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? (check any that apply)

- ☐ **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?

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?

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?

Are you fleeing from domestic violence, dating violence, sexual assault, stalking, or other dangerous life-threatening conditions that relate to violence against you?

Do you have any of the following?

Birth Certificate

Social Security card

Drivers License

Minnesota ID card

Metro Mobility card

Tribal ID card

US Armed Forces **DD-214**

Health insurance **Medical Insurance Name**_____

Medical Insurance Address_____

Medical Insurance ID _____

Medical Insurance Group Number_____

Secondary Insurance **Secondary Insurance Name**_____

Secondary Insurance Address_____

Secondary Insurance ID_____

Secondary Insurance Group Number_____

Gov Assistance **Case number**_____

County Case Manager **Name**_____

Address_____

Phone/Fax number_____

Supportive Services **Name**_____

Address_____

Phone/Fax number_____

Waivered Services **Program name**_____

Psychologist **Name**_____

Address_____

Phone/Fax number_____

Psychiatrist **Name**_____

Address_____

Phone/Fax number_____

Do you need psychiatric services **Concern** _____

Current Physician **Name**_____

Address_____

Phone/Fax number_____

Do you need medical attention **Concern** _____

Latest Tuberculosis testing **Date**_____ **Results** ☐ **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 **Name**_____

Address_____

Phone/Fax number_____

Do you need dental attention? **Concern** _____

Guardian **Name**_____

Address_____

Phone/Fax number_____

Rep Payee **Name**_____

Address_____

Phone/Fax number_____

Probation Officer **Name**_____

Address_____

Phone/Fax number_____

Parole Officer **Name**_____

Address_____

Phone/Fax number_____

Pending legal issues? **Violation**_____

Are you on court commitment? **Detail**_____

Are you a registered sex offender? **Detail** _____

Do you have housing restrictions? **Detail** _____

Pending Workman's Comp Case? **Notes (QRC)**_____

Emergency Contact **Name**_____

Address_____

Phone/Fax number_____

Substance Use Disorder/CD? **Diagnosis** _____

When was your last use of recreational drugs or alcohol?

_____/_____/_____

Physical limitations? **Medical Diagnosis**_____

Medical Equipment? **Item description**_____

Are you independent with the medical equipment?

Assistance needed_____

Mental Health condition? **Psychiatric Diagnosis**_____

Current medication list required, see check-list.

Have you ever hit your head? **Date**_____

Circumstances_____

_____

Outcome_____

Do you have children under the age of 18?

Do you have custody? **Unsupervised visitation rights**

Do you hear voices? **Frequency**_____

Have you tried to hurt or killing yourself? **Frequency**_____

Do you have thoughts of hurting or killing yourself? **Frequency** _____

List your last three jobs with the most recent listed first

Employer _____ **Dates** _____**to**_____

Duties_____

Reason for leaving_____

- **Employer**_____ **Dates** _____**to**_____

  Duties_____

  Reason for leaving_____

- **Employer**_____ **Dates**_____**to**_____

  Duties_____

  Reason for leaving_____

Do you have you High School Diploma **Last grade completed** _____

Do you have your GED **Would you like to go back to school**

Additional education _____

Are you looking for employment ☐ **FULL-TIME** ☐ **PART-TIME**

Do you receive RSDI **Amount** _____

Do you receive SSI **Amount** _____

Do you receive retirement benefits **Amount** _____

Do you receive Veterans benefits **Amount** _____

Do you think you may be eligible for Social Security benefits

Explanation _____

_____

Do you have a vehicle **Transportation method** _____

Will you sign a 12 month lease

Will you give written 30 day notice when you leave

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 to the attention of Renee Olson**
- **Questions or concerns? Call Gina Chamberlin at 763-210-6708 or gchamberlin@vinlandcenter.org Or Paula Provost-Greene at 763-210-6709 or PaulaP@vinlandcenter.org**