Shelter From The Storm
P.O. Box 257
Jaffrey, NH 03452
603-532-8222
sftsnh@gmail.com - www.shelterfromthestormnh.org

APPLICATION FORM

NAME:_____ **DATE:** _____

Maiden or other names used: _____

Address: _____ Phone: _____

_____ OK to leave message? _____

Email: _____D.O.B. _____ Married ___ Single ___ Div.___Sep.___

Are you in a relationship now? Yes No With whom? _____

Contact Information: _____

Emergency Contact Information: Name:_____

Relationship: _____ Phone _____

Address _____

Are you a US citizen? Yes __ No __ Social Security # _____

Who referred you to SFTS? _____

Are you currently pregnant? Yes ____ No ____ Due Date? _____

Family members who would be staying at SFTS:

Name _____ DOB _____ Relationship _____ Sch/grade _____

Soc. Security # _____ Father's Name _____

Birth Certificate: Yes No (Explain)

Name _____ DOB _____ Relationship _____ Sch/grade _____

Soc. Security # _____ Father's Name _____

Birth Certificate: Yes No (Explain)

Name _____ DOB _____ Relationship _____ Sch/grade _____

Soc. Security # _____ Father's Name _____

Birth Certificate: Yes No (Explain)

Name _____ DOB _____ Relationship _____ Sch/grade _____

Soc. Security # _____ Father's Name _____

Birth Certificate: Yes No (Explain)

Do you have physical custody through the courts for the children listed above? Yes _____ No _____

School or day care attending _____

Will you need childcare? Yes _____ No _____

DCYF or DHS Caseworker name and dates of involvement:

_____

Have you resided in similar housing before? Yes _____ No _____

If yes, please list program, address (group home, transitional housing, shelter, etc.) and dates:

_____

Reason for needing shelter: (Dom. Violence; restraining orders; job loss; financial; medical; other)

_____

Have you applied for assistance through the town welfare? Yes ____ No ____

If yes, are they currently or willing to assist you? Yes _____ No _____

If an apartment is not available, are you interested in being put on a waiting list? Yes _____ No _____

Do you have storage for your belongings? Yes _____ No _____

We do not take pets. If you have a pet, are you able to make arrangements for it to be taken care of while in our program? Yes _ No__

Please provide any additional information you feel may be helpful. _____

_____

SUBSTANCE/ALCOHOL HISTORY ***(Shelter From The Storm reserves the right to do random drug testing at any time.)***

Do you or other members of the family smoke? Yes _____ No _____

Are you or have you ever used any narcotic or illegal drug including marijuana? Yes __ No __

If yes, explain: _____

What is your level of alcohol use? 3+ a day _____ 1-2 a day _____ 1-2/wk _____ None _____

Have you ever been treated for substance or alcohol abuse? Yes __ No __

If you are recovering from an addiction, what rehab program, if any, did you attend?

_____

Are you currently taking Suboxone or Methadone as a treatment? Yes___ No ___

How long have you been in recovery? _____How often do you attend AA or NA? _____

Do you have a sponsor or recovery coach? Yes No

Recovery Coach or Sponsor's Name _____

Contact Information: _____

BANKING:

Please rate your financial/credit history: Poor _____ Fair _____ Good _____ Excellent _____

Please explain: _____

_____

Do you have a bank account? Yes ____ No ____ Type: Checking _____Savings _____Both _____

Name of bank? _____ Current balance $ _____

If no, do you have past due, overdrawn bank accounts? Amount owed? _____

EDUCATION:

Highest level completed: _____ Do you have a copy of your Diploma/GED? Yes ____ No ____

Degrees/ Certifications/Course of Study: _____

Are you currently participating in any type of job placement or training program: Yes ____ No ____

Have you defaulted on any student loan? Yes _____ No _____ If so how much is owed? _____

Have you ever been diagnosed or suspected of having a learning disability? Yes __ No ___

If so, what? _____

What are your specific education/career goals? _____

_____

_____

EMPLOYMENT:

Are you employed? Yes _____ No _____ Do you have pay stubs? _____

PRESENT ADDRESS OF EMPLOYER:

Address _____

Dates employed: From: _____ to: _____ Rate $ _____ How often paid: _____

Supervisor: _____ Phone: _____

Position: _____ May we contact to verify employment: Yes No

PREVIOUS EMPLOYERS:

Previous employment & address: _____

Dates employed: From: _____ to: _____ Rate $ _____ How often paid: _____

Supervisor: _____ Phone: _____

Reason for leaving: _____

Position: _____ May we contact to verify employment: Yes No

Previous employment & address: _____

Dates employed: From: _____ to: _____ Rate $ _____ How often paid: _____

Supervisor: _____ Phone: _____

Reason for leaving: _____

Position: _____ May we contact to verify employment: Yes No

MILITARY SERVICE: _____

_____

LEGAL:

Do you have a criminal record / history? Yes ___ No ___

Have you ever been convicted of a misdemeanor? Yes ___ No ___

Have you ever been convicted of a felony? Yes ___ No ___

If Yes explain: _____

_____

Do you have a parole or probation officer? Yes ___ No ___

If Yes please list name and contact #: _____

Do you have a restraining order against you or in place against someone else? Yes ___ No ___

If Yes please list name and contact #: _____

Describe: _____

Have you ever experienced domestic violence or sexual assault against you? Yes ____ No ____

Do you or any member of your household, have any current or pending legal matters? Yes ____ No ____

If yes, please indicate below:

___ Sexual Offenses ___ Parole/Probation ___ Child Support ___Child Custody ___DCYF ___ Divorce

___DUI ___Separation ___Criminal Charges ___Assault Charges ___Other Charges ___Parking Tickets

If other, please explain/date: _____

_____

VEHICLE/DRIVER'S LICENSE:

Do you have a valid driver's license? Yes ___ No ___ License # & State _____

If no, license status: _____

Do you have a vehicle? Yes __ No __ Make/model/Yr/Color: _____

Registered in your name? Yes _____ No _____ Inspected: Yes _____ No _____ Insurance: Yes _____ No _____

License Plate Number: _____

What condition is your car? List any problems you have or foresee in the near future with your car:

_____

_____

If you do not have a car how do you get around? _____

LAST THREE ADDRESSES NOT INCLUDING PRESENT:

Landlord Name _____

Phone #_____ From _____ To_____

Address _____

_____

Reason for moving _____Rent _____

Landlord Name _____

Phone #_____ From _____ To_____

Address _____

_____

Reason for moving _____Rent _____

Landlord Name _____

Phone #_____ From _____ To_____

Address _____

_____

Reason for moving _____Rent _____

IMMEDIATE NEEDS:

What are your immediate areas of need? Please number in order of need.

Housing	_____	Mental Health	_____
Employment	_____	Childcare	_____
Financial	_____	Transportation	_____
Counseling	_____	Food	_____
Spiritual Wellbeing	_____	Medical	_____

SUPPORTS:

Who do you consider are supports in your life? (Parents, siblings, friends, etc.)

_____

_____

Describe the relationships you have and/or had with parents, siblings, children, father of children, friends? (good or bad)

_____

_____

_____

_____

PARENTING:

What do you think are your strengths as a parent?

_____

_____

_____

What do you think you could improve? _____

_____

_____

Have you ever attended a parenting group, course or have had individual parenting assistance? Y __ N __

If so, please list dates and where: _____

INCOME & EXPENSE SUMMARY REPORT

INCOME/ASSISTANCE	AMOUNT	MONTHLY/WEEKLY
Wages	$ _____	_____
TANF	$ _____	_____
Food Stamps	$ _____	_____
Child Support	$ _____	_____
Self-Employment	$ _____	_____
Alimony	$ _____	_____
Unemployment	$ _____	_____
Workers Compensation	$ _____	_____
SSI (supplemental sec. inc.)	$ _____	_____
SSDI (S.S. disability insurance)	$ _____	_____
SSA (Social Security Admin)	$ _____	_____
APDT (Aid to permanently & totally disabled)	$ _____	_____
Disability Insurance	$ _____	_____
Other Income	$ _____	_____

WIC - Yes ___ No ___

Most Recent Tax Refund: Date _____ Amount $_____

Checking _____ Savings _____ Other _____

Have you applied for any of these programs and been refused?
If yes, why?

_____

_____

_____

Have any of your entitlements been reduced due to sanctions or for any other reason?

_____

_____

_____

Please don't leave any blank answers. Estimate if necessary.

EXPENSES	AMOUNT	MONTHLY/WEEKLY
Bank Fees	$ _____	_____
Cable/TV/Internet	$ _____	_____
Car Payment	$ _____	_____
Car Insurance	$ _____	_____
Car Registration		
Car Repairs	$ _____	_____
Childcare/Babysitting	$ _____	_____
Child Support	$ _____	_____
Cigarettes	$ _____	_____
Clothing	$ _____	_____
Coffee/Snacks/Fast Food	$ _____	_____
Credit Cards	$ _____	_____
Entertainment	$ _____	_____
Fines/Penalties	$ _____	_____
Food	$ _____	_____
Gas	$ _____	_____
Laundry	$ _____	_____
Legal/Court Fees	$ _____	_____
Loans/Bank	$ _____	_____
Loans Family/Friends	$ _____	_____
Loans/Student	$ _____	_____
Loans/Other	$ _____	_____
Medical Bills	$ _____	_____
Medications/Prescriptions/Vitamins	$ _____	_____
Paper Products (Diapers, kleenex, towels)	$ _____	_____
Personal Items (toiletries)	$ _____	_____
Phone (landline)	$ _____	_____
Phone (Cell)	$ _____	_____
Recreation (Movies, bowling, etc.)	$ _____	_____
Rent/Housing	$ _____	_____
School Lunches	$ _____	_____
Storage Unit	$ _____	_____
Transportation	$ _____	_____
Utility Bills (Electric/Gas Heat/water, etc.)	$ _____	_____
Other	$ _____	_____
Other	$ _____	_____
Other	$ _____	_____

PLEASE LIST ALL PAST DUE DEBT NOT LISTED ABOVE:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you received or gone on line for a free copy of your credit report? Yes ____ No ____

If yes when?

How would you rate your credit?

MEDICAL INFORMATION

Date: _____

NAME (Self): _____ D.O.B. _____

Do you have medical insurance for yourself? Yes _____ No _____

If yes, please list your health insurance coverage. _____

Primary Care Physician _____ Phone_____

Address: _____Date of last physical: _____

Please list current medical or physical conditions, food allergies, addictions, etc. and medications taken for each (i.e. High Blood Pressure – lisonopril) and prescribing doctor:

Condition: _____
Medication: _____ Dosage _____Start Date _____
Doctor _____ Phone _____
Address: _____

Condition: _____
Medication: _____ Dosage _____Start Date _____
Doctor _____ Phone _____
Address: _____

Condition: _____
Medication: _____ Dosage _____Start Date _____
Doctor _____ Phone _____
Address: _____

Condition: _____
Medication: _____ Dosage _____Start Date _____
Doctor _____ Phone _____
Address: _____

Have you ever been diagnosed with a mental or physical disability? Yes __ No __ If yes, please explain.

_____

_____

Have you ever been hospitalized for mental health? _____

Have you ever been involved in counseling or therapy? Yes __ No __

Name of Therapist: _____ Phone _____

Address: _____ Dates: _____

Name of Psychiatrist: _____ Phone _____

Address: _____ Dates: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

CHILDREN MEDICAL HISTORY:

CHILD'S NAME/AGE: _____

Health Insurance _____

Date of last well child visit: _____ Immunizations up to date? Yes __ No __

Physician(s) and phone number: _____

Address: _____

Please list current medical or physical conditions, food allergies, addictions, etc. and medications taken for each (i.e. High Blood Pressure – lisonopril) and prescribing doctor:

Condition: _____

Medication: _____ Dosage _____Start Date _____

Doctor _____ Phone _____

Address: _____

Condition: _____

Medication: _____ Dosage _____Start Date _____

Doctor _____ Phone _____

Address: _____

Has child ever been diagnosed with a mental or physical disability? Yes __ No __ If yes, please explain.

_____

_____

Has child ever been hospitalized for mental health? _____

Has child ever been in counseling or therapy? Yes __ No __

Name of Therapist: _____ Phone _____

Address: _____ Dates: _____

Name of Psychiatrist: _____ Phone _____

Address: _____ Dates: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

CHILD'S NAME/AGE: _____

Health Insurance _____

Date of last well child visit: _____ Immunizations up to date? Yes __ No __

Physician(s) and phone number: _____

Address: _____

Please list current medical or physical conditions, food allergies, addictions, etc. and medications taken for each (i.e. High Blood Pressure – lisonopril) and prescribing doctor:

Condition: _____

Medication: _____ Dosage _____Start Date _____

Doctor _____ Phone _____

Address: _____

Condition: _____

Medication: _____ Dosage _____Start Date _____

Doctor _____ Phone _____

Address: _____

Has child ever been hospitalized for mental health? _____

Has child ever been in counseling or therapy? Yes __ No __

Name of Therapist: _____ Phone _____

Address: _____ Dates: _____

Name of Psychiatrist: _____ Phone _____

Address: _____ Dates: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

CHILD'S NAME/AGE: _____

Health Insurance _____

Date of last well child visit: _____ Immunizations up to date? Yes __ No __

Physician(s) and phone number: _____

Address: _____

<u>Please list current medical or physical conditions, food allergies, addictions, etc. and medications taken for each (i.e. High Blood Pressure – lisonopril) and prescribing doctor:</u>

Condition: _____

Medication: _____ Dosage _____Start Date _____

Doctor _____ Phone _____

Address: _____

Condition: _____

Medication: _____ Dosage _____Start Date _____

Doctor _____ Phone _____

Address: _____

Has child ever been hospitalized for mental health? _____

Has child ever been in counseling or therapy? Yes __ No __

Name of Therapist: _____ Phone _____

Address: _____ Dates: _____

Name of Psychiatrist: _____ Phone _____

Address: _____ Dates: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

_____

CHILD'S NAME/AGE: _____

Health Insurance _____

Date of last well child visit: _____ Immunizations up to date? Yes __ No __

Physician(s) and phone number: _____

Address: _____

Please list current medical or physical conditions, therapeutic supports, food allergies, or addictions:

_____

_____

<u>Please list current medical or physical conditions, food allergies, addictions, etc. and medications taken for each (i.e. High Blood Pressure – lisonopril) and prescribing doctor:</u>

Condition: _____

Medication: _____ Dosage _____Start Date _____

Doctor _____ Phone _____

Address: _____

Condition: _____

Medication: _____ Dosage _____Start Date _____

Doctor _____ Phone _____

Address: _____

Has child ever been hospitalized for mental health? _____

Has child ever been involved in counseling or therapy? Yes __ No __

Name of Therapist: _____ Phone _____

Address: _____ Dates: _____

Name of Psychiatrist: _____ Phone _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

Medication: _____ Dosage _____Start Date _____

Reason for medication: _____

MEDICAL EMERGENCY CONTACT NAME:

Name _____

Address _____

Phone _____ Relationship _____

PERSONAL GOALS

REASONS YOU WOULD LIKE TO BE IN OUR PROGRM

Please list some of the reasons you would like to be in our program.

1._____

2._____

3._____

What does self-sufficiency mean to you? _____

_____

Please list your immediate goals.

1._____

2._____

3._____

How do you want to improve your life and the lives of your children?

1._____

2._____

3._____

I certify that the information contained in this application are true and complete to the best of my knowledge and understand that if accepted as a guest of SFTS, falsified statements on this application shall be grounds for removal.

I authorize investigation of all statements contained herein and the references, landlords and employers listed above to give you any and all information concerning my previous rentals, employment and any pertinent information they may have, personal or otherwise, and release SFTS from all liability for any damages that may result from utilization of such information.

Signature: _____ Date: _____

Signature: _____ Date: _____