Mercy Center for Women
Application for Housing

Name:_____ Phone #: _____

SS#: _____ Alt. Phone #: _____

Date of Birth: _____ Current Address: _____

Age: _____ _____

How long have you been at this address? _____

Discharge date: _____

Interview Dates: #1: _____ #2: _____ Arrival: _____

Referred By (agency): _____

Marital Status:_____ Maiden Name: _____

Natural Disaster
Building condemned/renovated
Overcrowding
Evicted
Other_____

Domestic Violence
Family Dispute
Runaway/Abandoned
Release from MH

Release from Hospital
Release from DA treatment
Release from Jail
In Transition

Ethnic Group: Black Asian
White Native American Biracial

Hispanic
Non-Hispanic

Children

Children **coming** to Mercy Center

Name	Birth date	Age	Sex	SS #

Fathers Name/ Age/ Relationship:

_____

_____

_____

Any special needs or concerns:

_____

_____

Children **not** currently in your custody

Name	Birth date	Age	Sex	SS #

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: _____

Income

No Income ( )

Income Information: List amount per month or week

SSI/SSDI $_____ Child Support $_____

DPW $_____ Other $_____

Food Stamps $ _____ Other $_____

Total Monthly Income: _____

Debts / Monthly Expenses:

Gas	$_____	Telephone	$_____	Luxuries	$_____
Electric	$_____	Cell Phone	$_____	Fines	$_____
Rent	$_____	School Loans	$_____	Medical expenses	$_____
Credit Cards	$_____	Loans	$_____	Restitutions	$_____
Cable	$ _____	Other	$ _____	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

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: _____ Date involved: _____

Counselor Name: _____ Phone #_____

Did you complete the program? _____

Facility Name: _____ Date involved: _____

Counselor Name: _____ Phone #_____

Did you complete the program? _____

Facility Name: _____ Date involved: _____

Counselor Name: _____ Phone #_____

Did you complete the program? _____

Facility Name: _____ Date involved: _____

Counselor Name: _____ Phone #_____

Did you complete the program? _____

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 arrested, convicted, and/or incarcerated?

Yes No

If yes, list dates, where and what for:

Do you have any **pending** charges?

Are you currently or have been 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 / Timeline

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:_____

Agency:_____ Time Period:_____

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_____ Agency_____

Dates of contact_____ Phone Number_____

Name_____ Agency_____

Dates of contact_____ Phone Number_____

Prior outpatient counseling

Name_____ Agency_____

Dates of contact_____ 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.

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:

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, 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)

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination 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.

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Washington, D.C. 20250-9410

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

(3) email: 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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