Approval status _____
Date of Status update _____
Staff name_____

ADVANTAGE TREATMENT CENTERS SUPPORTIVE HOUSING APPLICATION

"Client success equals community success"

Client Name:_____ DOB:_____

SSN:_____ Place of Birth:_____

Organization referred/attached to: _____

Date needed for housing to start:_____ Length of Time needed for housing:_____

Have you reviewed the rules and regulations of the Supportive Housing? Yes or No

Do you agree to follow the rules and reglations of Supportive Housing? Yes or No

Rate the following on level of need: 1 being not needed at all, 5 being super high needs

Employment:___ Substance Abuse Treatment: ___ Mental Health Treamtent: ___

Physical Health Needs (include dental and vision needs): ___ Life Skills Needs: ___

Do you need help in getting insurance (medicaid or CHP) ? Yes or No

Do you need help in getting food assistance? Yes or No

Do you have any physicial disabilities? _____

Do you take any Medications? Please list: _____

_____

_____

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Emergency Contact Name: _____

Address: _____

Phone Number: _____

Do you have a Drivers License? Yes or No Do you have a vehcile? Yes or No

If Yes, do you have the vehicle properly licensed and insured? Yes or No

Do you have the ability to pay rent or have an arragement with your referring source to help out? Yes or No, (does not preclude you from approved placement) Please explain:

_____

_____

What do you hope to get out of your time in Supportive Housing?

_____

_____

Are you currently engaged in any form of mental health, substance abuse, or cognitive behavioral treatment? Yes or No

If so, are you willing to add Advantage Treatment Supportive Housing to your release of information to cordinate quality of care? Yes or No

Please attach any assessments from your referring source in the last 6 months as we use these valuable documents to serve you.

We look forward to working with you and helping our in any way possible, we will be in touch very soon on this application directly to the person applying.