Phased Assessment Part 7 – Housing Stabilization Plan

*The information is needed to assist in providing you with appropriate supports and assistance to stabilize and succeed in housing, in addition to meeting varying landlord requirements. The information is **NOT** used as criteria for program eligibility.*

EMERGENCY CONTACT INFORMATION

Participant MUST provide at least one emergency contact.

PRIMARY EMERGENCY CONTACT INFORMATION

May contact the following in case of ( ) Medical emergency, ( ) inability to reach participant, ( ) other _____

Name _____ Relationship to Participant:

Street Address _____ _____
(friend, sibling, etc.)

City _____

State, Zip _____

Phone _____

SECONDARY EMERGENCY CONTACT INFORMATION

May contact the following in case of ( ) Medical emergency, ( ) inability to reach participant, ( ) other _____

Name _____ Relationship to Participant:

Street Address _____ _____
(friend, sibling, etc.)

City _____

State, Zip _____

Phone _____

Supportive Services Assessment:

EMPLOYMENT

If currently EMPLOYED:

Name of Employer: _____

Approximate hours per week: _____

Length of time in position: _____

Current monthly wage: _____

If currently UNEMPLOYED:

Last job held: _____

Dates of last employment: _____

Length of time in position: _____

Ending monthly wage: _____

Collecting Unemployment benefits? _____

If yes, on what date will benefits expire? _____

INCOME*, (e.g. SSI, SSDI, General assistance) other than earned income*

Please report the amount, source and start date of **ALL income** that you **currently** receive. If source is not included on the list, please use the "Other" category.

	Amount	**Frequency** (Monthly/weekly)	**Start Date** (Approximate)
☐ Supplemental Security Income (SSI)	$_____	_____	_____
☐ Social Security Disability Income (SSDI)	$_____	_____	_____
☐ Social Security Retirement (SSA)	$_____	_____	_____
☐ General (Public) Assistance	$_____	_____	_____
☐ Veteran's Benefits			
☐ Service Connected %: _____	$_____	_____	_____
☐ Non-Service Connected	$_____	_____	_____
☐ VA Pension	$_____	_____	_____
☐ Employment Income	$_____	_____	_____
☐ Unemployment Benefits	$_____	_____	_____
☐ TANF	$_____	_____	_____
☐ Link/SNAP (Food Stamps)	$_____	_____	_____
☐ Child Support	$_____	_____	_____
☐ Other: _____	$_____	_____	_____

Total Monthly Income $_____

If receiving any Public Aid benefits (SNAP, TANF, etc.), please provide your Public Aid Office Location:

_____

_____

Description of any pending government income assistance: _____

Verification of reported income has been included with application. ☐ Yes ☐ No

OUTSTANDING DEBT

Please provide a list of all debt including: utilities (electric, gas, phone, etc.), any back rent owed, etc.

Company: _____ Total amount owed: _____

Company: _____ Total amount owed: _____

Company: _____ Total amount owed: _____

Company: _____ Total amount owed: _____

Company: _____ Total amount owed: _____

Total Debt: _____

Have you ever filed for bankruptcy? ☐ Yes ☐ No If yes, when? _____

If yes, how did you file? ☐ Chapter 7 ☐ Chapter 13 ☐ Other: Specify: _____

CLIENT NARRATIVE

What do you consider to be your strengths?

_____

_____

_____

What do you consider to be challenging for you?

_____

_____

_____

SUPPORT SYSTEM: How would you describe your relationship with your family of origin?

_____

_____

_____

Are there any other relationships in your life or organizations that you belong to that you consider important? Please describe:

_____

_____

_____

Health and Wellness History:

The information requested here is Important for development of a comprehensive supportive services plan. The information is NOT used as criteria for program eligibility

INSURANCE

- ☐ None
- ☐ Private Insurance
  Name _____
- ☐ Medicaid ID# _____
- ☐ Medicare ID# _____

MEDICAL CONDITIONS, including behavioral health conditions

What condition/s do you currently have that affects your health and well-being?

_____

_____

_____

MEDICAL PROFILE

For effective services, the following medication information should be obtained now or at a later date. However, please provide what you are able to now.

- ☐ DETAILED BELOW
- ☐ WILL BE OBTAINED AT A LATER DATE

ALLERGIES

List all allergies, including medication related allergies.

_____

_____

MEDICATIONS

DRUG	DOSAGE	FREQUENCY	PRESCRIBING M.D.

VITAMINS AND SUPPLEMENTS

DRUG	DOSAGE	FREQUENCY	PRESCRIBING M.D.

HEALTH CARE PROVIDERS *(e.g. primary care, mental health, rehabilitation, substance abuse, etc.)*

TYPE OF PROVIDER	NAME	ADDRESS	PHONE

EMERGENCY ROOM VISITS IN LAST SIX MONTHS, including mental health related visits.

DATE of VISIT	HOSPITAL	REASON	OUTCOME

HOSPITALIZATIONS IN LAST SIX MONTHS, including mental health related visits.

DATES OF HOSPITALIZATION STAY	HOSPITAL	REASON	OUTCOME