REFERRAL APPLICATION

Please email all referrals to info@nelsonhomeliving.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

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 ($575+/mo) ☐ Private Room ($750+/mo)

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: _____