

# DAHIR SERVICES

A REPUTATION BUILT ON RESULTS



## IDENTIFYING INFORMATION

Date Information is Gathered: \_\_\_\_\_

1. Applicant Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

2. Address: \_\_\_\_\_

3. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ **Zip of Last Address:** \_\_\_\_\_

4. Phone where applicant can be reached: (ex. xxx-xxx-xxxx) \_\_\_\_\_

5. Social Security Number: \_\_\_\_\_ 6. Date of Birth: \_\_\_\_\_ 6a. Place of Birth: \_\_\_\_\_  
(ex. NNN-NN-NNNN) (mm/dd/yyyy)

7. Gender: \_\_\_ a. Male \_\_\_ b. Female \_\_\_ c. Transgender

8. Race:  
\_\_\_ a. White \_\_\_ b. Black/African American \_\_\_ c. Asian  
\_\_\_ d. Multi-Racial (Please specify) \_\_\_\_\_

9. Ethnicity: \_\_\_ a. Hispanic or Latino \_\_\_ b. Non Hispanic or Non-Latino

10. What is applicant's primary language? \_\_\_\_\_ Secondary language, if applicable? \_\_\_\_\_

11. Relationship Status: \_\_\_ a. Single \_\_\_ b. Married \_\_\_ c. Widowed/Widower  
\_\_\_ d. Married & Separated \_\_\_ e. Divorced \_\_\_ f. Significant Other  
\_\_\_ g. Domestic Partner \_\_\_ h. Other (Specify) \_\_\_\_\_

12. Are there any identified, past or current, domestic violence issues? \_\_\_ Yes \_\_\_ No \_\_\_ Currently

a. Please describe, with dates of incidents. \_\_\_\_\_

13. Is applicant a Veteran, (anyone who has been on active military duty) \_\_\_ Yes \_\_\_ No

**FAMILY**

14. Enter family members that may live with the applicant (If applicable, complete attached Children's Education Form)

Name (Not Applicant)	Relationship to Applicant	Social Security Number	Gender	Date of Birth

a. Identify any service needs of applicants immediate family members: \_\_\_\_\_

\_\_\_\_\_

b. Identify any family members who have been supportive: \_\_\_\_\_

\_\_\_\_\_

c. Identify any family members who have not been supportive: \_\_\_\_\_

\_\_\_\_\_

15. Enter family members that do not live with the applicant :

**Family Providers Only**

If the parent/guardian of children, identify the number of children and dates of birth of children living in the home. For Children age 6 or older, name of school attending, any after-school or activities the children are attending. For children age 0-5, identify participation in Head Start/Early Head Start, or school readiness, program, Birth to Three day care. For school aged children, information about school attendance/absenteeism.

Name (Not Applicant)	Relationship to Applicant	Social Security Number	Gender	Date of Birth

15a. Child Welfare Involvement: For Parents of minor children, including non-custodial parents, history of child welfare involvement, including current case status: \_\_\_\_\_

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15b. Identify the ability of the parent(s)/guardian(s) to meet the needs and ensure the safety of minor children. Identify parenting strengths and areas of support needed: \_\_\_\_\_

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### **SUPPORTIVE HOUSING REFERRAL**

16. Date of Referral \_\_\_\_\_ 17. Referring Person's Name: \_\_\_\_\_

18. Referring Person's Agency & Telephone Number: \_\_\_\_\_

19. Application Date: \_\_\_\_\_

### **HOUSING HISTORY**

**As part of questions 20 & 21, the attached Homelessness Verification Form needs to be completed.**

20. Is this person at risk of homelessness? \_\_\_\_ Yes \_\_\_\_ No

a. Please describe circumstances: \_\_\_\_\_

21. Length of homelessness this episode:

- |   |   |
|---|---|
| ____ a. Not homeless at present                 | ____ e. At least 1 year but less than 2 years |
| ____ b. Less than one month                     | ____ f. Two years but less than three         |
| ____ c. At least 1 month but less than 6 months | ____ g. Three years or more                   |
| ____ d. At least 6 months but less than 1 year  |   |

22. Number of episodes in past five years: \_\_\_\_\_

23. Approximate number in lifetime: \_\_\_\_\_

24. Within the last four (4) years, how many nights, months, or years, if any, have you spent in a shelter (s)? \_\_\_\_\_

a. Could you provide the names and dates of your shelter stay?: \_\_\_\_\_

25. Where have you slept for the last thirty (30) days? Check all that apply.

**Check all that apply.**

a. Non-housing (Street, park, car)	
b. Emergency Shelter, please name.	
c. Transitional Housing	
d. Psychiatric Facility	
e. Substance Abuse Treatment Facility	
f. Hospital	
g. Prison/Jail	
h. Domestic Violence Shelter	
i. Living with friends/family	
j. Rental Housing	
k. Own apartment or house	
l. Motel/hotel	
m. Foster Care	
n. Other (specify): _____	

26. Is applicant receiving a housing subsidy?  Yes  No

a. What type of housing subsidy is the applicant receiving? \_\_\_\_\_

27. Does/did applicant pay own rent?  Yes  No

28. Does/did applicant pay for own utilities?  Yes  No

29. Has applicant ever been evicted?  Yes  No

30. Reason for leaving last housing situation.

a.  Eviction due to unpaid rent

b.  Eviction for reason other than unpaid rent

c.  Conflict with friends or family

d.  Overcrowding

e.  Domestic violence

f.  Incarceration

g.  Hospitalization, including long term treatment

h.  Housing condemned

i.  Fire

j.  Other, please explain \_\_\_\_\_

31. Please list housing history for last five (5) years including: Location, approximate dates, lease holder or relationship to primary tenant, reason(s) for leaving. \_\_\_\_\_

31a. Please identify any contributing factors to housing instability: \_\_\_\_\_

**PERSONAL HEALTH INFORMATION**

As part of questions 32 & 33, the attached Disability Verification Form needs to be completed.

32. Does applicant have a disability of a long duration?  Yes  No  Don't Know  Refused

33. Is applicant currently or have they ever been diagnosed with any of the following?

- a. Mental illness.....  Yes  No  Currently
- b. Alcohol abuse.....  Yes  No  Currently
- c. Drug abuse.....  Yes  No  Currently
- d. HIV/AIDS and related diseases.....  Yes  No  Currently
- e. Developmental disability.....  Yes  No  Currently
- f. Physical disability.....  Yes  No  Currently

34. Does applicant have a history of any psychiatric conditions?  Yes  No

**Check all that apply.**

	Currently Experiences:	History of:
Homicidal ideas/attempts		
Assaultive behavior		
Delusions		
Severe depression		
Severe thought disorder		
Cognitive impairment		
Suicidal ideas		
Suicidal attempts		
Hallucinations		
Arson/fire setting		
Victim of Sexual abuse/assault		
Victim of Trauma		
Other (specify)		

a. If applicable, please list hospitalizations for these conditions.

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35. Does applicant receive psychiatric care?  Yes  No

a. If yes, please list name, address and phone number of all psychiatric care providers.

36. Does applicant have a history of any substance abuse disorders?  Yes  No

a. If yes, please list drug(s) of choice, frequency of use, approximate date of last use.

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37. Does applicant have any current or past history of substance abuse treatment?  Yes  No

a. If yes, please list name, address and phone number of all substance abuse providers.

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38. Is applicant involved in any 12-step or other self help recovery programs?  Yes  No

a. If yes, which program(s)? \_\_\_\_\_

39. If applicant is substance free, for how long has s/he been substance free? \_\_\_\_\_

40. If applicant is currently using substances, is s/he interested in substance abuse treatment?  Yes  No

a. If no, what type of treatment is applicant interested in? \_\_\_\_\_

41. Does applicant have a history of any medical conditions?  Yes  No

a. If yes, please list conditions. If applicable, please list hospitalizations for these medical conditions.

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41a. Date of last physical; OB/GYN, and dental appointments for all household members as appropriate: \_\_\_\_\_

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42. Is applicant allergic to any medications?  Yes  No

a. If yes, please list medication allergies.

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42A. PLEASE LIST CURRENT MEDICATIONS THE TENANT IS ON: \_\_\_\_\_

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43. Where does applicant receive medical care? Please list name, address and phone number of all health care providers.

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**SOCIALIZATION**

44. Describe applicant's participation in faith/spiritual activities, if any?

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45. Describe applicant participate in any social networks, or recreational activities? Please list the name(s) of the social/recreational network:

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**VOCATIONAL & EDUCATION HISTORY**

46. Does applicant or anyone living with him/her have a source of income?  Yes  No

a. What is the source of income? \_\_\_\_\_

47. Does applicant or anyone living with him/her have any entitlements pending?  Yes  No

a. What entitlement(s) is/are pending? \_\_\_\_\_

Person Receiving Income	Other's Name	Source of Income	Date Applied	Amount Receiving
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	a. Social Security Income (SSI)	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	b. Social Security Disability Income (SSDI)	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	d. General Assistance (SAGA)	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	e. Temporary Aid to Needy Families (TANF)	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	f. Child Support	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	n. Alimony	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	g. Veteran Benefits	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	h. Employment Income	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	i. Unemployment	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	j. Medicare	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	k. Medicaid	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	l. Food Stamps	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	m. Other (please specify)	_____	\$ _____
<input type="checkbox"/> Applicant	<input type="checkbox"/> Other _____	n. No financial resources	_____	\$ _____

48. Please list any outstanding debts, including type of debt and amount: \_\_\_\_\_

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49. Please list any financial obligations including the amount (e.g. child support, alimony): \_\_\_\_\_

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50. Is applicant currently employed, either part-time or full-time?  Yes  No

a. If yes, where is applicant employed? \_\_\_\_\_

b. If no, does applicant wish to be employed, either now or in the future?  Yes  No

b2. If yes, in what area of employment does applicant wish to work? \_\_\_\_\_

c. Describe applicant's work experience or history, if applicable.

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51. Does applicant need training or vocational support to achieve employment in desired occupation? \_\_\_ Yes \_\_\_ No

52. Is applicant currently participating in vocational or employment training programs? \_\_\_ Yes \_\_\_ No

a. If yes, please identify the training program? \_\_\_\_\_

b. If no, does applicant wish to enroll in a vocational or employment training program? \_\_\_ Yes \_\_\_ No

52a. Is applicant currently enrolled in an educational program, either part-time or full-time? \_\_\_ Yes \_\_\_ No

a. If yes, where is the applicant enrolled? \_\_\_\_\_

b. If no, does the applicant wish to be enrolled, either now or in the future? \_\_\_ Yes \_\_\_ No

**LEGAL INFORMATION/HISTORY**

53. Does applicant have any current legal issues? \_\_\_ Yes \_\_\_ No

a. If yes, please list description of charges and any pending court dates.

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b. Does applicant have legal representation? \_\_\_ Yes \_\_\_ No

b2. If yes, please list name and address and phone number of attorney or legal advocate.

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54. Is applicant currently on probation? \_\_\_ Yes \_\_\_ No

55. Is applicant currently on parole? \_\_\_ Yes \_\_\_ No

a. If yes to either #54 or #55, please list name and contact information of probation/parole officers(s)

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56. Does applicant have any prior arrests, convictions or incarceration? \_\_\_ Yes \_\_\_ No

a. If yes, please list.

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57. Does applicant have a conservator? \_\_\_\_ Yes \_\_\_\_ No
- a. If yes, is he/she a conservator of person? \_\_\_\_ Yes \_\_\_\_ No,
- b. If yes, is he/she conservator of estate (money)? \_\_\_\_ Yes \_\_\_\_ No
- c. If yes, is he/she conservator of both person and state? \_\_\_\_ Yes \_\_\_\_ No
- d. If yes, enter name and address of conservator:
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**ADL's**

58. Does the applicant have difficulty with any of the following areas of daily living? In addition, please list any strengths the tenant may have.

**Check all that apply.**

a. Paying rent/utilities	
b. Lease compliance	
c. Housekeeping	
d. Money management	
e. Driving/using public transportation	
f. Arranging apartment repairs	
g. Use of mental health services	
h. Use of health services	
i. Securing/Maintaining Benefits	
j. Meal preparation	
k. Shopping for food and other necessities	
l. Taking medication as prescribed or instructed	
m. Filling prescriptions	
n. Socialization	
o. Hygiene	
p. Other (specify): _____	

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**EMERGENCY CONTACT**

59. Emergency Contact: \_\_\_\_\_ Telephone # \_\_\_\_\_

Address: \_\_\_\_\_

Date of Application for Housing: \_\_\_\_\_

Applicant: \_\_\_\_\_ Date \_\_\_\_\_

Signature

Case Manager: \_\_\_\_\_ Date \_\_\_\_\_

Signature

Case Management Supervisor: \_\_\_\_\_ Date \_\_\_\_\_

Signature