TLP/SHP
Admission Application

For Service Coordinator to complete:

Name of Service Coordinator:_____ Youth ID#: _____Type of Funding: _____

Date of Assessment: _____ Anticipated Admission Date: _____

Personal Information

Last Name: _____First Name: _____Middle Name:_____

Work Phone Number: _____ Home Phone Number: _____

Email Address:_____ Preferred Method of Contact:_____

Age: _____ Birth Date: _____ Place of Birth (City, State):_____

Date of Application: _____

Race: ___ African American ___ American Indian ___ Asian ___Hispanic
___White ___Selection not provided

Tribal Affiliation: _____

Ethnicity: ___Non-Hispanic/Latino ___ Hispanic/Latino ___ Selection not provided

Sexual Orientation: ___ Bisexual ___ Gay ___ Heterosexual ___ Other
Gender Identity: ___ Male ___ Female ___ Transgender ___ Other
Preferred Pronoun (i.e. he, she, they):_____

Do you have children: ___ Yes ___ No
If so, names and ages of children:
_____

Social Security Number (if applicable): _____

State Identification / Driver's License Number: _____

Primary Language: _____ Other Languages: _____

Which of the following best describes the last place that you slept:

- Emergency Shelter, including Hotel or Motel Paid for with an Emergency Shelter Voucher
- Foster Care Home or Foster Care Group Home
- Hospital or Other Residential Non-Psychiatric Medical Facility
- Hotel or Motel Paid for without an Emergency Shelter Voucher
- Jail, Prison, or Juvenile Detention Facility
- Long-Term Care Facility or Nursing Home
- Permanent Housing for Formerly Homeless Persons (e.g., CoC project, HUD legacy programs, HOPWA PH)
- Place Not Meant for Habitation (e.g., Vehicle, Abandoned Building, Bus/Train/Subway Station/ Airport, Outside Anywhere)
- Psychiatric Hospital or Other Psychiatric Facility
- 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 (incl. Homeless Youth)
- **RENTAL** by Client, **No** Housing Subsidy
- **RENTAL** by Client with **VASH** Housing Subsidy
- **RENTAL** by Client with **GDP TIP** Subsidy
- **RENTAL** by Client with **Other** Ongoing Housing Subsidy
- **HOME OWNED** by Client, **No** Ongoing Housing Subsidy
- **HOME OWNED** by Client, **With** Ongoing Housing Subsidy
- Client Doesn't Know
- Other _____

  If Other, specify: _____

Current Relationship Status: Single: ____ Married: ____ Divorced: ____ Separated: _____

Are you currently in a relationship with anyone? Yes_____No _____
If yes, how long? _____

Are you currently on probation or have you ever been in trouble with the law? ___ Yes ___ No
If yes, please explain: _____
_____

Contact Person in Case of Emergency:

Name: _____ Relationship to you:_____

Address: _____ Phone Number: _____

Name of Social Worker (if applicable) _____ Phone Number: _____

Social Assessment Information

Please answer all questions, leaving no question blank. You may not have definite answers now, but write what you believe to be true.

1 .Who referred you to Casa de Libertad?

___ Self Referral ___ Street Outreach ___ Temporary Shelter
___ Residential Program ___ Juvenile Justice ___ Law Enforcement
___ Friend ___ Other Community Agency

2. Describe what the last three months have been like for yourself and/or your child?

Please describe: living arrangement, employment, health, and relationships/family support, transportation, etc.

_____
_____
_____
_____
_____

3. Why have you decided to apply for the program? What do you hope to gain?

_____
_____
_____
_____

Medical Information

1. Do you have physical or mental disabilities or limitations? Yes_____ No _____

2. Have you ever had a traumatic brain injury? Yes_____ No _____
   If yes, please describe:

_____
_____
_____
_____

3. Are you currently taking any medication? Yes _____ No _____
   If yes, please list:

_____
_____
_____
_____
_____

Counseling

1. Have you been in another residence, hospital, or treatment center in the past?
   Yes _____ No _____
   If yes, when, where, and for what purpose?

_____
_____

2. Have you ever visited with a psychologist, counselor, or therapist in the past?
   Yes _____ No _____
   If yes, when, with whom, and for what purpose:

_____
_____
_____

3. Do you have a history of suicide attempts or self-harming behavior? Yes ____ No ___
   If yes, Please give additional information (i.e. when, how, and why): _____

_____
_____
_____

Please check all that apply to you now or have applied to you in the past:

( ) Sexually abused
( ) Physically abused
( ) Emotionally abused
( ) Drug abuse/ Alcohol abuse
( ) Depression
( ) Can not talk openly w/parent(s)
( ) Problems in school
( ) Problems living independently
( ) Confused about what to do in life
( ) Under a lot of stress

Behavioral Information

1. What does is it look like when you are angry?

_____
_____
_____

2. What does is it look like when you are sad?

_____
_____
_____

3. How would you prefer the staff to respond when you are angry or sad?

_____
_____
_____

4. How will you manage your anger so that you do not become out of control or involve the other residents in your feelings?

_____
_____

Educational Information

School Status: __currently in school __in a GED program __ graduated __dropped out

Special Education: ___Yes ___No

Completed formal education: _____ Grade Level completed
_____ High School Diploma
_____ GED
_____ Years of college
_____ College diploma
_____ Other: _____

High School or College attended: _____

Average grades attained: _____

Favorite Subjects: _____

Least Favorite Subjects: _____

Vocational Training: _____

Employment

Do you currently have a job? Yes___ No___
If no, are you looking for work? Yes___ No___
If yes, how long have you worked at your current job? _____
What is your job? _____ How many hours do you work per week? ____

Personal Income: $_____per: ____ Hour ____ Week ___ Month ___ Year

If you have worked in the past, please describe the employment history (this would include what kind of jobs, dates of employment):

_____
_____
_____

If you are currently employed please list your work schedule:

_____
_____

What kinds of employment are you interested in finding?

_____
_____

Family Information

Is your **biological mother** alive today? ____ Yes ____ No

Name:_____

Address: _____

Phone Number: _____

HOW is your relationship with your mother? _____

Is your **biological father** alive today? _____ Yes ____No

Name:_____

Address: _____

Phone Number: _____

HOW is your relationship with your father? _____

Please list any other significant family members or friends who have been a source of support to you:

Name: _____ Relationship to you: _____

Address: _____ Phone number: _____

Name: _____ Relationship to you:_____

Address: _____ Phone number: _____

Name: _____ Relationship to you: _____

Address: _____ Phone number: _____

Goals

What are your educational goals?

1._____
2._____
3._____

What are your employment goals?

1._____
2._____
3._____

What are your interests or hobbies?

1._____
2._____
3._____

Are there any classes or programs that you want to start, or activities that you would like to do more of? (i.e. a fitness class, read more books, join soccer team)

_____
_____
_____

What life skills are important for you to learn right now?

1._____
2._____
3._____

What do you feel is your greatest challenge in life?

_____
_____
_____

How can this Transitional Living Program help you through this challenge?

_____
_____
_____

(TLP can only accept a parenting applicant with one child)

Child(rens) name(s) (Please attach additional sheet if the respondent has more children)

Name: _____ Sex: ___M ___ F

Date of birth M/D/Y: _____ Place of birth city/state:_____

Social Security Number: _____ Ethnicity: _____

Child's mother/father (*the other parent*):

Last name: _____ First name: _____ M.I. __

Nickname: _____ Nationality/Ethnicity: _____

Address: _____

Phone: _____

Describe the relationship between you and your child (i.e. custody, time spent with child, activities you do with your child):

_____
_____
_____

Describe the relationship between the other parent and your child:

_____
_____
_____

Describe the relationship between you and the other parent of the child:

_____
_____
_____

Does your child(ren) have physical or mental disabilities or limitations? Yes ___ No ___
If yes, please describe:

_____
_____
_____

Medications taken by your child(ren)? Please list and state their purpose:

_____
_____
_____

Any medication, food, insect, or other allergies for your child(ren)? If yes, please list and describe:

_____
_____
_____

Emotional Needs:

_____
_____

Intellectual/School needs:

_____
_____

Are you willing to participate in case management, health interventions, and education with the Pregnant and Parenting Youth Coordinator?

_____
_____

Is there anything additional you would like us to know about you or your child(ren)?

_____
_____