APPLICATION for Housing Services Mid Michigan

**Please note: These questions are asked for statistical purposes only and will not affect your eligibility.

Name:_____ Date:_____
Last First M.I.

List all members of your household including yourself.
Gender:(woman, man, culturally specific identity, transgender, non-binary, questioning, different identity)

Name First Name, Middle Initial, Last Name	DOB	Race & Ethnicity	Gender	Social Security #	Relationship Self, Spouse, Son, Daughter etc.	Grade Level of Children

Contact Phone #: _____ Work Phone #: _____

We conduct follow-up surveys to ensure funding.
Do we have your permission to send you text messages to the above number? ☐Yes ☐No Other number:_____

Please check **all** the possible ways to contact you:
☐Call contact phone ☐Text message ☐Mail to below address ☐Email: _____

What is **your current address** (If homeless provide last **permanent** address):

_____
Street Address Apt. # City County State Zip

Emergency Contact

Please list an emergency contact: _____ *Phone #:*_____

*Address:*_____
Street address *City* *State* *Zip* *Relationship*

Have you or anyone in your household served in the US military? ☐Yes ☐No
If yes, which family member served in the US military? _____

Do you or anyone in your household have a disability? ☐Yes ☐No
If yes, which family member is it? _____
Is the disability long term? ☐Yes ☐No
What type of disability do you/they have? Please check the boxes that apply: ☐ Alcohol Use Disorder ☐ Both Alcohol and Drug Use Disorder ☐ Chronic Health condition ☐ Developmental ☐ Drug Use Disorder ☐HIV/AIDS ☐ Mental Health Disorder ☐ Physical

What is your current living situation? (where did you sleep last night)
☐Rental Unit ☐Own Home ☐living with family ☐living with friends ☐Hospital or Facility
☐Street/Car/Tent ☐Jail, Prison, or Juvenile Detention ☐Shelter (includes hotel paid for by shelter/church)
☐Foster Care ☐Transitional Housing ☐Substance Abuse Treatment Facility ☐Hospital

How long have you stayed there? ☐ One night or less ☐ 2 to 6 nights ☐more than a week, but less than a month
☐More than one month but less than 90 days ☐90 days or more but less than 1 year ☐1 year or more

Homeless History:
Are you entering our program from an Emergency Shelter or from the streets (car, tent, etc)? ☐Yes☐No
If yes, give approximate date that you started living in the shelter or streets: _____
What city did you stay in last night? _____

Regardless of where you slept last night,

how many times have you stayed in a shelter or streets in the last 3 years? _____

Total number of months on the streets or in Emergency Shelter in the past 3 years? _____

Are you or anyone in your household covered by HEALTH INSURANCE? (check all that apply)

☐Medicaid, please list which family members are covered:_____

☐Medicare, please list which family members are covered:_____

☐ State Children's Health Insurance, please list which family members covered:_____

☐VA Medical Services, please list which family members are covered:_____

☐Employer Provided Health Ins. please list which family members are covered:_____

☐Health Insurance obtained through COBRA, please list which family members are covered:_____

☐Private Pay Health Insurance, please list which family members are covered:_____

☐State Health Insurance for adults, please list which family members are covered:_____

☐Indian Health Services program, please list which family members are covered:_____

☐Other, please list which family members are covered:_____

INCOME (check all that apply and write the monthly amount received next to the appropriate source.)

	Yourself	2nd Adult Name_____	3rd Adult Name_____
☐ADC/TANF/FIP Grant	$_____ per month	$_____ per month	$_____ per month
☐Child support	$_____ per month	$_____ per month	$_____ per month
☐SSI	$_____ per month	$_____ per month	$_____ per month
☐SSDI	$_____ per month	$_____ per month	$_____ per month
☐Social Security Retirement	$_____ per month	$_____ per month	$_____ per month
☐Unemployment Benefits	$_____ per month	$_____ per month	$_____ per month
☐VA Service connected Disability	$_____per month	$_____ per month	$_____ per month
☐VA Non-service Disability	$_____ per month	$_____ per month	$_____ per month
☐State Disability Benefits	$_____ per month	$_____ per month	$_____ per month
☐Worker's Compensation	$_____ per month	$_____ per month	$_____ per month
☐Alimony/Spousal Support	$_____ per month	$_____ per month	$_____ per month
☐Private Disability Payment	$_____ per month	$_____ per month	$_____ per month
☐Pension from job	$_____ per month	$_____ per month	$_____ per month
☐Other	$_____ per month	$_____ per month	$_____ per month
☐Employment	$_____ per month	$_____ per month	$_____ per month
Total Monthly Income	$_____per month	$_____ per month	$_____ per month

OTHER BENEFITS (check all that apply)

☐Food Stamps $_____ per month ☐DHHS Transportation services ☐ Rental Assistance (section 8, public housing, etc.)

☐WIC ☐DHHS Child Care ☐Other:_____

Are you a victim of domestic violence? ☐Yes ☐No

If yes, when did the experience occur? ☐Within last 3 months ☐3-6 months ago ☐ 6-12 months ago ☐Over a year ago

If yes for domestic violence victim/survivor, are you currently fleeing? ☐Yes ☐No

How did you hear about our agency? ☐Agency ☐Lender ☐ Mailer ☐Walk in ☐Word of mouth ☐Face Book

☐ Our Website ☐211 ☐Newspaper

Have you worked with our agency, Housing Services, before? ☐Yes ☐No If yes, how long ago?_____

Your Signature:_____Date_____