



SHELTER/HOUSING APPLICATION

(Check all you want to apply for. See attached page for descriptions.)

__RR Crossings __Kelly Shelter __Hope Village __Restart Retreat (__1 BR __2 BR) __Housing Retreat (__1 BR __2 BR)

Head of Households full name: _____ Alias _____ Date Received: _____

Mailing Address: (INCLUDE City, State and Zip Code) _____

Email Address: _____ Phone #: _____ Text OK? Y / N

UNIVERSAL DATA ELEMENTS	Individual 1	Individual 2	Individual 3	Individual 4	Individual 5
SERVICEPOINT ID NUMBER					
First Name					
Last Name					
Social Security Number					
Are you a US Military Veteran	Yes / No				
Date of Birth	/ /	/ /	/ /	/ /	/ /
GENDER: (Write Red letter for each person) Woman or Girl (if child) M an or Boy (if child) Culturally Specific Identity (e.g., Two Spirit) OR Different Identity (Write Identity for each person) NB (Non-Binary) T (Transgender) Q (Questioning) DKN (Doesn't Know) PNA (Prefers not to answer)					
SEXUAL ORIENTATION: (Write Red letter for each person) Heterosexual G ay L esbian B isexual Questioning/Unsure O ther (Write what other is) DKN (Doesn't Know) PNA (Prefers not to answer)					
American Indian/Alaskan Native/Indigenous					
Asian or Asian American					
Black, African American or African					
Hispanic/Latina/e/o					
Middle Eastern or North African					
Native Hawaiian or Pacific Islander					
White					
Client doesn't know					
Client prefers not to answer					

FOR ROGUE RETREAT USE ONLY:

Rogue Retreat Employee that checked application

Print Name:

HOUSEHOLD TYPE:

SI Single Individual FSP Female Single Parent GPC Grandparent(s) and Child
 CNC Couple No Children MSP Male Single Parent FP Foster Parent(s)
 TPF Two Parent Family NCC Non-Custodial Caregiver(s)

What is your relationship to the head of household?

SELF

HISTORY OF HOMELESSNESS

Where did you (and your family if they are with you) spend the night last night? (please be specific, you do not need to disclose your location but please indicate where.) Examples: Emergency Shelter, Hospital, Jail, Place not meant for habitation (Camp, Street, Car etc.), With Family or Friends.

Length of stay in the place above (How long in a row, this homeless episode? One day or Less 2 days to one week
 More than a week, less than a month 1-3 months More than 3 months, less than a year One year or longer
 Doesn't Know Refused

Approximate date THIS PERIOD of homelessness started?	/ /	/ /	/ /	/ /	/ /
How many times have you been on the streets, in ES, or SH in the past three years including today?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+
Total number of months experiencing homelessness in the last three years?					

Have you ever received services from Rogue Retreat? **Circle one** Yes / No

Do you have a service animal or pet? If yes, what kind of animal and how many?

Yes / No : How many? _____ Kinds: _____

HEALTH INSURANCE

Do you have Health Insurance? DKN (Don't Know) PNA (Prefer not to answer)	<input type="checkbox"/> Yes <input type="checkbox"/> DKN <input type="checkbox"/> No <input type="checkbox"/> PNA	<input type="checkbox"/> Yes <input type="checkbox"/> DKN <input type="checkbox"/> No <input type="checkbox"/> PNA	<input type="checkbox"/> Yes <input type="checkbox"/> DKN <input type="checkbox"/> No <input type="checkbox"/> PNA	<input type="checkbox"/> Yes <input type="checkbox"/> DKN <input type="checkbox"/> No <input type="checkbox"/> PNA	<input type="checkbox"/> Yes <input type="checkbox"/> DKN <input type="checkbox"/> No <input type="checkbox"/> PNA
Check what type of Health Insurance	<input type="checkbox"/> Medicaid/OHP <input type="checkbox"/> Medicare <input type="checkbox"/> State Children HI <input type="checkbox"/> Veteran (VHA) <input type="checkbox"/> From Employer <input type="checkbox"/> Cobra <input type="checkbox"/> Private Pay <input type="checkbox"/> Indian Services <input type="checkbox"/> Other	<input type="checkbox"/> Medicaid/OHP <input type="checkbox"/> Medicare <input type="checkbox"/> State Children HI <input type="checkbox"/> Veteran (VHA) <input type="checkbox"/> From Employer <input type="checkbox"/> Cobra <input type="checkbox"/> Private Pay <input type="checkbox"/> Indian Services <input type="checkbox"/> Other	<input type="checkbox"/> Medicaid/OHP <input type="checkbox"/> Medicare <input type="checkbox"/> State Children HI <input type="checkbox"/> Veteran (VHA) <input type="checkbox"/> From Employer <input type="checkbox"/> Cobra <input type="checkbox"/> Private Pay <input type="checkbox"/> Indian Services <input type="checkbox"/> Other	<input type="checkbox"/> Medicaid/OHP <input type="checkbox"/> Medicare <input type="checkbox"/> State Children HI <input type="checkbox"/> Veteran (VHA) <input type="checkbox"/> From Employer <input type="checkbox"/> Cobra <input type="checkbox"/> Private Pay <input type="checkbox"/> Indian Services <input type="checkbox"/> Other	<input type="checkbox"/> Medicaid/OHP <input type="checkbox"/> Medicare <input type="checkbox"/> State Children HI <input type="checkbox"/> Veteran (VHA) <input type="checkbox"/> From Employer <input type="checkbox"/> Cobra <input type="checkbox"/> Private Pay <input type="checkbox"/> Indian Services <input type="checkbox"/> Other

IS TRANSLANTION ASSISTANCE NEEDED FOR HEAD OF HOUSEHOLD?
 YES (Check Language) ___ NO ___ DON'T KNOW ___ PREFER NOT TO ANSWER

- Arabic Spanish Afrikaans American Sign Language Black American Sign Language Chinese French Tlingit Ukrainian
 Different Preferred Language

DISABILITY STATUS

Do You Have a Disabling Condition? (Check all that apply below)	Yes / No				
Alcohol Use Disorder (HUD)					
Drug Use Disorder (HUD)					
Both Alcohol and Drug Use Disorder (HUD)					
Developmental (HUD)					
HIV / AIDS (HUD)					
Mental Health Disorder (HUD)					
Physical					
Chronic Health Condition (HUD)					

PROJECT SPECIFIC ADDITIONAL INFORMATION

If applying to Kelly Shelter can you use top bunk?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
If applying for other projects does ANY PERSON in your family require special features?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
IF SO WHAT ARE THEY?	<input type="checkbox"/> Grab Rails	<input type="checkbox"/> No Stairs	<input type="checkbox"/> Hearing Impaired Smoke Detectors		
	Other				
How long have you resided in Jackson County?					

NON-CASH BENEFITS

Do you receive Food Stamps?	Y / N \$				
Do you receive WIC?	Y / N \$				

INCOME

Do you receive any reliable income each month	Yes / No				
What is your source of income?					
Is there any other source of income?					
Is there any other source of income? If so what?					
How much total income each month?	\$	\$	\$	\$	\$

By signing this application I understand that the information I provide will be entered into the ServicePoint HMIS database and my records will be updated as I receive services. I ___ GIVE ___ DO NOT GIVE my permission to share this data with local agencies to better provide me care.

Signature: _____

Date: _____

