



HOUSING APPLICATION

Please email all applications to intake@dayspringcommunities.com.

Who is submitting this application? Applicant Family Member or Friend
 Other (Caseworker, Social Worker, Housing Coordinator, etc.)

A. APPLICANT PERSONAL DETAILS

Full Name: _____

Phone Number: _____

Email Address: _____

Date of Birth: _____

Social Security Number: _____

Age: _____

Gender: Male Female

Marital Status: _____

Emergency Contact Name: _____ Phone Number: _____

Relationship to Applicant: _____

B. INTAKE QUESTIONS

Has the applicant ever lived in a DaySpring Communities home before? Yes No

Preferred room type: Private Room Semi-Private Room

Desired location(s) to live? City: _____ State: _____

If you are applying for a specific DaySpring Communities home, please provide that information here? A list of the available homes [can be found here](#). _____

When would the applicant like to enroll into the housing program? _____

How long will the applicant like to stay in the housing program?

Short-term (under 3 months) Mid-term (3-9 months) Long-term (1+ years)

Applicant's current housing situation: _____

Has the applicant ever lost housing? Yes No

If yes, please explain: _____

Has the applicant previously lived in any shared housing program? Yes No

If yes, please explain: _____

Are there any concerns about sharing common spaces (kitchen, bathrooms, etc.)?

Does the applicant have mobility issues or difficulty with stairs?

Please specify any special accommodations needed:

Is the applicant currently employed or retired? _____

If employed, what is their occupation? _____

Is the applicant a military veteran? Yes No

If yes, did they receive an honorable discharge? Yes No

Does the applicant have a vehicle? _____

What are some of the applicant's hobbies or interests?

Does the applicant have a personal goal they would like to accomplish while living here?

Please explain the applicant's current support system (family, friends, community services, etc.):

Which form of verifiable income does the applicant receive?

SSI/SSDI Retirement VA Benefits W2 Income Family Will Provide Payment

Other, please explain: _____

How much total monthly income does the applicant receive? \$_____

Will the applicant receive financial housing assistance from a third-party organization?

Yes No Other _____

If we are full, would the applicant like to be added to our waitlist? Yes No

If we are unable to assist, would the applicant like us to share this housing request with our associates? Yes, share my contact info No, do not share my contact info

C. SUITABILITY FOR INDEPENDENT HOUSING PROGRAM

Daily Living & Independence

- Can the applicant cook simple meals for themselves? Yes No
- Can the applicant manage their own laundry and personal care? Yes No
- Can the applicant perform household chores & maintain their area? Yes No
- Can the applicant live independently without assistance? Yes No
- Is the applicant able to understand and follow house rules? Yes No

Financial Stability

- Is the applicant able to pay monthly housing fees consistently? Yes No
- Does the applicant need a payee service to manage funds? Yes No

Behavioral Expectations

- Has the applicant ever had conflicts in shared living settings? Yes No
If yes, explain: _____
- Has the applicant ever been removed from shared/group housing? Yes No
If yes, explain: _____

Emergency Preparedness

- Does the applicant know how to contact emergency services? Yes No
- Can the applicant evacuate unassisted in an emergency? Yes No

Policy Acknowledgement

Please check off that the applicant understands and agrees that this program is:

- Drug & alcohol-free.
- Pet-free.
- Visitor-free.
- A shared living environment requiring cooperation and respect.
- Not a medical facility, nursing home, or hospice care setting.

- No personal care, medical supervision, or skilled nursing services are provided.
- Residents must be able to manage their own health, medications, and daily living needs independently.

D. MEDICAL HISTORY

Medical & Physical Health

How would you describe the applicant's current physical health?

- Excellent Good Fair Poor

Does the applicant have any known medical conditions or disabilities? Yes No

If yes, please describe: _____

Is the applicant responsible for managing their own medications? Yes No

Does the applicant currently take any prescribed or over-the-counter medications?

- Yes No

If yes, please list: _____

Does the applicant have any known allergies? Yes No

Recent Medical Care

- Has the applicant been hospitalized or had surgery in the past 12 months?

- Yes No

If yes, please explain: _____

Mobility & Physical Functioning

- Does the applicant have any mobility limitations? Yes No
- Does the applicant use any assistive devices (e.g., cane, walker, wheelchair)?

- Yes No

If yes, please describe: _____

Cognitive Function

- Does the applicant experience memory loss, confusion, or difficulty managing daily routines? Yes No

If yes, please describe: _____

Medical Equipment or Special Requirements

- Does the applicant use any medical equipment that requires electricity (e.g., oxygen, CPAP)? Yes No

If yes, please describe: _____

Mental & Behavioral Health

- Has the applicant ever been diagnosed with a mental health condition?

Yes No

If yes, please specify: _____

- Is the applicant currently receiving mental health treatment? Yes No

If yes, please describe (e.g., outpatient therapy, medication management): _____

- Does the applicant require ongoing supervision, monitoring, or medical oversight for any mental health condition? Yes No

If yes, please explain: _____

- Has the applicant had any recent hospitalizations for mental health reasons?

Yes No

If yes, please provide date(s) and reason(s): _____

Primary Care & Health Planning

- Name of Primary Care Physician or Clinic: _____
- Last routine medical check-up: _____
- Does the applicant have a health care proxy or advance directive? Yes No

(A health care proxy or advance directive identifies who can make medical decisions for the applicant if they become unable to do so.)

Important Note:

Our housing program is not a medical or behavioral health treatment facility. Residents must be able to manage their own medical and mental health needs independently or with support from outside providers.

E. SUBSTANCE USE HISTORY

Does the applicant have a history of substance or alcohol use? Yes No

If yes, please explain: _____

Is the applicant currently in recovery or treatment? Yes No

Date of last known use (if applicable): _____

F. LEGAL HISTORY

Has the applicant ever been convicted of a crime? Yes No

If yes, please explain: _____

Is the applicant currently on probation or parole? Yes No

If yes, which county? _____ End date: _____

Is there a history of domestic violence? Yes No

If yes, please explain: _____

Is the applicant a registered sex offender? Yes No

If yes, please explain: _____

G. ADDITIONAL DETAILS

Please tell us anything that would be helpful for us to know when contacting you.

H. REFERRING AGENCY/ORGANIZATION INFORMATION (if applicable)

Referring Agency: _____

Employee's Name: _____

Phone Number: _____

Email Address: _____

I. SIGNATURE(S)

Applicant Certification

I certify that the information provided in this housing application is true and complete to the best of my knowledge. I understand that providing false information may result in denial of admission or termination from the housing program.

Applicant Signature: _____ Date: _____

Referring Representative Certification

I confirm that I have completed this housing application to the best of my ability and believe this applicant meets the program's eligibility requirements.

Representative Signature: _____ Date: _____