HMIS #:

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA SRO HOUSING PROGRAM APPLICATION

To apply for housing at the Downtown YMCA Men's Residence complete this application. A complete application can be sent via email to Becca Duncan – rduncan@ymcacny.org or via fax at 315-474-6857. **All applications must have a copy of the applicant's photo ID and insurance cards.**

BACKGROUND INFORMATION

APPLICANT NAME:_____ **DATE:**_____

DATE OF BIRTH:_____ **AGE:**_____ **SOCIAL SECURITY #:**_____

PHONE NUMBER:_____ **E-MAIL:**_____

CURRENT (OR LAST) ADDRESS:_____

_____**(COUNTY)**_____

TYPE OF HOUSING AT CURRENT (OR LAST) ADDRESS

___ EMERGENCY SHELTER ___ OWN APARTMENT / HOUSE ___ JAIL / PRISON
___ SUBSTANCE TREATMENT / DETOX CENTER ___ LONG TERM CARE / NURSING HOME
___ TRANSITIONAL HOUSING ___ PERMANENT HOUSING (HUD) ___ HOSPITAL
___ TRANSIENT / LIVING ON STREETS ___ FAMILY / FRIEND ___ HOTEL /MOTEL
___ OTHER: _____

LENGTH OF STAY AT PREVIOUS OR CURRENT PLACE:_____

REASON FOR HOMELESSNESS AND/OR NEED FOR SUPPORTIVE HOUSING:_____

_____

REFERRED BY:_____ **PHONE NUMBER:**_____

DEMOGRAPHIC INFORMATION

___ AFRICAN AMERICAN ___ WHITE ___ HISPANIC/LATINO
___ ASIAN ___ NATIVE HAWAIIN/PACIFIC ISLANDER ___ INDIAN

ARE YOU A VETERAN? ☐ YES ☐ NO **IF YES, WHAT BRANCH?:**_____

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MARITAL STATUS _____**SINGLE** _____**MARRIED** _____**DIVORCED** _____**SEPERATED**

ARE YOU DISABLED? ☐ YES ☐ NO **IF YES, EXPLAIN:**_____

_____

HAVE YOU LIVED AT *THE Y* BEFORE? ☐ YES ☐ NO **IF SO, WHEN?:**_____

FINANCIAL RESOURCES

HAVE YOU RECEIVED INCOME IN THE LAST 30 DAYS? ☐ YES ☐ NO ☐ I DON'T KNOW

SOURCE OF INCOME (CHECK ALL THAT APPLY):

___ EMPLOYED ___ UNEMPLOYMENT INSURANCE ___ PENSION
___ PUBLIC ASSISTANCE ___ SSI ___ SSDI (DISABILITY) ___ VA BENEFITS
___ WORKER'S COMP ___ OTHER: _____

EMPLOYER / PAYEE'S NAME & PHONE NUMBER: _____

TOTAL MONTHLY INCOME: _____ **DO YOU RECEIVE SNAP BENEFITS?:**_____

LEGAL HISTORY

DO YOU HAVE ANY UNRESOLVED CHARGES OR CURRENT WARRANTS?:_____

ARE YOU ON PROBATION, PAROLE, AND/OR DRUG COURT?:_____

NAME AND PHONE NUMBER OF P.O. (IF APPLICABLE):_____

HAVE YOU EVER BEEN CONVICTED OF A SEXUAL OFFENSE? ☐ YES ☐ NO

HAVE YOU EVER BEEN CONVICTED OF ARSON? ☐ YES ☐ NO

SUBSTANCE USE HISTORY

DO YOU HAVE A HISTORY INVOLVING DRUGS AND/OR ALCOHOL? ☐ YES ☐ NO

ARE YOU CURRENTLY RECEIVING SUBSTANCE ABUSE TREATMENT? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN:_____

_____

_____

SUBSTANCE(S) OF CHOICE:_____

IMMEDIATE NEEDS

ARE YOU IN NEED OF BASIC NEED SUPPLIES? (PERSONAL HYGIENE ITEMS, BEDDING, FOOD/WATER, IDENTIFICATION) ☐YES ☐NO ☐ NO, BUT I WILL SOON

ANY OTHER PERSONAL CONCERNS?_____

PHYSICAL HEALTH

DO YOU HAVE ANY CHRONIC HEALTH CONDITIONS OR DISABILITIES? ☐YES ☐ NO
IF YES, PLEASE LIST CONDITIONS OR DISABILITIES:_____

_____

PRIMARY CARE DOCTOR:_____ **PHONE NUMBER:**_____

MEDICAL INSURANCE TYPE (MEDICAID, ETC.):_____

INSURANCE POLICY NUMBER:_____

LIST ANY ACUTE OR IMMEDIATE NEEDS:_____

LIST ANY ALLERGIES:_____

LIST ALL MEDICATIONS:_____

MENTAL HEALTH

LIST ANY MENTAL HEALTH DIAGNOSIS:_____

TREATMENT AGENCY:_____

THERAPIST/COUNSELER/CASE MANAGER:_____ **PHONE:**_____

APPOINTMENT SCHEDULE: WEEKLY☐BI-WEEKLY☐MONTHLY☐ OTHER:_____

MENTAL HEALTH SERVICES USED:_____

LIST ALL MEDICATIONS:_____

DATE OF LAST HOSPITALIZATION:_____ **REASON:**_____

TRIGGERS TO BE MADE AWARE OF:_____

OTHER

ARE YOU IN ADULT PROTECTIVE SERVICES?: YES☐ NO☐ **WORKER:**_____

EMERGENCY CONTACT:_____ **PHONE NUMBER:**_____
RELATIONSHIP TO APPLICANT:_____

ARE YOU FLEEING DOMESTIC VIOLENCE? ☐YES ☐NO

APPLICANT STATEMENT

My signature below certifies that all information on this application is true, correct, and complete to the best of my knowledge, and contains no willful falsifications or misrepresentations. I understand that the YMCA reserves the right to ask me to leave the program for violating rules/regulations or for willfully providing false information on this application or during the intake process, and the YMCA can do so at any time.

Applicant Signature:_____

Date:_____

STAFF USE ONLY

____ APPLICATION HAS BEEN REVIEWED BEFORE CLIENT LEAVES TO ENSURE COMPLETION

____ COPYS OF THE FOLLOWING NEED TO BE ATTACHED TO THE APPLICATION

_____ PHOTO ID

_____ SOCIAL SECURITY CARD

_____ MEDICAID CARD (IF AVAILABLE)

____ INTAKE FORM HAS BEEN ATTACHED TO APPLICATION

(PLEASE INITIAL ONCE COMPLETED)