

Independence House Application

Date: _____

The undersigned hereby makes an application for rental accommodations located at _____ beginning _____

The undersigned hereby declares that he/she has 30 days or more drug and alcohol free.

YES NO Number of day/ months/ years: _____

PLEASE PRINT

Demographic Information

Full Name _____

Date of Birth _____

Social Security No. _____

Sex _____

Marital Status _____

Home Phone _____

Other Phone _____

Name of Person assisting w/ application (if applicable): _____

Relationship to the applicant: _____

Address: _____

Home Phone: _____ Other Phone: _____

Information about Your Injury

What was the date of the injury? _____

What was your age at the time of the injury? _____

What was the cause of the brain/ spinal cord injury? _____

Were there any other injuries that occurred at the time of the brain/ spinal cord injury? _____

Course of Treatment

Please list each medical facility you have attended and any treatment received as a result of the injury. Please include the initial hospital where you were taken, any rehabilitation hospitals or programs, any outpatient services you may have received, vocational services, etc.

Facility Name _____

Date of Treatment _____

Type of Treatment _____

Insurance/ Benefits Information

____ Private Insurance Company Name _____
Policy Number _____

____ DD Medicaid Waiver Support Coordinator _____

____ Medicaid Medicaid Number _____

____ Medicare Medicare Number _____

____ SSI/SSDI Amount _____

____ Other (please specify) _____

Please check off any items that you currently experience and explain below.

Physical Issues:

- | | |
|---|------------------------|
| ____ Generally Healthy (not often sick) | ____ Seizures |
| ____ Poor Sense of Balance | ____ Blackouts |
| ____ Paralysis | ____ General Weakness |
| ____ Vision Disorders | ____ Hearing Disorders |
| ____ Loss of taste | ____ Loss of smell |

Cognitive Issues:

- | | |
|--------------------------------|----------------------|
| ____ Memory | ____ Persistence |
| ____ Decision Making | ____ Initiation |
| ____ Processing Speed | ____ Self Perception |
| ____ Judgment | ____ Inflexibility |
| ____ Organization | ____ Thinking |
| ____ Problem Solving Abilities | ____ Perception |

Emotional/ Behavioral Issues:

- | | |
|---------------------------------------|------------------------------------|
| ____ Depression | ____ Reduced Self Esteem |
| ____ Weak Social Skills | ____ Difficulty with Relationships |
| ____ Mood Swings | ____ Difficulty Relating to Others |
| ____ Inappropriate Behavior | ____ Stress |
| ____ Inability to Inhibit Remark | ____ Anxiety |
| ____ Failure to Recognize Social Cues | ____ Low Tolerance for Frustration |

Please explain any issues checked above: _____

Drug/ Alcohol History

Pre-injury:

Post-injury:

Community Services/Agencies

Department of Rehabilitative Services Counselor _____
Phone _____

Department of Rehabilitative Services Caseworker _____
Phone _____

Social Services Contact _____
Phone _____

Other Agencies _____
Phone _____

Daily Skills and Abilities

Please Check the Column that best describes you current abilities in each area; skip those areas that do not apply.

<u>Ability</u>	<u>Fully Independent</u>	<u>Minimal Assistance</u>	<u>Substantial Assistance</u>	<u>Fully Dependent</u>
Eating	_____	_____	_____	_____
Dressing	_____	_____	_____	_____
Showering/ Bathing	_____	_____	_____	_____
Toileting	_____	_____	_____	_____
Walking in the home	_____	_____	_____	_____
Walking in the community	_____	_____	_____	_____
Use of public Transportation	_____	_____	_____	_____
Driving a car	_____	_____	_____	_____
Managing Money	_____	_____	_____	_____

Transportation

_____ Able to Drive

Type of auto (make & model) _____ License _____

Driver's License No _____ State _____

_____ Family Member/ Friend Name: _____ Phone: _____

_____ CARE Name: _____ Phone: _____

_____ Medicaid Transport Name: _____ Phone: _____

_____ Cab Company Name: _____ Phone: _____

_____ Other/ Explain Name: _____ Phone: _____

Social Support Network

Whom do you rely on for your primary support and assistance?

<u>Name</u>	<u>Relationship to you</u>
_____	_____
_____	_____
_____	_____
_____	_____

Educational History

Beginning with your most recent educational experience, list the schools you have attended, years of attendance, and degrees earned.

<u>School Attended</u>	<u>Years</u>	<u>Degree</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Work History

Begin with your most recent job.

<u>Position</u>	<u>Company</u>	<u>Duties</u>	<u>Period Employed</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list your present and past housing information

Present address, including city, state, & zip code (County _____)

Present Landlord _____ Phone No _____

Present Landlord's address, including city, state, and zip code

Length of Occupancy: From: _____ to _____

Do you pay rent? Yes _____ No _____ If yes, what amount? _____

Reason for leaving _____

Previous address, including city, state, & zip code (County _____)

Previous Landlord _____ Phone No _____

Previous Landlord's address, including city, state, and zip code

Length of Occupancy: From: _____ to _____

Did you pay rent? Yes _____ No _____ If yes, what amount? _____

Reason for leaving _____

INCOME FROM OTHER SOURCES INCLUDING MILITARY ALLOTMENTS, BANK INTEREST, STOCK DIVIDENDS OR FROM ANY OTHER SOURCES

Type and amount annually: _____

Bank Account: _____
Name of Bank Address Account No.

List any/all liabilities, debts and liens against you:

Date	Creditor	Amount
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EMERGENCY INFORMATION

In case of emergency, please list 2 people to contact (next of kin)

1 – Name _____
 Phone _____ Other Phone _____

Address _____

Relationship to you _____

2 – Name _____
 Phone _____ Other Phone _____

Address _____

Relationship to you _____

CRIMINAL RECORD PRE-INJURY

Offense _____ Date _____ Felony _____

Offense _____ Date _____ Felony _____

Probation/Parole Officer's Name _____ Phone No. _____

CRIMINAL RECORD POST-INJURY

Offense _____ Date _____ Felony _____

Offense _____ Date _____ Felony _____

Probation/Parole Officer's Name _____ Phone No. _____

PERSONAL REFERENCES

1 - _____
 Name Address City Phone

2 - _____
 Name Address City Phone

The undersigned Applicant has examined the statements made on this application form and hereby certifies that they are true, correct and complete, and that all family income has been listed above. The statements are made so that Virginia Supportive Housing can determine if the Applicant is eligible to enter into a lease for the efficiency apartment that may be available. The Applicant understands that the management company will request a credit, rental or residential history check, housekeeping check, employment check when applicable and a criminal history report. Further all information on this application will be verified to assist in determining his/her eligibility.

THIS DATA AND ALL DATA RECEIVED BY THE MANAGEMENT RELATIVE TO INCOME OF APPLICANTS IS REGARDED AS BEING CONFIDENTIAL IN NATURE AND PROTECTED TO THE EXTENT PERMITTED BY LAW.

I HEREBY AUTHORIZE VIRGINIA SUPPORTIVE HOUSING TO PERFORM AN INVESTIGATION IN ORDER TO VERIFY THE INFORMATION CONTAINED HEREIN.

APPLICANT

DATE

OFFICE USE ONLY:

Section 8 approved: _____

Credit Report Rec: _____

Landlord Reference: _____

Police Report: _____

Lease Date: _____

Deposit: _____

Rent: _____

Supportive Services Report: _____