KELLY SHELTER APPLICATION

(Application not complete without a Risk Assessment)

THE KELLY SHELTER
Providing Dignity and Hope

ROGUE RETREAT
Restoring Lives

Head of Households full name: Alias Date Received:

Mailing Address:

Email Address: Phone #: Text OK?_____

UNIVERSAL DATA ELEMENTS		Individual 1	Individual 2	Individual 3	Individual 4	Individual 5
SERVICEPOINT ID NUMBER						
First Name						
Last Name						
Social Security Number						
Are you a US Military Veteran		Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Date of Birth		/ /	/ /	/ /	/ /	/ /
GENDER: M=Male F=Female TG=Transgender NSG=(No Single/Specific Gender, non-binary, genderfulid, agender) Q=Questioning, DKN=Doesn't Know, CR= Refused						
Race: Check all that apply ~circle primary~	American Indian/Alaskan Native/Indigenous					
	Asian or Asian American					
	Black, African American or African					
	Native Hawaiian or Pacific Islander					
	White					
	Refused / Unknown					
Ethnicity: Hispanic or Latin (a) (o) (x)? Circle One		Yes / No / Refused	Yes / No / Refused	Yes / No / Refused	Yes / No / Refused	Yes / No / Refused

HOUSEHOLD TYPE:

- ☐ **SI** Single Individual
- ☐ **CNC** Couple No Children
- ☐ **FSP** Female Single Parent
- ☐ **MSP** Male Single Parent
- ☐ **TPF** Two Parent Family
- ☐ **GPC** Grandparent(s) and Child
- ☐ **FP** Foster Parent(s)
- ☐ **NCC** Non-Custodial Caregiver(s)

What is your relationship to the head of household?	SELF				

HISTORY OF HOMELESSNESS

Where did you (and your family if they are with you) spend the night last night? (please be specific, you do not need to disclose your location but please indicate where.) Examples: Emergency Shelter, Hospital, Jail, Place not meant for habitation (Camp, Street, Car etc.), With Family or Friends.

_____

Length of stay in the place above (How long in a row, this homeless episode? ☐ **One day or Less** ☐ **2 days to one week**
☐ **More than a week, less than a month** ☐ **1-3 months** ☐ **More than 3 months, less than a year** ☐ **One year or longer**
☐ **Doesn't Know** ☐**Refused**

Approximate date this current occurrence of homelessness started?	/ /	/ /	/ /	/ /	/ /

How many times have you been on the streets, in ES, or SH in the past three years including today?	☐ 1 ☐ 2 ☐ 3 ☐ 4+	☐ 1 ☐ 2 ☐ 3 ☐ 4+	☐ 1 ☐ 2 ☐ 3 ☐ 4+	☐ 1 ☐ 2 ☐ 3 ☐ 4+	☐ 1 ☐ 2 ☐ 3 ☐ 4+
Total number of months experiencing homelessness in the last three years?					
Have you ever received service from Rogue Retreat? Circle one Yes / No	**Person doing the assessment, please ask person applying which family member/s and what services they received and annotate it.** _____				
Do you have a service animal or pet? If yes, what kind of animal and how many?	Yes / No : How many?_____ Kinds:_____				
HEALTH INSURANCE					
Do you have health insurance?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Who is your health insurance provider? Check one	☐All Care ☐OHP ☐JCC ☐Other	☐All Care ☐OHP ☐JCC ☐Other	☐All Care ☐OHP ☐JCC ☐Other	☐All Care ☐OHP ☐JCC ☐Other	☐All Care ☐OHP ☐JCC ☐Other
What is your insurance ID#?					
DISABILITY STATUS					
Do You Have a Disabling Condition? (Check all that apply below)	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Alcohol Use Disorder (HUD)					
Drug Use Disorder (HUD)					
Both Alchohol and Drug Use Disorder (HUD)					
Developmental (HUD)					
HIV / AIDS (HUD)					
Mental Health Disorder (HUD)					
Physical / & Are you able to use a top Bunk?	/ Y or N	/ Y or N	/ Y or N	/ Y or N	/ Y or N
Chronic Health Condition (HUD)					
NON-CASH BENEFITS					
Do you receive Food Stamps? Amount $	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Do you receive WIC? Amount $	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
INCOME					
Do you receive any reliable income each month?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
What is your source of income?					
Is there any other source of income?					
How much income do you have each month?					

By signing this application I understand that the information I provide will be entered into the ServicePoint HMIS database and my records will be updated as I receive services. I ____ GIVE _____ DO NOT GIVE my permission to share this data with local agencies to better provide me care.

Signature: _____ Date: / /