

Your Name: \_\_\_\_\_

Your Phone: \_\_\_\_\_



**CATHOLIC CHARITIES TOMPKINS/TIOGA**  
**A PLACE TO STAY**

Eligibility Criteria

Determination of acceptance into A Place To Stay will be made on a case by case basis, based on the following *minimum* criteria:

Applicant must be:

- At least eighteen years old
- Currently homeless OR have had three (3) episodes of homelessness in the past year OR been couch surfing for the past three (3) months
- Free of illegal drugs and/or alcohol, including marijuana
- If there has been substance abuse with drugs or alcohol, applicant must be actively participating in a treatment program
- Must be able to get along with others in the house
- If in custody of any animal, willing to rehome the animal
- Willingness, desire, and ability to participate in A Place To Stay group meetings
- Willing to participate in individual case management meetings; failure to do so may result in termination from program
- Willing to participate with a local Care Management agency
- Willingness and desire to participate in A Place To Stay Supportive Living Program; failure to do so may result in termination from program
- If not already on the community-wide shelter wait list, willing to be added and sign release.
- Willingness to follow house rules and guidelines; failure to do so may result in termination from program
- Willingness and ability to arrange own transportation to and from appointments, shopping, etc.
- Willingness to provide a complete list from PCP of any and all prescription and over-the-counter medications used
- Willingness to work toward personal goals and meet weekly with the service navigator about goals
- Willingness to create a personal safety plan
- Ability to live safely without 24/7 staff support

If you meet and accept all of the criteria, please continue to the next page for the application. If you do not meet and accept all of the criteria, please return this application without filling it out. There will be no hard feelings on either side.



CATHOLIC CHARITIES TOMPKINS/TIOGA

A Place to Stay

**Expectations**

A Place To Stay is not just a home. It is a program based on personal goals towards self-sufficiency. We expect you to WANT to be in your own private home; we expect you to set attainable goals; and we expect you to do everything in your power to meet these goals.

We expect you to attend individual meetings for case management. These should be every other week at a minimum. We expect you to attend house meetings. These will be monthly, and everyone living in the house is expected to attend. House meetings are group meetings. We expect you to attend self-sufficiency workshops, either at the house or at another agency. We expect you to attend activities scheduled to enhance your quality of life. Workshops and life-enrichment are group events. YOU must be willing to work these into your schedule, and doing so requires flexibility on your part.

We expect you to stay in contact, via text, phone, or email, with program staff. We expect that if we text you a question regarding your schedule, your goals, your availability, that you answer within a reasonable amount of time. Even if you are working, you will have a break; you WILL have time to respond.

We expect you to arrange ALL of your own transportation as needed; there is no “staff car” and staff isn’t to be expected to transport you. There is a public transportation for your use if you cannot walk. This applies to moving in, moving out, attending your medical appointments, and more.

You’ll be provided an emergency contact number for staff. We expect you to use best judgement and only call or text for emergencies (house fire, fight, etc. – not someone using your coffee).

We expect you to follow our house rules. For example, we require you to provide a weekly schedule to program staff by 9:00 Monday mornings, no exceptions. It’s best if you bring it to the office, but in certain circumstances you may be permitted to leave it in the proper place at the house.

We expect that if our residents have an ongoing personal conflict, they will attend mediation at Community Dispute Resolution Center.

We exist on the generosity of the community; we expect you to pay that generosity forward via volunteering. You can volunteer with us in our clothing closet, or at any of a number of agencies throughout town. We will give you 30 days to do so; you will receive a form to be signed by the supervisor at your volunteer site. Other women have done it; you can too.

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_  
Witness Printed Name \_\_\_\_\_ Signature \_\_\_\_\_  
Date \_\_\_\_\_



Catholic Charities Tompkins/Tioga  
A Place to Stay Application  
Biographical Information

**Please fill out completely. Do not leave any sections blank. Please provide a copy of photo ID *with* this application.  
Please have all consents and pages that ask for a witness signature signed *before* turning it in.**

Date of Application: \_\_\_\_\_

Name: \_\_\_\_\_  
Last Name First Name MI

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

\_\_\_\_\_ City State Zip Code

Are you on the community-wide shelter wait list (CAT list)? \_\_\_\_\_

Name of individual you are staying with/relation to you: \_\_\_\_\_

Phone Number where you can be reached: Cell: \_\_\_\_\_  
Other Number: \_\_\_\_\_  
Email: \_\_\_\_\_

Whose phone is this/relation to you: \_\_\_\_\_

If we contact you by phone, is it safe to leave a message? Yes \_\_\_\_ No \_\_\_\_

Do you have another alternate number if we cannot reach you on the above? \_\_\_\_\_

Are there any special instructions for sending/leaving a message (i.e. certain words not to use; certain time of day not to leave a message)? \_\_\_\_\_

Gender: \_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Other: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_

Marital Status: \_\_\_\_\_

Are you pregnant? \_\_\_\_ If yes, when is your due date? \_\_\_\_/\_\_\_\_/\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Disabled: Yes/No (*circle one*)

Ethnicity

Hispanic/Latino     Non-Hispanic/Latino

**Race** (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Asian                            | <input type="checkbox"/> White                                     |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Other: _____                              |

Please explain why you are unable to live/stay where you are. **Be specific.** If you have moved out, please state when you moved out. If you are homeless, please explain what happened.

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Have you looked into any other programs? If so, what programs? \_\_\_\_\_

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How did you find out about our program? \_\_\_\_\_

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Do you have any siblings?  Yes (complete next section)  No (move on)

Sibling's Name	Age	Where do they live?	Do you have contact?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please name 2 workers within the human services community (DSS caseworker, housing program caseworker, etc.) that know you and can give you a good reference/recommendation. Include phone number and organization.

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**Personal Information**

**Are you or have you ever been involved in/with:**

*Check all that apply*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Family Court   | <input type="checkbox"/> Lawyer              | <input type="checkbox"/> Mental Health Facility/Hospital |
| <input type="checkbox"/> Criminal Court | <input type="checkbox"/> Case Manager        | <input type="checkbox"/> Gangs                           |
| <input type="checkbox"/> Arrested       | <input type="checkbox"/> Order of Protection | <input type="checkbox"/> Other:                          |
| <input type="checkbox"/> Probation      | <input type="checkbox"/> Emergency Shelter   |  |
| <input type="checkbox"/> Rehab          | <input type="checkbox"/> Jail or detention   |  |

If you checked any of the above please explain: \_\_\_\_\_

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**Criminal Involvement**

Do you have a criminal history? \_\_\_\_\_

Please list charges: \_\_\_\_\_

Have you been in placement/jail before? \_\_\_\_\_

If yes, when and where?: \_\_\_\_\_

Have you had any criminal court involvement? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Are there current charges pending against you? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Are you on probation? \_\_\_\_\_ Dates of Probation: \_\_\_\_\_ Probation Officer/Phone/County: \_\_\_\_\_

**Please list all of your closest friends and people you associate with:**

First and Last name	Age
_____	_____
_____	_____
_____	_____

**How do you know your friends?** \_\_\_\_\_  
\_\_\_\_\_

**What activities are you involved in/would you like to be involved in?** \_\_\_\_\_  
\_\_\_\_\_

**What do you like to do in your free time?** \_\_\_\_\_  
\_\_\_\_\_

**What are your hobbies?** \_\_\_\_\_  
\_\_\_\_\_

**What is something that you are proud of?** \_\_\_\_\_  
\_\_\_\_\_

**What is something that you would like to improve?** \_\_\_\_\_  
\_\_\_\_\_

**What type of work would you like to do?** \_\_\_\_\_  
\_\_\_\_\_

**Please list three (3) things you'd like to accomplish while you're with this program.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Are you willing to participate in our mandatory supportive living program (this includes regularly scheduled workshops and life enrichment activities)?**  Yes  No

**Educational Information**

**1.) Did you graduate from High School?**  Yes – skip to question 2  No-go to question 1a, 1b

1a. What is the last grade you completed: \_\_\_\_\_

1b. Have you received your GED?  Yes  No-go to question 1c

1c. Are you planning on receiving your GED?  Yes (*continue*)  No (*skip to question 2*)

Anticipated Graduation/GED date \_\_\_\_\_

**2.) Name of Last/Current School attended** \_\_\_\_\_

Address \_\_\_\_\_

Current grade (if in school) \_\_\_\_\_ Special Programs / Trainings \_\_\_\_\_

**Medical/Mental Health History**

**Do you have medical insurance?:** Yes \_\_\_\_\_ No \_\_\_\_\_ **Insurance plan:** \_\_\_\_\_

**Medicaid #:** \_\_\_\_\_

*Continued on page 6*

**Do you see/have you seen:** *Please check all that apply*

- doctor     dentist     counselor     psychologist     Psychiatrist

If you checked any, name and date when you last saw them (if ongoing, explain): \_\_\_\_\_

**Have you ever had a PAP test? Date of last exam:** \_\_\_\_\_

**Do you have a regular OB/GYN? Name:** \_\_\_\_\_

**Do you have a service animal or emotional support animal?**  Yes     No **Can you provide a prescription letter for the animal from your doctor or mental health counselor?**  Yes     No

**Do you have/have you had:** *Please check all that apply*

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> prescribed medications             | <input type="checkbox"/> bladder infection                  | <input type="checkbox"/> severe mood swings  | <input type="checkbox"/> obesity                         |
| <input type="checkbox"/> over the counter medications       | <input type="checkbox"/> itching/irritation in genital area | <input type="checkbox"/> health concerns     | <input type="checkbox"/> Tuberculosis                    |
| <input type="checkbox"/> vitamin, mineral, food supplements | <input type="checkbox"/> respiratory disease                | <input type="checkbox"/> medical problem     | <input type="checkbox"/> medication allergies            |
| <input type="checkbox"/> rash from medication               | <input type="checkbox"/> liver disease                      | <input type="checkbox"/> serious illness     | <input type="checkbox"/> food allergies                  |
| <input type="checkbox"/> rash from food                     | <input type="checkbox"/> Hepatitis B                        | <input type="checkbox"/> serious accident    | <input type="checkbox"/> birth defect                    |
| <input type="checkbox"/> heart condition                    | <input type="checkbox"/> chronic diseases                   | <input type="checkbox"/> glasses or contacts | <input type="checkbox"/> epilepsy, seizures, convulsions |
| <input type="checkbox"/> rheumatic fever                    | <input type="checkbox"/> pregnancies                        | <input type="checkbox"/> trouble seeing      | <input type="checkbox"/> drug abuse                      |
| <input type="checkbox"/> heart murmur                       | <input type="checkbox"/> STDs/STIs                          | <input type="checkbox"/> dental problem      | <input type="checkbox"/> glandular problem               |
| <input type="checkbox"/> blood disorder                     | <input type="checkbox"/> unexplained weight loss/gain       | <input type="checkbox"/> trouble sleeping    | <input type="checkbox"/> Thyroid problem                 |
| <input type="checkbox"/> bladder control problem            | <input type="checkbox"/> special diet                       | <input type="checkbox"/> sleep walk          | <input type="checkbox"/> high blood pressure             |
| <input type="checkbox"/> burning when urinating             | <input type="checkbox"/> physical disability                | <input type="checkbox"/> sleep aid           | <input type="checkbox"/> mental illness                  |
| <input type="checkbox"/> blood in urine                     | <input type="checkbox"/> mental disability                  | <input type="checkbox"/> asthma              | <input type="checkbox"/> anemia                          |
|   | <input type="checkbox"/> learning disability                | <input type="checkbox"/> cancer              | <input type="checkbox"/> other                           |
|   | <input type="checkbox"/> depression                         | <input type="checkbox"/> diabetes            |  |
|   | <input type="checkbox"/> anxiety                            | <input type="checkbox"/> eating disorder     |  |
|   | <input type="checkbox"/> anger problems                     | <input type="checkbox"/> heart disease       |  |
|   |   | <input type="checkbox"/> migraines           |  |

If you checked any, please explain: \_\_\_\_\_

**Will you provide a complete list of any and all medications you're taking?**  Yes     No

*The list must be from your primary care physician*

**Would you like a referral for a mental health evaluation?** \_\_\_\_\_

**Would you like a referral for a physical?** \_\_\_\_\_

**Date of last physical exam:** \_\_\_\_\_ **Date of last dental exam:** \_\_\_\_\_

**Do you have a primary doctor? Name:** \_\_\_\_\_

**Do you have a care manager? Agency/their name:** \_\_\_\_\_

**Do you have a dentist? Name:** \_\_\_\_\_

**Have you ever attended/stayed at:** *Please check all that apply*

- |  |   |
|--|---|
| <input type="checkbox"/> Counseling or Therapy | <input type="checkbox"/> CPEP (Crisis Center) |
| <input type="checkbox"/> Hospital              | <input type="checkbox"/> Rehab facility       |
| <input type="checkbox"/> Psychiatric Hospital  | <input type="checkbox"/> YMCA/YWCA            |

**Do you have a history with:** *Please check all that apply*

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Suicide Attempts               | <input type="checkbox"/> Verbally Aggressive/Abusive behavior | <input type="checkbox"/> Sexual Abuse           |
| <input type="checkbox"/> Suicide Threats                | <input type="checkbox"/> Fire Setting                         | <input type="checkbox"/> Physical Abuse         |
| <input type="checkbox"/> Self-Harm                      | <input type="checkbox"/> Eating Disorder                      | <input type="checkbox"/> Mental/Emotional Abuse |
| <input type="checkbox"/> Physically Aggressive Behavior | <input type="checkbox"/> Family Violence                      |   |
| <input type="checkbox"/> Sexually Aggressive Behavior   | <input type="checkbox"/> Anger Management                     |   |

If you checked any of the previous, please explain: \_\_\_\_\_

**Imminent Risk**

**Danger from others**

Have you ever been physically abused? \_\_\_\_\_  
If yes, by whom? \_\_\_\_\_ When? \_\_\_\_\_

Have you ever been sexually abused? \_\_\_\_\_  
If yes, by whom? \_\_\_\_\_ When? \_\_\_\_\_

Have you ever been exposed to domestic violence? \_\_\_\_\_  
If yes, by whom? \_\_\_\_\_ When? \_\_\_\_\_

Have you ever been hospitalized for medical reasons? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized for mental health reasons? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

Have you ever had medical problems not be addressed? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

Have you ever felt unsafe? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

**Danger from self**

Have you ever seriously threatened to harm anyone other than yourself? \_\_\_\_\_  
If yes, when and what was the threat? To whom? \_\_\_\_\_

Were there charges against you? \_\_\_\_\_  
If yes please explain the charges: \_\_\_\_\_

**Have you ever harmed yourself?** \_\_\_\_\_

**Drug and Alcohol History**

**Have you ever used/tried:** *Please check all that apply*

- |                                     |  |                                  |                                       |
|-------------------------------------|--|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Prescription  | <input type="checkbox"/> Cocaine | <input type="checkbox"/> LSD          |
| <input type="checkbox"/> Tobacco    | <input type="checkbox"/> drugs for fun | <input type="checkbox"/> Heroin  | <input type="checkbox"/> Other (list) |
| <input type="checkbox"/> Alcohol    | <input type="checkbox"/> Marijuana     | <input type="checkbox"/> Crack   |                                       |

Have you ever been treated for substance use/abuse?  Yes  No

**Are you in treatment for a substance abuse disorder now?**  Yes  No

If yes, where; who is your primary counselor? \_\_\_\_\_

**If you checked any of the above please explain:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Financial & Employment**

**1.) Do you receive any of the following as income?**

*Please check all that apply:*

- |   |   |
|---|---|
| <input type="checkbox"/> Public Assistance ( <i>see question 7</i> )            | <input type="checkbox"/> Survivor Benefits      |
| <input type="checkbox"/> Social Security Income (SSI) ( <i>see question 6</i> ) | <input type="checkbox"/> Wages                  |
| <input type="checkbox"/> Social Security Disability (SSD)( <i>see</i>           | <input type="checkbox"/> Income other than work |

SNAP (Food Stamps)

2.) **Do you have a bank account?**  Yes  No  
2a.) **Is it checking or savings?** \_\_\_\_\_

**3.) Work History**

Have you ever had a job?  Yes  No      Have you ever quit a job?  Yes  No

Have you ever been fired from a job?  Yes  No

4.) **Are you currently employed?**  Yes (go to 4a)  No (go to next section)

4a) Place of Employment: \_\_\_\_\_

How long have you worked here? \_\_\_\_\_

Pay Rate: \_\_\_\_\_ Hours worked per week: \_\_\_\_\_

5.) **Are you/were you in the military? From:** \_\_\_\_\_ **To:** \_\_\_\_\_

**Discharge Date/Type/Reason:** \_\_\_\_\_

6.) Do you currently receive Medical Assistance or Temporary Assistance?  Yes  No

7.) If you receive SSD or SSI who is the rep payee? \_\_\_\_\_

8.) If you receive SSD or SSI how much do you receive? \_\_\_\_\_

9.) If you receive Public Assistance payments how much? \_\_\_\_\_

**Drug Testing Agreement**

I, \_\_\_\_\_, agree to voluntary drug testing as a part of my screening process. If accepted to the program I agree that A Place To Stay Program staff may arrange for random tests at will.

I understand that refusal to submit to a drug screening at any time will lead to denial or discharge from A Place To Stay

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_

Witness Printed Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_

**\*Do not return this application without witness signatures, including all consent forms, and photo ID!\***

**Is there anything else that you would like to share?** (Attach an additional sheet if needed.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

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





Name Release Form

On occasion we may need to share your name with the current residents of A Place To Stay. We do this in part to help keep everyone safe. We do not want anyone moving into a home currently occupied by a woman she may have conflict with. If the situation arises, we will schedule mediation individually and between both parties so the new tenant and the current tenant may cohabit amicably.

I, \_\_\_\_\_, do hereby authorize consent to release of my full name to the current residents of A Place To Stay.

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_  
Witness Printed Name \_\_\_\_\_ Signature \_\_\_\_\_  
Date \_\_\_\_\_



Multiple Party Release Form

Authorization for Release and Disclosure of Confidential Information

I, \_\_\_\_\_, do hereby authorize consent to release of information and communication between and among the following agencies:

- |   |   |
|---|---|
| The Rescue Mission                                | Ithaca Housing Authority  |
| Catholic Charities of Tompkins/Tioga              | Ithaca Neighborhood Housing Services                                |
| Tompkins Community Action (TCA)                   | Ithaca Community Treatment Court (Drug Court)                       |
| Tompkins County Dept. of Social Services          | Opportunities, Alternatives, and Resources of Tompkins County (OAR) |
| Tompkins County Mental Health                     | Cayuga Addiction Recovery Services (CARS)                           |
| Law NY  | Alcohol and Drug Council of Tompkins County (ADC)                   |
| The Advocacy Center                               | Health Care Provider (write in):                                    |
| Southern Tier Care Coordinators                   | Tompkins County Mental Health Care Management                       |
| Lakeview Mental Health                            | Tompkins County Probation Dept/Day Reporting                        |
| Human Services Coalition of Tompkins County (HSC) |   |
| Landlord (write in):                              |   |

I understand that I am consenting to the release of information that is otherwise specifically excluded from release under the law.

I understand that this consent will remain in effect for one year after signature or upon my written revocation.

I understand that the designated agency may not disclose any of this information beyond the above listed agencies unless I give prior consent in writing.

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_  
 Witness Printed Name \_\_\_\_\_ Signature \_\_\_\_\_  
 Date \_\_\_\_\_



Photo Release

I hereby authorize Catholic Charities of Tompkins/Tioga , hereafter referred to as "CCTT" to publish photographs taken of me during my stay at A Place To Stay and my name and likeness and any information I provided verbally or in written form, for use in CCTT's print, online and video-based marketing materials, as well as other CCTT publications.

I hereby release and hold harmless CCTT from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in CCTT marketing materials or other CCTT publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release CCTT, the Catholic Diocese of Rochester, their contractors, their employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

**Authorization**

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Witness Printed Name: \_\_\_\_\_ Witness Signature: \_\_\_\_\_

Witnessed Date: \_\_\_\_\_