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/substance abuse services received: ______________________________

Current mental health/substance abuse diagnosis: _____________________________________

Prior Hospitalizations: ____

____

Who referred you to the Supported Housing Program? ____________________________

Current Living Arrangements: ____

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 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: ____

____

Financial Information- list amount received per month:

SSDI: $______ SS: $________ Employment: $_____ Pension: $_________

Other: $____

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: ____________