LivingWorks Ventures Lodge Pre-Application

Date_______/_______/_________

Referent____ Tel_______-______-________

Applicant Legal Name____ Tel_______-______-________

Date of birth _____/______/________ Age _______ Social Security number _________-_________-_____________

Current address____

Move in date____

Previous address____

Dates of occupancy from ________/________/_________ to _______/_______/_________ (Shelters included)

Have you stayed in one of the following shelters within the past three months? (Circle)

- **Salvation Army**
- **People Serving People**
- **Park Avenue**
- **People Inc. Hennepin House**
- **St. Anne's**
- **Other**

Do you have written shelter verification from the above shelter? (Circle) YES NO

Is your primary nighttime residence a public or private place not meant for regular sleeping accommodations, including a car, park, abandoned building, airport, train station or camping grounds? YES NO

Are you exiting an institution where you have resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution? YES NO

Are you fleeing from domestic violence, dating violence, sexual assault, stalking, or other dangerous life-threatening conditions that relate to violence against you? YES NO

Do you have any of the following? (Circle)

Birth Certificate YES NO

Social Security card YES NO

Drivers License YES NO

Minnesota ID card **YES** **NO**

Metro Mobility card **YES** **NO**

Tribal ID card **YES** **NO**

US Armed Forces **YES** **NO** **DD-214** **YES** **NO**

Health insurance **YES** **NO** **Medical Insurance Name**______________________________

Medical Insurance Address______________________________

Medical Insurance ID ______________________________

Medical Insurance Group Number______________________________

Secondary Insurance **YES** **NO** **Secondary Insurance Name**______________________________

Secondary Insurance Address______________________________

Secondary Insurance ID______________________________

Secondary Insurance Group Number______________________________

Gov Assistance **YES** **NO** **Case number**______________________________

County Case Manager **YES** **NO** **Name**______________________________

Address______________________________

Phone/Fax number______________________________

Supportive Services **YES** **NO** **Name**______________________________

Address______________________________

Phone/Fax number______________________________

Waivered Services **YES** **NO** **Program name**______________________________

Psychologist **YES** **NO** **Name**______________________________

Address______________________________

Phone/Fax number______________________________

Psychiatrist **YES** **NO** **Name**______________________________

Address______________________________

Phone/Fax number______________________________

Do you need psychiatric services **YES** **NO** **Concern**______________________________

Current Physician **YES** **NO** **Name**______________________________

Address______________________________

Phone/Fax number____

Do you need medical attention YES NO Concern____

Latest Tuberculosis testing Date_____/_____/_______ Results (Circle) POSITIVE NEGATIVE

Previous hospitalizations Date____/____/____ Procedure___________________________________

Date____/____/____ Procedure___________________________________

Previous hospitalizations, Cont. Date____/____/____ Procedure___________________________________

Date____/____/____ Procedure___________________________________

Previous Substance Use Disorder/CD Treatment

Date ____/____/____ Location_____________________________________

Date ____/____/____ Location_____________________________________

Date ____/____/____ Location_____________________________________

Date ____/____/____ Location_____________________________________

Current Dentist YES NO Name____

Address____

Phone/Fax number____

Do you need dental attention? YES NO Concern____

Guardian YES NO Name____

Address____

Phone/Fax number____

Rep Payee YES NO Name____

Address____

Phone/Fax number____

Probation Officer YES NO Name____

Address____

Phone/Fax number____

Parole Officer YES NO Name____

Address____

Phone/Fax number____

Pending legal issues? YES NO Violation____

Are you on court commitment? **YES** **NO** **Detail**____

Are you a registered sex offender? **YES** **NO** **Detail** ____

Do you have housing restrictions? **YES** **NO** **Detail** ____

Pending Workman's Comp Case? **YES** **NO** **Notes (QRC)**______________________________________

Emergency Contact **YES** **NO** **Name**____

Address____

Phone/Fax number____

Substance Use Disorder/CD? **YES** **NO** **Diagnosis**____

When was your last use of recreational drugs or alcohol?

_______/_________/_________

Physical limitations? **YES** **NO** **Medical Diagnosis**____

Medical Equipment? **YES** **NO** **Item description**____

Are you independent with the medical equipment? **YES** **NO**

Assistance needed____

Mental Health condition? YES NO **Psychiatric Diagnosis**____

Current medication list required, see check-list.

Have you ever hit your head? **YES** **NO** **Date**______/______/_________

Circumstances____

____

Outcome____

Do you have children under the age of 18? **YES** **NO**

Do you have custody? **YES** **NO** **Unsupervised visitation rights** **YES** **NO**

Do you hear voices? **YES** **NO** **Frequency**____

Have you tried to hurt or killing yourself? **YES** **NO** **Frequency**___________________________________

Do you have thoughts of hurting or killing yourself? **YES** **NO** **Frequency** ____________________________

List your last three jobs with the most recent listed first

- **Employer**____ **Dates** ______/_______/_________

  Duties____

  Reason for leaving____

- **Employer**____ **Dates** _______/_______/_________

  Duties____

  Reason for leaving____

- **Employer**____ **Dates**__________________________________

  Duties____

  Reason for leaving____

Do you have you High School Diploma YES NO Last grade completed __________________________

Do you have your GED YES NO Would you like to go back to school YES NO

Additional education ____

Are you looking for employment YES NO FULL-TIME PART-TIME

Do you receive RSDI YES NO Amount ____

Do you receive SSI YES NO Amount ____

Do you receive retirement benefits YES NO Amount ____

Do you receive Veterans benefits YES NO Amount ____

Do you think you may be eligible for Social Security benefits YES NO

Explaination____

____

Do you have a vehicle YES NO Transportation method _______________________________________

Will you sign a 12 month lease YES NO

Will you give written 30 day notice when you leave YES NO

X___________________________________

Applicant

Application check-list:

- **Current Medication List**
- **Diagnostic Assessment / Neuropsychological Evaluation**
- **In order to process your application the above documentation along with the completed application is necessary.**
- **Fax application to 763-479-4372**

  Attention: Gina Chamberlin/Colleen Larson
- **Questions or concerns 763-210-4708**