



CATHOLIC COMMUNITY SERVICES
CATHOLIC HOUSING SERVICES
OF WESTERN WASHINGTON

Katherine's House and Rita's House are transitional housing for homeless women in recovery from drugs and alcohol. We serve addicts/alcoholics who are willing to engage in outpatient treatment, attend recovery meetings, and meet weekly with the Program Manager on-site.

Our houses are structured. This means there is a curfew, daily house chore, and weekly yard chores. We meet weekly to recap the week and support each other.

We live in community. You will have your own bedroom but share every other space of the house. We go on outings together and celebrate holidays together. Your children may visit and possibly enjoy a sleepover with you.

Our hope is that at the end of your time with us, you will be stronger in your recovery, permanently housed, and employed or pursuing education.

Name: _____ Cell Phone: _____

E-mail: _____

Referent Information- Staff: _____ Agency: _____

Staff phone: _____ E-mail: _____

Homeless Status- Where did you sleep last night?

Outdoors (street/car) Shelter (name): _____

Inpatient/Hospital (Where): _____

Housed-Feeling Domestic Violence Other (Explain): _____

Please specify your treatment needs-

Medical Diagnoses: _____

Mental Health Diagnoses: _____

Substance Use History: _____

If applicable, what are you doing to address your mental health challenges?

What is your clean date? _____ Drug of choice: _____

What are you doing now to maintain your recovery?

Living with people is difficult. How have you struggled to live in community with others?

For questions contact Stephanie Obad Schmor at 253-508-2755 or StephaneSc@ccsww.org. Please fax your full application to 253-856-7948.

*Please Note:

- Katherine's House and Rita's House does not maintain a waitlist.
- Katherine's House and Rita's House is a clean and sober program. Absolutely no alcohol or drugs on the agency property.
- An incomplete application will not be considered.



CCS-CHS Intake form

Program: _____

Entry Date: _____

Form for clients to fill out. 9-19-19

Print Name: _____

Age: _____ **Date of birth:** _____ **SSN:** _____

Optional info:

Your phone: _____ **Email:** _____

Next of kin, name & phone: _____

Gender Identity: F M Transgender M/F Transgender F/M Gender non-binary

What is your ethnic background? (Please check all that apply)

- Asian/Asian American Native Hawaiian/Pacific Islander White Black/African American
 Native American/Alaskan Native Refused

Do you identify as Hispanic OR Non-Hispanic

Have you ever served in the U.S. Military? Yes No

If you served: Year in: _____ Year out: _____

- If you served in war: WW 2 Korea Vietnam Persian Gulf/Desert Storm Afghanistan
 Iraq Op. Freedom Iraq New Dawn Other peace-keeping operations

Branch: Army Air Force Navy Marines Coast Guard **Discharge Status** _____

Last place you lived, housed: City: _____ **State:** _____

Where are you staying now? Zip code: _____ **and City:** _____ **State:** _____

- | | | | | |
|----------------------------------|--------------------------------------|--|-----------------------------------|--|
| Check one: | <input type="checkbox"/> Streets | <input type="checkbox"/> Transitional housing | } How long there? _____ | <input type="checkbox"/> Family |
| | Vehicle: | <input type="checkbox"/> Motel with voucher | | <input type="checkbox"/> Friends |
| | <input type="checkbox"/> Van | <input type="checkbox"/> Jail/prison | | <input type="checkbox"/> Motel you paid for |
| | <input type="checkbox"/> Auto / car | <input type="checkbox"/> Treatment/detox | | <input type="checkbox"/> Apt./house you paid for |
| | <input type="checkbox"/> RV / camper | <input type="checkbox"/> Hospital <input type="checkbox"/> Care facility | | <input type="checkbox"/> Apt./house with subsidy |
| | <input type="checkbox"/> Squatting | Other: _____ | | TYPE of Subsidy: _____ |
| <input type="checkbox"/> Shelter | | | | |

Length of stay at current place: _____

How long have you been continuously homeless for? _____ **Since what date?** (more or less): _____

How many times have you been homeless in the last 3 years? _____

And for how long altogether in these last 3 years? _____

Do you have a disability? Yes No

Check all that apply: Physical Developmental Chronic Health Issue HIV-AIDS Mental Health
 Alcohol Drugs Other special needs

Staff: List the disabilities which are long term & affect client's ability to live alone:

Have you experienced domestic violence recently? Yes No If yes, how long ago? _____

Are you currently fleeing? Yes No

Are you currently under a no-contact order? If so, with whom? _____

Are you pregnant? Yes No If so, due: _____

Immigrant or refugee? Yes No

Can you communicate in English? Yes No

Are you the spouse/partner of a veteran? Yes No

Do you have income? Yes No **Monthly amount \$** _____

Looking for work? (only if not working now) Yes Unable to work No

Source of income:

Employment → Full time Part Time Seasonal/Day Labor

Unemployment L&I (worker's comp) VA Disability → Is it service-connected? Yes No

SSDI SSI SS Retired Pension TANF ABD Alimony Child Support

Other _____

Do you receive non-cash benefits?

Food stamps or Benefits Card WIC TANF Non cash Benefits Other sources: _____

What type of health insurance do you have?

None Medicaid (Apple Health) Medicare Veteran's Health Care Employer provided COBRA

Self paid on your own, no subsidy Subsidy through the state exchange Indian Health

Other, specify: _____

Thank you.

Staff only:

HMIS Consent Yes No **Unique Identifier #** _____ **Client Name:** _____

Homeless status at entry documented? Yes No n/a

Staff Name: _____

Verification of Homelessness

Are you currently homeless or losing your place to stay with nowhere else to go?

If yes, sign and date below.

Applicant's Signature

Date

Where are you staying at night right now? (Check **one** and answer all the questions across.)

| ASK WHERE | Zip code/Area | How long have you been there? |
|-----------------------------|---------------|-------------------------------|
| Streets / Car <i>where?</i> | | |
| Shelter <i>which one?</i> | | |

| ASK WHERE | Zip code/Area | How long have you been there? | How much longer can you stay there? | Why do you have to leave? |
|--|---------------|-------------------------------|-------------------------------------|--|
| Transitional housing <i>which one?</i> | | | | |
| Apartment | | | | Why do you have to leave: Are you on the lease? <input type="checkbox"/> yes <input type="checkbox"/> no |
| Domestic violence situation | | | | |
| Other: (<i>explain</i>) | | | | |
| Motel/Hotel | | | | <i>Do you have a voucher from an agency?</i> <input type="checkbox"/> yes <input type="checkbox"/> no <i>If yes, what agency?</i> |

| ASK WHERE | Zip code/Area | When did you enter? | When do you have to leave? | Where were you staying before? |
|--|---------------|---------------------|----------------------------|--------------------------------|
| Psychiatric facility: <i>which one?</i> | | | | |
| Hospital: <i>which one?</i> | | | | |
| Substance abuse or treatment facility: <i>which one?</i> | | | | |
| Work release: <i>which one?</i> | | | | |

I have determined this applicant is staying either on the streets or in a shelter, or is now losing their place to stay and has nowhere else to go.

Staff or Case Manager

Date

Katherine's House/Rita's House Income Verification

Applicant Name _____

| Sources of Income (check all that apply) | Amount per month? | When did you <u>start</u> receiving this income? | When will you <u>stop</u> receiving this income? |
|---|----------------------|---|---|
| <input type="checkbox"/> Work | \$ | | |
| <input type="checkbox"/> Unemployment Benefits | \$ | | |
| <input type="checkbox"/> ABD | \$ | | |
| <input type="checkbox"/> SSI or <input type="checkbox"/> SSDI | \$ | | |
| <input type="checkbox"/> Social Security | \$ | | |
| <input type="checkbox"/> ADATSA | \$ | | |
| <input type="checkbox"/> Veterans Benefits | \$ | | |
| <input type="checkbox"/> TANF | \$ | | |
| <input type="checkbox"/> Other (not food stamps) | \$ | | |
| <input type="checkbox"/> No income | | | |

❖ Are You Receiving Medical Care Services? (Circle One): Yes No

| Type of Documentation provided | Allowable Documents (Attach written documentation to this form) |
|--|---|
| <input type="checkbox"/> Benefits | Third-party written verification directly from the information source, such as employer, DSHS, Employment Security, Social Security, VA, etc. |
| <input type="checkbox"/> Employment | May include pays stubs, statement from employer, etc. |
| <input type="checkbox"/> Oral | Document in the spaces below the conversation. |
| <input type="checkbox"/> Self-Declared | Acceptable only when other verifications are unavailable. Use for zero income. |

Oral documentation (use for phone conversations with employers, etc):
Date: _____ **Contact Person:** _____

Source of Income: _____

Amount of Income: _____ **Staff signature:** _____

Applicant signature _____ Date _____

Staff Signature _____ Date _____

Pre-screening review:

The resident verified that this is their current income at time of program entry.

The resident's income has changed since the time of application.

Please attach an updated income verification form for the resident's income at time of entry.

Staff Signature _____ Date _____