

KRISTA TRANSITIONAL HOUSING APPLICATION

NAME: _____ DATE: _____
LAST FIRST MI

ADDRESS: _____
STREET CITY STATE ZIP CODE

BIRTHDATE: _____ HOME PHONE: _____
MONTH/DAY/YEAR

SEX [] [] SOCIAL SECURITY #: _____
MALE FEMALE

FOSTER PARENT OR PLACEMENT NAME: _____

HOW LONG HAVE YOU BEEN AT YOUR CURRENT PLACEMENT? _____
YEARS MONTHS

LIST PREVIOUS PLACEMENT(S): _____

PROBATION OFFICER:

SOCIAL WORKER:

NAME

NAME

PHONE

PHONE

IF SELECTED, WHEN WOULD YOU BE AVAILABLE TO MOVE IN? _____

WHO IS YOUR I.L.S. WORKER? _____
NAME PHONE #

EDUCATION

GRADE LEVEL: _____ NUMBER OF UNITS COMPLETED: _____

WHEN DO YOU GRADUATE? _____

SCHOOL CURRENTLY ATTENDING? _____

NAME

ADDRESS

PHONE #

CONTACT PERSON

IF NECESSARY, ARE YOU WILLING TO CHANGE HIGH SCHOOLS TO BE PART OF THIS PROGRAM? _____ IF NO, PLEASE EXPLAIN: _____

WHAT ARE YOUR FUTURE EDUCATION/VOCATIONAL GOALS?

EMPLOYMENT

Please list most current information first.

FROM

TO

EMPLOYER NAME

POSITION

ADDRESS

PHONE#

SUPERVISOR

FROM

TO

EMPLOYER NAME

POSITION

ADDRESS

PHONE#

SUPERVISOR

WHAT ARE YOUR JOB/CAREER GOALS?

MEDICAL

When was your last C.H.D.P. exam? _____

Dental exam? _____

Vision exam? _____

List any medical condition you have including dental and visual. _____

(Females) Are you using any form of birth control?

Are you taking medication? If so, list what you take and how often.

Tell me about your mental health history. _____

List your drug and alcohol use and age used.

_____	AGE _____	_____	AGE _____
_____	AGE _____	_____	AGE _____
_____	AGE _____	_____	AGE _____

Are you currently or have you been in a drug/alcohol counseling program? If so, where, when, and with whom? _____

Physician's Name: _____ Phone#: _____

Dentist's name: _____ Phone#: _____

Optometrist's Name: _____ Phone#: _____

Mental health provider's name: _____ Phone#: _____

Therapist or counselor's name: _____ Phone#: _____

LEGAL

Have you ever been arrested? Yes_____ No_____

What were you arrested for and how old were you? _____

What else would you like us to know about you? _____

Convince us why we should accept you for this program. Tell us your strengths and how they will help you succeed in T.H.P.P.

*We will not discriminate based on race, gender, sexual orientation, or disability.

The above information is true. I understand that if I purposefully leave out information, I may be turned down for this program.

SIGNED

DATE