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: Renee Olson
- **Questions or concerns 763-479-4518 or reneeo@vinlandcenter.org**