Cedars HOPE, Inc.
RESIDENT APPLICATION

REFERRING AGECNY INFORMATION		
Agency Name:		
Agency address:		
Phone:		Fax:
City:	State:	ZIP Code:
Referring Person Name:		
Contact Email Address:		Date of Referral: / /

APPLICANT INFORMATION		
Name:		
Date of birth: / /	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:

EMERGENCY CONTACT		
Emergency contact name (1):		
Contact address:		
City:	State:	ZIP Code:
Email:	Phone:	Relationship:
Emergency contact name (2):		
Contact address:		
City:	State:	ZIP Code:
Email:	Phone:	Relationship:

FAMILY CONTACT INFORMATION		
Name of a relative not residing with you:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		Last date of contact: / /

PERSONAL INFORMATION		
Race: ☐ White, Non-Hispanic ☐ Black, Non-Hispanic ☐ Native Hawaiian / Other Pacific Islander ☐ Asian ☐ American Indiana or Native American ☐ Other Ethnicity: ☐ Hispanic or Latino ☐ Black, Non-Hispanic	Current marital status: ☐ Single, Never Married ☐ Currently Married ☐ Divorced/Separated ☐ Widowed ☐ Currently living with significant other /domestic partner Veteran: ☐ Yes ☐ No Discharge status:	Children: ☐ No children ☐ Have children – older than 18 years ☐ Minor children living in client's custody ☐ Minor children, not living in client's custody with access ☐ Minor children, not living in client's custody with no access Number of children:
Primary Language:		☐ Does not speak English
Language Proficiency: ☐ Excellent ☐ Good ☐ Fair ☐ Poor		

Homeless situation: ☐ Person living on street ☐ Person coming from living on the street (and into a place meant for human habitation) ☐ Person coming from an emergency shelter for homeless persons ☐ Person coming from transitional housing for homeless persons ☐ Person being evicted from a private dwelling ☐ Person coming from a short-term stay in an institution who previously resided on the street or in an emergency shelter (been residing in the institution for less than 31 days) ☐ Person being discharged from a longer stay in an institution	Current education level: ☐ No formal education ☐ Completed grade school (grades 1-8) ☐ Some high school, no diploma ☐ HS diploma or GED ☐ Vocational/Technical training ☐ Some college, no degree ☐ Associate degree ☐ Bachelor degree ☐ Master degree ☐ Other ☐ Unknown

HOUSING INFORMATION

Current address:		
City:	State:	ZIP Code:
Own Rent (Please circle)	Monthly rent:	How long?
Previous address:		
City:	State:	ZIP Code:
Own Rent (Please circle)	Monthly rent:	How long?

EMPLOYMENT INFORMATION

Current employment: ☐ No employment ☐ Full-time ☐ Part-time ☐ Shelter work/training ☐ Volunteering ☐ Has previous job experience ☐ Other ☐ Unknown

Current or previous employer:		
Address:		How long?
City:	State:	ZIP Code:
Phone:	E-mail:	Fax:
Position:	Hourly Rate:	Annual income:
Volunteer Organization:		
Address:		How long?
City:	State:	ZIP Code:
Phone:	Position:	Contact:

Have you ever been evicted due to violent behavior or drug/alcohol issues? ☐ Yes ☐ No
If yes, please explain:

INCOME

Source	Monthly Amount
☐ Social Security	$
☐ SSI/SSDI	$
☐ TANF	$
☐ Food stamps	$
☐ Employment	$
☐ Unemployment	$
☐ Pension	$
☐ Veterans Benefits	$
☐ Other	$

Do you manage your own finances?
☐ Yes ☐ No

Do you have a representative payee?
☐ Yes ☐ No

If no, would you like Cedars HOPE to be your payee?
☐ Yes ☐ No

If applicable, provide name and address of payee:

Other information you would like us to know about your financial situation or concerns:

INSURANCE INFORMATION

Type(complete below): ☐ Medicaid ☐ Medicare ☐ Medicare Part D ☐ Private ☐ None

Medicaid number:	Medicare number:
Private insurance name:	Policy number:

LEGAL INFORMATION

Legal guardian/benefactor:

Address:		Phone:
City:	State:	ZIP Code:

Relationship:

Do you have: ☐ Power of attorney ☐ Living will ☐ Advance directive ☐ Irrevocable burial trust

Explain:

Current legal information: ☐ No apparent history of legal involvement ☐ No apparent legal involvement in the last 12 months ☐ Legal involvement in the last year, currently meeting all legal obligations ☐ Legal involvement in the last year, charges pending ☐ Periodic legal involvement, not meeting all legal obligations ☐ Released from incarceration in the past year ☐ Multiple arrests in the last year, or currently incarcerated ☐ Convicted of a felony in the past 7 years (Please explain below)	Check any that apply: ☐ Court Ordered Treatment ☐ Child Protective Services ☐ Adult Protective Services ☐ Assisted Outpatient Treatment ☐ Probation ☐ Parole ☐ Criminal Procedure ☐ Other (Please explain below)

Explain:

MEDICAL HISTORY

Last Exam	Last Date
☐ Physical Exam	/ /
☐ Dental Exam	/ /
☐ Eye Exam	/ /
☐ Hearing Exam	/ /
☐ Mammogram	/ /
☐ Pap smear	/ /
☐ Past surgery Type:	/ /
☐ Glasses or contacts	
☐ Dentures	

☐ No medical issues or symptoms
☐ Has some medical symptoms; will contact medical services (self)
☐ Has moderate medical symptoms; need to connect with medical services
☐ Experienced emergency room or hospital inpatient admissions (past 30 days)
☐ Needs immediate or ongoing medical care
☐ Planning to have surgery

Check all that apply: (circle)
☐ Headache/migraine
☐ Lung problems/ COPD/Asthma
☐ Diabetes
☐ Heart problems
☐ Seizures
☐ High blood pressure
☐ Chronic Pain
☐ Allergy
☐ Weight Concern
☐ Incontinent
☐ Impaired

☐ Hearing aids		When? / / Type:	hearing/deaf ☐ Impaired vision/blind ☐ Impaired speech ☐ Impaired walking ☐ Poor coordination ☐ Poor balance ☐ Require special medical equipment ☐ Other
Additional information:			
Physician Name:			
Dentist Name:			

MEDICATIONS		
Name of medication	Dose / frequency	Details (include oral/injection)

MEDICATION USE	
Check all statements that apply: ☐ Medication not prescribed/recommended ☐ Compliant with taking medication as prescribed ☐ Takes medication as prescribed--most of the time ☐ Sometimes takes medication as prescribed ☐ Rarely takes medication as prescribed ☐ Symptoms of mental illness interferes with taking medication ☐ Currently administer your own medication ☐ Need assistance/reminder to take medication ☐ Other	Please explain challenges with taking your medication:

MENTAL HEALTH HISTORY	
Current diagnosis:	
Psychiatric symptoms:	
Past psychiatric symptoms:	
Past or current drug and alcohol use? ☐ Yes ☐ No	If yes, please explain when you last used substances:
List all psychiatric hospitalizations (most recent visit first)	
Date: / /	Explain:
Date: / /	Explain:
Date: / /	Explain:

Date: / /	Explain:	
Date: / /	Explain:	
Outpatient Treatment Provider:		
Address:		Phone:
City:	State:	ZIP Code:
Name of Psychiatrist:		Phone:
Name of Therapist:		Phone:
Name of Case Manager:		Phone:
Explain treatment programs or groups attending currently or in the past 6 months:		

SAFETY INFORMATION	
Check the statement that applies: ☐ No apparent risk or history of harm to self or others ☐ No apparent risk or harm to self or others in the last 12 months ☐ Concerned about risk for harm to self or others, but no history of unsafe behavior (in the last 12 months) ☐ Recent harm to self or others; may need a safety plan	Please explain challenges:

DAILY LIVING SKILLS (CHECK ALL THAT APPLY)		
Community living	☐ Has not required assistance for more than 6 months; self-sufficient ☐ Has not required assistance in the last 3-6 months ☐ Requires assistance to live independently ☐ Plans to live in private housing in 3-6 months ☐ Plans to be self-sufficient in 3-6 months	Please explain:
Daily living	☐ Requires assistance with cooking ☐ Requires assistance with laundry ☐ Requires assistance with performing household chores ☐ Requires assistance with maintaining a clean living area (bedroom, bath room, etc.) ☐ Needs guidance to perform certain tasks ☐ Needs personal instruction to complete tasks ☐ Occasionally needs advice about certain tasks ☐ Depends on assistance from others ☐ Self-sufficient	Please explain:
Personal care	☐ Requires assistance with personal hygiene ☐ Requires assistance with dressing ☐ Depends on assistance from others ☐ Occasionally needs advice with personal hygiene issues ☐ Self-sufficient	Please explain:

Transportation	☐ Willing to use public transportation ☐ Requires assistance to use public transportation ☐ Depends on assistance from others ☐ Occasionally needs guidance to use public/private transportation ☐ Needs to know about all transportation options ☐ Maintains personal vehicle ☐ Self-sufficient	Please explain:
Social relationships	☐ Able to establish satisfactory relationships ☐ Requires assistance to establish satisfactory relationships ☐ Occasionally needs guidance to handle personal relationships ☐ Depends on assistance from others ☐ Would like to work on developing new relationships	Please explain:
Self-direction	☐ Requires assistance to make personal decisions ☐ Able to make decisions for myself ☐ Requires assistance to control self/impulsiveness ☐ Able to control self/impulsiveness ☐ Depends on assistance from others for self-direction and behavior	Please explain:
Please provide any additional information that you feel would be important for us to know about you:		
Please list you interests and hobbies:		

CONSENT INFORMATION	
I am the individual requesting services and agree to the submission of this information. ☐ Yes ☐ No	Initial: Date: / /
I received assistance with the completion of the application from my case manager or other applicant representative. ☐ Yes ☐ No Name and contact information of the person who helped complete this application:	Initial: Date: / /
I authorize Cedars HOPE, Inc. to verify the information provided on this form as to my personal, medical, and mental health history. ☐ Yes ☐ No	Initial: Date: / /
I authorize all physicians and mental health care providers to release any and all records in my file to Cedars HOPE, Inc. (including medical and psychological information protected under HIPAA). This information should only be shared with Cedars HOPE, Inc., or its designated representative. ☐ Yes ☐ No	Initial: Date: / /
By signing this application, I certify that the information provided is accurate to the best of my knowledge. I understand that providing false information can result in disqualification from the application process or dismissal from Cedars HOPE.	Initial: Date: / /
Signature of applicant: Printed name:	Date: / /
Signature of referring agency representative: Printed name:	Date: / /
Cedars HOPE representative: Printed name:	Date: / /

Please provide the following documentation with this application:

- ☐ Verification of psychiatric services, diagnosis, and treatment (submitted by provider)
- ☐ Documentation of income (if applicable)
- ☐ Documentation of health insurance (if applicable)
- ☐ Documentation of discharge by current housing agency (on agency letterhead)
- ☐ Referring Agency Agreement form

Mail application to Cedars HOPE, Inc. 527 W. Berry Street, Fort Wayne, IN 46802 or call us at (260) 420-3507.