

APPLICATION FOR WOMEN'S COMMUNITY

(Revised August 2024)

DATE _____

Harmony/Shiloh Transitional Housing (2 year time limit)

Selah Long Term Housing

PLEASE PRINT

1. Client's Name: _____ Sin # _____

Care Card # _____ Age: _____ Birthdate: _____

Ethnicity/Indigenous: : _____ Veteran: _____ Yes

_____ No

Address: _____

Phone _____ (wk) _____ best time to call: _____

License Plate # _____ Make/model of vehicle: _____

Marital Status: _____ single _____ engaged _____ married _____ widowed _____ divorced

_____ separated _____ common-law _____ how long _____ how many times _____

Education _____ Occupation _____

Spouse's Name _____ Age _____

Birth date _____ Sin # _____ Care Card _____

Family Doctor _____

Phone # _____

Ministry Worker _____ A/D Worker _____

Other _____

Income source _____ Monthly Income _____

2. List name, birth date, sex, relationship of all children, and whether they live at home with you.

NAME	BIRTH DATE	SEX	RELATIONSHIP	AT HOME?
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----

3. **CRISIS INFORMATION:**

Do you have any current suicidal thoughts feelings or actions? _____ yes _____ no

If yes please explain:

Do you have any past problems with hospitalizations, or jailing for suicidal or assaultive behavior?

_____ yes _____ no - If yes please explain:

Do you experience any current threats of significant loss or harm (illness, divorce, custody, job loss etc.)?

_____ yes _____ no - If yes please explain:

Are you presently on probation, or parole? _____ yes _____ no. If yes please explain:

Name of Parole/ Probation Officer: _____

Phone: _____

4. MEDICAL INFORMATION:

Family Doctor: _____ Phone: _____

Are you presently taking any medications? If yes, please list below:

MEDICATIONS:

Any problems with: _____eating _____sleeping _____chronic pain_____ recent weight changes.

Describe any answers checked above:

Any other medical problems:

Do you have a mental health diagnosis?

Have you or a family member ever been hospitalized for mental or emotional illness?

_____yes _____no - If yes, please explain dates, places, reason:

5. Who referred you to us? (Name, relationship, and phone number(s))

6. Previous housing over the last 2 years:

7. Taxes up to date: _____ Yes _____ No

8. Outstanding financial issues: _____

9. Do you attend a local church? If yes, which one

10. Are you baptized? _____

11. ID: Identification needs replacing:
- a. Driver's License _____
 - b. Birth Certificate _____
 - c. Care Card _____
 - d. Passport _____
 - e. BC Picture ID _____

12. By signing this form, I agree to follow all guidelines. I will show up for scheduled appointments.

Signed this _____ day of _____ 200_____

Client Signature: _____

Women's Community Director: _____