



The Front Door Agency, Inc.
Transitional Housing Program
603-886-2866
FAX 603-821-6054

APPLICATION FOR RESIDENCY

Please note: Incomplete applications will not be processed. Please make sure to answer all questions as thoroughly as possible to the best of your ability.

Name: _____ Today's Date: _____

Street Address: _____ Date of Birth _____ Age _____
City, State, Zip: _____ Length of Time at Address _____

Telephone #(s): _____ Email Address: _____

Is it OK to call? Please circle: YES NO Is it OK to leave message? Please circle: YES NO

Are you a US Citizen? Please circle: YES NO Social Security #: _____

Marital Status -(Please circle): Single Married Separated Divorced Widowed

RACE- -(Please circle): White Black Asian Native American Black/White Other

Ethnic Background: ___Hispanic ___Non-Hispanic

Total # of Children: _____ Total # of Children Living With You: _____

Are you currently pregnant? _____ Anticipated Due Date: _____

Have You Resided Here or in Similar Housing Before? YES NO

If Yes, Please List Program and Dates:

Who referred you? (agency, friend, online, etc.)

(group home, transitional housing, shelter, etc.)

EMERGENCY CONTACT INFO

Name: _____

Relationship to You: _____

Address, City, State: _____

Contact Phone: _____

Is there anyone you wish we NOT contact or leave a message with? YES NO

Name: _____

CHILDREN

Child Name: (First, Last)	Date of Birth:	Age:	Race W-white B- Black N-native American A- Asian O-Other	School status (home, daycare, grade)	Social Security # (last 4 digits)	Father's Name	DCYF/DSS case worker name & dates of involvement If none- list n/a	Who does the Child Currently Live with?

EMPLOYMENT (From most recent to past):

Employer/Address	Position	Amount per hr.	Start/End Dates	Reason for Leaving

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EDUCATION (From most recent to past):

Name of School/City (Latest first)	Dates Attended	Highest Level of Education Completed (Degree, Grade level, etc.)	Course of Study
Have you defaulted on any student loans?	Yes No	Have you Ever Been diagnosed or suspected to have a Learning Disability?	Yes No What?

TRANSPORTATION

Do you have a valid driver's license? What State? _____	Yes No	If no, please explain:
Do you own a car? License Plate # _____	Yes No	Make _____ Color _____ Model _____ Year _____
Is it registered in your name?	Yes No	Do you have auto insurance? Yes No

HOUSING

Please List Last Three Addresses (not including your current address)	Length of Time:	Amount of Rent Paid:	Reason for Leaving

CRIMINAL HISTORY INFORMATION

Have you ever been arrested/ convicted of a crime ?	____ Yes ____ No	If Yes, Please Explain:	Where the charges dropped? Circle: Yes No
Have you ever been convicted of a felony ?	____ Yes ____ No	If Yes, Please Explain:	Where & When did you serve time in jail?
Do you have a parole or probation officer?	____ Yes ____ No	If Yes, Please List Name & Contact #:	Length of Time Remaining

Is there currently a restraining order on/ <i>against you</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please List Name & Contact #:	Describe:
Do you currently have a restraining order in place <i>on/ against someone</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please List Name & Contact #:	Describe:
Are you or have you ever experienced domestic violence or sexual assault against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	No explanation needed here....	

MEDICAL HISTORY-SELF

Do you have medical insurance? Yes No Insurance Co. Name _____

Primary Care Physician _____ Address _____
 Phone Number _____ Date of Last Physical: _____

OB/GYN _____ Address _____
 Phone number _____ Date of Last Visit _____

Please list any present health concerns: _____

Please list any prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dosage as Prescribed	Start Date	Reason for Medication

MENTAL HEALTH

Are you or have you ever been involved in any counseling or therapy? ___ Yes ___ No

Name of Therapist: _____ Address: _____
 Phone Number: _____ Dates: _____

Name of Psychiatrist: _____ Address: _____
 Phone Number: _____ Dates: _____

Are you or have you ever been diagnosed with a mental illness? ___ Yes ___ No
 Diagnosis: _____

Have you ever been hospitalized for mental health? ___ Yes ___ No

Date of Hospitalization	Reason	Outcome

SUBSTANCE/ALCOHOL HISTORY

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

If yes, list drug of choice and last time used: _____

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

If yes, list dates of Treatment: _____ Successfully graduate? ___ Yes ___ No

Are you in recovery? ___ Yes ___ No If so, how long have you been in recovery? _____

Do you currently have a sponsor? ___ Yes ___ No Name Sponsor: _____

Are you currently drinking alcohol? ___ Yes ___ No

If yes, how often do you drink in a week? ___ 1-4 drinks ___ 5-8 ___ 9-12 ___ over 12/week

Are you currently taking soboxian or methadone? ___ Yes ___ No

CHILDREN - MEDICAL HISTORY

Child's Name	Age	Is Child up to date with immunizations?	Name & Address of Pediatrician	Date of last immunization or well child visit	If the child is receiving any therapeutic supports.. (Occupational, speech, etc.) If yes, please list dates & provider	List any health concerns or dates of any hospitalizations

Please list any prescription and non-prescription medicines, vitamins, home remedies, herbs: (please use back side if necessary)

Child's Name	Name of Medication	Dosage	Name of Physician Who Prescribed:	Length of Time on Medication (# of months/years, etc.)	Purpose for Medication

SUPPORTS (please use other side if needed)

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

Describe the relationships you have and/or have had with child(ren) father(s) (good and bad)

PARENTING (please use other side if needed)

What do you think are your strengths as a parent? _____

What do you think you could improve upon in your parenting? _____

Have you ever attended a parenting group, course or have had individual parenting assistance? _____ Yes _____ No

If so, please list dates and where: _____

Do you have a current religious or spiritual practice or preference? _____ Yes _____ No Please list: _____

What are your specific education/career goals? _____

FINANCIAL:

The program requires a \$360 security deposit and one month's rent of \$360. It also requires an ability to pay monthly rent of \$360 while in residence at the Norwell.

Do you have the ability to pay the rent and security deposit up front? _____ Yes _____ No

What does self-sufficiency mean to you? _____

List some of the reasons why you would like to be in our program, in priority order:

1. _____ 2. _____ 3. _____

The Front Door Agency, Inc. does not discriminate against any applicant on the basis of race, color, religion, creed, national origin, or sexual orientation. The Front Door Agency will provide reasonable accommodations for persons with disabilities. Reasonable accommodations in rules, policies, practices, and services will be allowed to give persons with disabilities an equal program, provided such accommodations do not impose an undue hardship to the agency. Applicants with disabilities seeking entry into our program and who can complete the program requirements with reasonable accommodations must notify the interviewer to make an accommodation request.

If you are currently working with any city or town welfare department please realize we will give them any information they request, relating to your application during the intake process.

The information I, _____, provided the Front Door Agency, Inc. is true, accurate, and honest. If any information that I have provided as actual and truthful is indeed false and untrue and has been deliberately lied about by myself, the Front Door Agency may ask me to leave the program immediately. I also absolve the Front Door Agency from any liability of any actions they may take based on this information that I have provided as truth.

Applicant Signature Date

I, _____ give the Front Door Agency, Inc. permission to speak to the individuals/companies listed in this application for the purposes of gaining more information and verification to make an informed decision about my possible entry into the program.

Applicant Signature

Date

INCOME			
Salary/earnings		SSDI	
TANF		SSI	
Worker's Comp		Unemployment	
Child Support		APTD	
Alimony		Other	
Food Stamps			
		TOTAL MONTHLY INCOME	\$
EXPENSES			
Housing Expenses		Personal Expenses	
Rent		Medications/Vitamins	
Electric		Child Care	
Gas		Hair/Nails	
Home Phone		Church Donations	
Cell Phone		School lunches	
Cable		Clothing	
Total	\$	Cigarettes	
		Recreation (fast food, movies, etc.)	
Household Expenses		Rent to Own	
Food		Credit Cards	
Toiletries		Child Support	
Diapers/Wipes		Security Deposit Loan to The Front Door Agency:	
Laundry		Other:	
Total	\$	Other:	
		Total	\$

Transpo rtation		Outstanding Debt:	
Car Payment		Back Rent Due	
Gasoline		Electric	
Car Insurance		Gas	
Car Registration		Cell Phone	
Maintenance		Child Care	
Bus/Taxi		Student Loan in Default	
Total	\$	Total	\$
		TOTAL MONTHLY EXPENSES	\$