Your Name: _____

Your Phone:_____

CATHOLIC CHARITIES TOMPKINS/TIOGA

A PLACE TO STAY

Temporary housing for women

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:

- Female
- Residents of Tompkins County
- 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 case manager about goals
- Willingness to create a personal safety plan
- Ability to live safely without 24/7 staff support

If you meet and accept all the criteria, please continue to the next page for the application. If you do not meet and accept all 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

Temporary housing for women

Expectations

A Place To Stay is not just a home. It is a sober living 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 your own transportation as needed; there is no "staff car" and staff is not 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 from the time you move in 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)? _____

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)*

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ 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.

_____
_____
_____

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

How did you find out about our program? _____
_____

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.

_____
_____

Personal Information

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

Check all that apply

- ☐ Family Court
- ☐ Criminal Court
- ☐ Arrested
- ☐ Probation
- ☐ Rehab
- ☐ Lawyer
- ☐ Case Manager
- ☐ Order of Protection
- ☐ Emergency Shelter
- ☐ Jail or detention
- ☐ Mental Health Facility/Hospital
- ☐ Gangs
- ☐ Other:

If you checked any of the above please explain:_____
_____

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 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*

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

If you checked any, please explain:_____

_____

Will you provide a complete list from your physician 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*

- ☐ Counseling or Therapy
- ☐ Hospital
- ☐ Psychiatric Hospital
- ☐ CPEP (Crisis Center)
- ☐ Rehab facility
- ☐ YMCA/YWCA

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

- ☐ Suicide Attempts
- ☐ Suicide Threats
- ☐ Self-Harm
- ☐ Physically Aggressive Behavior
- ☐ Sexually Aggressive Behavior
- ☐ Verbally Aggressive/Abusive behavior
- ☐ Fire Setting
- ☐ Eating Disorder
- ☐ Family Violence
- ☐ Anger Management
- ☐ Sexual Abuse
- ☐ Physical Abuse
- ☐ Mental/Emotional Abuse

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*

☐ Cigarettes	☐ Prescription drugs for fun	☐ Cocaine	☐ LSD
☐ Tobacco		☐ Heroin	☐ Other (list)
☐ Alcohol	☐ Marijuana	☐ 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:

- ☐ Public Assistance *(see question 7)*
- ☐ Social Security Income (SSI) *(see questions 7 & 8)*
- ☐ Social Security Disability (SSD)*(see Questions 7 & 8)*
- ☐ Survivor Benefits
- ☐ Wages
- ☐ 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: _____

Catholic Charities
Tompkins/Tioga

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:

St. John's Community Center
Catholic Charities of Tompkins/Tioga
Tompkins Community Action (TCA)
Tompkins County Dept. of Social Services
Tompkins County Mental Health
Law NY
The Advocacy Center
Southern Tier Care Coordinators
Lakeview Mental Health
Human Services Coalition of Tompkins County (HSC)
Landlord (write in):

Ithaca Housing Authority
Ithaca Neighborhood Housing Services
Ithaca Community Treatment Court (Drug Court)
Opportunities, Alternatives, and Resources of Tompkins County (OAR)
Cayuga Addiction Recovery Services (CARS)
Alcohol and Drug Council of Tompkins County (ADC)
Health Care Provider (write in):
Tompkins County Mental Health Care Management
Tompkins County Probation Dept/Day Reporting
Peer Support Specialist

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: _____