

Caseworker Name: Phone Number: Date of involvement:

Are you having regular visits with your children: Circumstances surrounding the case: \_

**Past/ Current Services the Children are Involved With**

**Childs Name**: Date involved:

**Agency & Counselor Name**: Phone #

Reason for Involvement:

**Childs Name**: Date involved:

**Agency & Counselor Name**: Phone #

Reason for Involvement:

**Childs Name**: Date involved:

**Agency & Counselor Name**: Phone #

Reason for Involvement:

**Childs Name**: Date involved:

**Agency & Counselor Name**: Phone #

Reason for Involvement:

**Relationship History**

( ) Not currently in a relationship

( ) Currently in a serious relationship

Person’s name:

How long in relationship:

Describe any past or current significant issues such as Domestic Violence in this relationship or past relationships:

\_

**Domestic Violence History**

Have you ever filed a protection from abuse order against anyone? Yes No Have you ever had a PFA ordered against you? Yes No

If yes, list date and name of the person involved:

Describe the situation of the abuse:

Childhood/ Family History:

**Education History**

Regular or Learning Support Classes: Highest grade completed: Degree: Where did you go to school:

Do you have a GED? Yes No Are you interested in getting your GED? Yes No

If applicable, why did you not finish High School:

**Employment History**

**Are you currently employed? Yes or No**

If no, are you looking for work? Yes or No

**Two Most Recent Jobs**

Employer: Dates:

Address: Responsibilities: Why did you leave:

Employer: Dates:

Address: Responsibilities: Why did you leave:

**No Income ( )**

**Income**

**Income Information**: List amount per month or week

SSI/SSDI $ DPW $

Food Stamps $

Child Support $ Other $

Other $

Total Monthly Income:

**Debts / Monthly Expenses:**

Gas $

Electric $

Rent $ Credit Cards $ Cable $

Telephone $ Cell Phone $ School Loans $ Loans $

Other $

Luxuries $

Fines $ Medical expenses $ Restitutions $ Other $

Total Monthly Expenses:

Total Debt:

**Medical History**

How would you describe current physical health: ( ) Good ( ) Fair ( ) Poor

**Primary Care Physician**:

Name Phone Address

Medical Card / Insurance:

**Mental Health**

Have you ever had a psychiatric evaluation or been diagnosed with an SMI? Yes No If yes, please give details

Have you ever tried to harm yourself? How many times? If yes, please give details:

Family Mental Health History:

**Inpatient Mental Health Treatment History** Have you ever had an Inpatient Stay at a BH HOSPITAL? Yes No If yes, on how many occasions .

1. Facility Name City/State SMI Diagnosis

Dates of Stay Aftercare Plan

2. Facility Name City/State SMI Diagnosis

Dates of Stay Aftercare Plan

3. Facility Name City/State SMI Diagnosis

Dates of Stay Aftercare Plan

**All current or prior medication usage**

**Medications Dosage Condition/Reason**

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**Drug & Alcohol History**

**Clean Date**:

Drug of choice:

Primary: Secondary: \_

What is your longest clean time?

When was it?

How old were you when you first started getting high? What happened that you started to use drugs or alcohol?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Substances used:**  (Check all that apply) | **First use age** | **Last use age** | **Frequency** | **Amount** |
| ( ) Alcohol |  |  |  |  |
| ( ) Meth Amphetamines |  |  |  |  |
| ( ) Cocaine |  |  |  |  |
| ( ) Crack cocaine |  |  |  |  |
| ( ) Marijuana/Weed |  |  |  |  |
| ( ) Heroin |  |  |  |  |
| ( ) Benzos |  |  |  |  |
| ( ) Opiate |  |  |  |  |
| ( ) Other |  |  |  |  |

**List Drug and Alcohol treatment facilities starting with current or most recent**

Facility Name: Counselor Name: Did you complete the program?

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Facility Name:

Counselor Name: Did you complete the program?

Date involved: Phone #

Date involved: Phone #

Date involved: Phone #

Date involved: Phone #

**Do you attend meetings (AA/NA)? Yes or No**

How often \_

Do you have a sponsor? Yes or No

Why do you want to remain clean and sober? What is different this time?

\_

**Legal / Criminal History**

Have you ever been incarcerated? Yes No If yes, list dates, where and what for:

Do you have any **pending** charges?

Are you currently on parole or probation? Yes No

If yes, list officer’s name and contact phone #:

**Homeless History**

List Shelter Stays for the last 3 years Dates and Agencies

**Rental History / Time Line**

Starting with the most recent for the last 3 years Must give dates

**More About You**

How do you handle anger or situations that are frustrating?

What/ Who in your life do you look to for support?

What are some of your goals?

1.

2.

3.

4.

5.

In which areas of your life do you feel like you need the most help with?

1.

2.

3.

4.

5. Why do you want to come to MCW?

Contacts / Agency Involvement

List all agencies in which you are currently involved with, e.g. OCY, Family Services, MH Counselors, D/A Counseling, education, law enforcement, etc:

**Agency**: Time Period:

Case Worker / Counselor:

**Agency**: Time Period:

Case Worker / Counselor:

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Case Worker / Counselor:

**Agency**: Time Period:

Case Worker / Counselor:

**Agency**: Time Period:

Case Worker / Counselor:

**Agency**: Time Period:

Case Worker / Counselor:

**Currently seeing a Counselor, Psychiatrist or Therapist** Name Dates of contact

Agency Phone Number

Name Dates of contact

Agency Phone Number

**Prior outpatient counseling**

Name Dates of contact

Agency Phone Number

Do you have a **BCM**?

Name

Agency

Phone Number

List any relatives or friends MCW could contact as a reference:

Name: Relation: Phone #

Name: Relation: Phone #

Name: Relation: Phone #

I certify that the information provided on this application is true, complete and correctly stated. I understand that any deliberate misstatement or omission can be cause for my application being denied or for my immediate dismissal from the program.

Applicant Signature Date

Staff Signature Date

**Treatment Facilities who need their release signed:**

* **Cove Forge Behavioral Health System**:
  + Williamsburg
  + White Deer Run/Cove Forge
  + Bowling Green Brandywine
* PYRAMID HELTHCARE, INC Erie
* UPMC WPIC (Warren Psych Hospital)
* Gaudenzia and Community House

## USDA Nondiscrimination Statement

SNAP and FDPIR State or local agencies, and their subrecipients, must post the following Nondiscrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies,

the USDA, its Agencies, offices, and employees, and institutions participating in or administering

USDA programs are prohibited from discriminating based on race,

color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights

1400 Independence Avenue, SW Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: [program.intake@usda.gov.](mailto:program.intake@usda.gov)

This institution is an equal opportunity provider.

## USDA Nondiscrimination Statement (Continued)

For all other FNS nutrition assistance programs, State or local agencies, and their subrecipients, must post the following Nondiscrimination Statement:

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color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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## USDA Nondiscrimination Statement (Continued)

Joint Application Form (HHS)

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Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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(3) email: [program.intake@usda.gov.](mailto:program.intake@usda.gov)

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: SNAP Hotline.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403

(voice) or (800) 537-7697 (TTY).

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