REFERRAL APPLICATION

Please email all referrals to info@nelsonhomeliving.com.

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

Applicant's current living situation: _____

Has the applicant previously lived in any shared housing programs? (Y/N)
If yes, please explain: _____

Preferred room type: ☐ Semi-Private Room ($775+/mo) ☐ Private Room ($950+/mo)

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

Are there any concerns about sharing common spaces (kitchen, living room, 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 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? (Y/N) _____
- Can the applicant manage their own laundry and personal care? (Y/N) _____
- Can the applicant perform household chores & maintain their area? (Y/N) _____
- Can the applicant live independently without assistance? (Y/N) _____
- Is the applicant able to understand and follow house rules? (Y/N) _____

Financial Stability

- Is the applicant able to pay program fees consistently? (Y/N) _____
- Does the applicant need a payee to manage funds? (Y/N) _____

Behavioral Expectations

- Has the applicant ever had conflicts in group living settings? (Y/N) _____
  If yes, explain: _____

- Has the applicant ever been removed from shared/group housing? (Y/N) _____
  If yes, explain: _____

Emergency Preparedness

- Does the applicant know how to contact emergency services if needed? (Y/N) ___
- Can the applicant evacuate the premises unassisted in an emergency? (Y/N) ___

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? (Y/N) _____
If yes, please describe: _____

Is the applicant responsible for managing their own medications? (Y/N) _____

Does the applicant currently take any prescribed or over-the-counter medications? (Y/N)
If yes, please list: _____

Does the applicant have any known allergies? (Y/N) _____

Recent Medical Care

- Has the applicant been hospitalized or had surgery in the past 12 months? (Y/N)
  If yes, please explain: _____

Mobility & Physical Functioning

- Does the applicant have any mobility limitations? (Y/N)
- Does the applicant use any assistive devices (e.g., cane, walker, wheelchair)? (Y/N) _____
  If yes, please describe: _____

Cognitive Function

- Does the applicant experience memory loss, confusion, or difficulty managing daily routines? (Y/N) _____
  If yes, please describe: _____

Medical Equipment or Special Requirements

- Does the applicant use any medical equipment that requires electricity (e.g., oxygen, CPAP)? (Y/N) _____
  If yes, please describe: _____

Mental & Behavioral Health

- Has the applicant ever been diagnosed with a mental health condition? (Y/N) ___
  If yes, please specify: _____

- Is the applicant currently receiving mental health treatment or counseling? (Y/N) _____
  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? (Y/N) _____
  If yes, please explain: _____

- Has the applicant had any recent hospitalizations for mental health reasons? (Y/N) _____
  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? (Y/N) _____

(*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? (Y/N) _____
If yes, please explain: _____

Is the applicant currently in recovery or treatment? (Y/N) _____

Date of last known use (if applicable): _____

F. LEGAL HISTORY

Has the applicant ever been convicted of a crime? (Y/N) _____
If yes, please explain: _____

Is the applicant currently on probation or parole? (Y/N) _____
If yes, which county? _____ End date: _____

Is there a history of domestic violence? (Y/N) _____

Is the applicant a registered sex offender? (Y/N) _____

G. REFERRING AGENCY/ORGANIZATION INFORMATION

Referring Agency: _____

Employee's Name: _____

Phone Number: _____

Email Address: _____

H. SIGNATURES

Applicant Certification

I certify that the information provided in this referral 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 program.

Applicant Signature: _____ Date: _____

Referring Agency Representative Certification

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

Representative Signature: _____ Date: _____