



APPLICATION FORM

Send or fax to:

SHP Program Director
14041 Icot Blvd.
Clearwater, FL 33760
Fax: (727) 450-7271

This section of the application will be used to assess the eligibility of the applicant and the program services that are needed.

Name: _____

Date: _____

DOB: _____

SSN: _____

Address: _____

Telephone: _____

Monthly Income: \$ _____

Case Manager/Therapist: _____

Telephone of Case Manager/Therapist: _____

Current mental health services received: _____

Current mental health diagnosis: _____

Prior Hospitalizations: _____

Who referred you to the Supported Housing Program? _____

Current Living Arrangements: _____

Note: A current psychiatric evaluation must be provided with this Application.

Which county would you like to live in if you do not already have housing of your choice (you must choose **ONE** county only):

Hillsborough

Pasco

Pinellas

Have you ever lived independently before? _____

Please state why you wish to enter the Supported Housing Program: _____

Are you currently employed? _____

If no, do you want to work? _____

Are you financially able to be independent without our assistance? _____

To what degree do you see yourself as presently needing and/or wanting assistance in the following areas (please check the boxes that apply):

	None	Very Little	Somewhat	Very Much
Grocery Shopping				
Money Management/Financial Assistance				
Personal Hygiene				
Use of Public Transportation				
Cooking/Nutrition				
House Cleaning				
Treatment Compliance				
Getting Along With Others				
Employment/Volunteer Work				

Locating Housing				
Other:				

Do you have a substance abuse history? Yes No

If yes, please explain: _____

Competent: Yes No

If no, is a Guardian assigned? List Guardians name, address & telephone #: _____

Financial Information- list amount received per month:

SSDI: \$ _____ SS: \$ _____ OSS: \$ _____ Pension: \$ _____

Other: \$ _____

Do you have a payee? Yes No Do you want a payee? _____

Insurance: Medicaid # _____ Medicare # _____

Other: _____

****THIS PAGE MUST BE COMPLETED****

Referral Source Verification/Interview

If there is information missing from this application and you cannot be reached, may Supported Housing Staff contact your referral source? Yes No

If no, please state why: _____

By signing this form, I attest that all information contained in this form is true and correct to the best of my knowledge.

Applicant Signature

Date

To Be Completed By Gulf Coast Staff Member:

Meets Criteria for Supported Housing Program: Yes No

If no, please explain: _____

Completed By: _____ Date: _____

Approved By: _____ Date: _____