

**Catholic Charities of Los Angeles
Good Shepherd Center for Homeless Women & Children
Women's Village Transitional Housing Program**

Referral Intake Application

Date: _____

We appreciate the opportunity to network with your agency for helping those in need of transitional housing. We have updated our intake process to better serve those who are seeking transitional housing through our program. Please provide the following information regarding the prospective client. Please understand that our objective is to make the transition easier for everyone.

Which program are you applying for: Hawkes (women without children) Farley (women with up to 2 children)

Referring Agency: _____

Person Making Referral: _____ Title/Position: _____

Phone Number: (____) - ____ ext. ____ Email Address: _____

Name of Applicant: _____ Date of Birth: ____ / ____ / ____

Phone Number: (____) - ____ Email Address: _____

Is the applicant a Veteran? Yes No Discharge Status: _____

Length of Homelessness: _____ months, _____ years

What is the applicant's current housing situation? _____

How long have they been in their current housing situation?

- Less than a week 1 to 2 weeks 3 weeks to 1 month 1 to 2 months
 2 to 3 months 4 to 6 months 7 months to 1 year More than 1 year

At what other shelters, if any, has the applicant stayed at? Please state duration of stay from initial date of homelessness.

Date Entered	Date Exited	Shelter Name (center, facility, institution, etc.)
/ /	/ /	
/ /	/ /	
/ /	/ /	
/ /	/ /	

Are you currently working with the applicant? Yes No

If yes, in what capacity? _____

Why are you recommending this client for residency in our program?

What progress has this client made in your program?

What are 3 specific goals that this client has identified and source of motivation?

1. _____
2. _____
3. _____

Are there any specific challenges that we should be aware of for this client? Yes No

If yes, please explain.

What, in your opinion, will the client achieve at Good Shepherd Center?

Domestic Violence

Has the applicant experienced domestic partner/family violence? Yes No

If yes, how long ago? Under 3 months 3-6 months 6-12 months over 1 year

Has the applicant ever received any treatment or counseling for domestic violence? Yes No

If yes, when and where? _____

Has the applicant ever had a DCFS case open in the past? Yes No

Does the applicant currently have an open DCFS case? Yes No

If yes, are there any DCFS requirements for the family to complete? Yes No

If yes, please explain briefly.

Health Status

Has the applicant completed a Tuberculosis Test within the last 6 months? Yes No

What is the status of the applicant's general health? Excellent Good Fair Poor

Does the applicant have any health problems and/or concerns? Yes No

If yes, please identify: _____

How often does the applicant see a doctor for her health? _____

Has the applicant been prescribed a special diet? Yes No

Is the applicant prescribed any medication? Yes No

If yes, please identify: _____

If yes, does it impair her daily routine? Yes No

Does the applicant have mobility limitations? Yes No

If yes, please explain: _____

Does the applicant have a physical disability? Yes No

If yes, please identify: _____

Does the applicant have a developmental disability? Yes No

Does the applicant consider herself to have a disabling condition? Yes No

Does the applicant require an accessible unit? Yes No

Does the applicant have current or past substance abuse issues? Yes No

If yes, has the applicant been clean and sober for at least 3 months? Yes No

If yes, is she able to continue treatment throughout her residency? Yes No

Does the applicant have a mental health diagnosis or history? Yes No

If yes, when was she treated and what was the diagnosis? _____

Has the applicant ever been treated or hospitalized for psychiatric issues? Yes No

If yes, when was she treated and what was the diagnosis? _____

If yes, is she currently in treatment? Yes No

Is the applicant currently receiving any mental health services? Yes No

If yes, does she agree to continue with treatment and/or compliance with medication? Yes No

Income Source

What is/are the applicant's source(s) and amount of income? Please list all types of income received, such as; CalWorks, GR, SSI, SSDI, Child Support, Alimony, Financial Aid, Unemployment, Employment, etc.

Source of Income	Amount of Income	How Often? (biweekly, monthly, etc.)
	\$	
	\$	
	\$	
	\$	

Does the applicant have any other source of income and/or additional benefits? Yes No

If yes, state source and amount. _____

Is the applicant currently employed? Yes No

If yes, please provide employer information.

Employer Name: _____

Address: _____

Position/Title: _____ Proof of Employment: _____

Number of Hours per Week: _____ Amount Paid per Hour: \$ _____

Contact Person & Title: _____ Phone Number: (____) ____ - _____

If no, please state why.

How long has the applicant been unemployed? _____

Is the applicant willing to find employment? Yes No

What are three employment goals that the applicant has?

1. _____
2. _____
3. _____

Educational Enrollment

Is the applicant in an educational/training program? Yes No

If yes, please provide school and enrollment information.

Name of School/Training: _____

Major/Field: _____ Number of Credits: _____

Length of Enrollment to Date: _____ Expected Date of Completion: _____

Class Hours / Days: _____

Contact Person & Title: _____ Phone Number: (____) ____ - _____

Legal Issues

Has the applicant been arrested and/or convicted of a crime, felony or misdemeanor? Yes No

If yes, please complete the following (list all charges, arrests and/or convictions):

Date	Place (City, State)	Reason (Offense)	Outcome (Conviction)
/ /			
/ /			
/ /			

Is the applicant currently on parole or probation? Yes No

If yes, please provide Parole/Probation Officer's contact information

Name: _____ Phone Number: () - ext. _____

Office Address: _____

Does the applicant currently have any other legal issues that need addressing? Yes No

If yes, please explain.

Is the applicant a registered sex offender? Yes No

Family/Social Network

Does the applicant have any family support system? Yes No

Please describe the applicant's current family situation. (# of children, living with family members, significant others, etc.)

Children's Name (under 16 years)	Date of Birth	Sex	Grade	Special Needs/Notes
	/ /			
	/ /			
	/ /			
	/ /			
	/ /			

Childcare Information (Answer only if you are applying for Farley House)

Have the applicant's children ever been in childcare? Yes No

Does the applicant currently have child care arrangements for her child(ren)? Yes No

If yes, please detail her child(ren) care plan:

Child Name	Age	Service Provider Information	Schedule
		Name: _____	Mon : to :
		Phone: () - _____	Tue : to :
			Wed : to :
			Thu : to :
			Fri : to :
			Sat : to :
			Sun : to :
Child Name	Age	Service Provider Information	Schedule
		Name: _____	Mon : to :
		Phone: () - _____	Tue : to :
			Wed : to :
			Thu : to :
			Fri : to :
			Sat : to :
			Sun : to :

Does the applicant have the ability to pay for childcare? Yes No

If yes, what resource(s) does she have? _____

If no, does she have access to support services to financially assist her with this cost? Yes No

If yes, what service(s) does she have? _____

Please fax this Referral Application, Certification of Homelessness and **ALL** supporting/required documents to the fax number listed on the criteria.

Thank you for taking your time to complete this application. All contact will be made via the Case Manager only. If you have any questions, please feel free to give us a call.

Good Shepherd Center
 1671 Beverly Blvd.,
 Los Angeles, CA 90026
 Phone: (213) 235-1460
 Fax: (213) 235-1480
 www.gschohomeless.org

Applicant Agreement

I agree to submit a drug test should the need arise. I understand that I cannot use alcohol or any non-prescription drug(s) during my stay at Good Shepherd Center. I also understand that my acceptance will also be contingent on a positive background check and if I am accepted into the program, a background check will be completed.

Along with this referral application, I agree to forward a Certification of Homelessness, copies of current TB test, I.D., Social Security Card (includes adult & children), Proof of Income, Birth Certificate (children only), Immunization records (children only). At intake, I agree to bring Original & Current TB, ID, Social Security Card (includes adult & children), Birth Certificate (children only), and Immunization Records (children only).

I certify that any statements made in this application are true and complete to the best of my knowledge. I do understand that giving false or misleading statements or misrepresenting, hiding or withholding material facts will subject me to disqualification or dismissal from the program.

Signature of Applicant

Date

Signature of Case Manager/Referral Coordinator

Date