LivingWorks Ventures Lodge Pre-Application

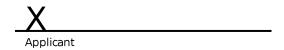
Date/	<i></i>								
Referent							Tel		
Applicant Legal Name	e			· · · · · · · · · · · · · · · · · · ·			Tel		
Date of birth/_	/_	Age _	So	cial Secu	rity number		-	-	
Current address									
Move in date									
Previous address									
Dates of occupancy f	rom			to	/	_/	(SI	nelters incl	luded)
Have you stayed in or	ne of the	e following sh	elters within	the past	t three mont	hs? (Ci	rcle)		
Salvation Arm	ıy								
People Servii	ng Peop	le							
Park Avenue									
People Inc. H	ennepin	House							
• St. Anne's									
• Other									
Do you have written s	shelter v	erification fro	m the above	e shelter?	? (Circle)			YES	NO
Is your primary night	time res	idence a publ	ic or private	place no	ot meant for	regular	sleeping	g accommo	odations,
including a car, park,	abando	ned building,	airport, trai	n station	or camping	ground	ls?	YES	NO
Are you exiting an ins	stitution	where you ha	ave resided	for 90 da	ys or less an	nd who	resided i	n an emer	gency shelte
or place not meant fo	r humar	n habitation in	nmediately l	oefore en	tering that ir	nstitutio	on? YES	NC)
Are you fleeing from	domesti	c violence, da	ating violend	e, sexua	l assault, sta	alking,	or other o	dangerous	
life-threatening condi	tions th	at relate to vi	olence agair	nst you?				,	YES
NO									
Do you have any of th	ne follow	ving? (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 Manage	r 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 psychiat	ric serv	rices	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 hospitaliza	ations		Date// Procedure				
			Date// Procedure				
Previous hospitaliza	ations, C	ont.	Date// Procedure				
			Date// Procedure				
Previous Substance	Use Dis	order/C	D 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	edical Equipment? YES NO Item description					
Are you independent with the med	cal 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 ag	e 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 you	rself? YES NO Frequency					
Do you have thoughts of hurting o	killing yourself? YES NO Frequency					
List your last three jobs with the m	ost recent listed first					
Employer						
Duties						
Reason for leaving						

•	Employer	 				
	Duties					
	Reason for leaving					
•	Employer			Dates		
	Duties					
	Reason for leaving					
Do you	ı have you High School Diplon	na	YES	NO Last grade completed		
Do you	ı have your GED YES	NO	Would	you like to go back to school YES NO		
Additio	onal education					
Are yo	u looking for employment	YES	NO	FULL-TIME PART-TIME		
Do you	ı receive RSDI	YES	NO	Amount		
Do you	ı receive SSI	YES	NO	Amount		
Do you	receive retirement benefits	YES	NO	Amount		
Do you	ı receive Veterans benefits	YES	NO	Amount		
Do you think you may be eligible for Social Security benefits YES NO						
Explair	nation					
Do you	ı have a vehicle YES	NO	Transp	portation method		
Will yo	u sign a 12 month lease	YES	NO			
Will yo	u give written 30 day notice w	hen you	leave	YES NO		



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