WELCOMING INTERIM SHARED HOUSING

"Helping Others Build Integrity"

Welcoming Interim Shared Housing Social Services Program Enrollment Form

Each client is welcomed to participate in any or our social service programs, as one should need.

Program Requirements:

Each Case must have 1 -2 proofs of income

Must be willing to participate in services at a minimum of 2 times a month (*This includes all W.I.S.H services*).

Must have proof of homelessness (*any HSP certification or DPSS documentation is allowed*), or income documentation establishing you, and/your family are within the low income population.

Must be willing to participate in at least 2 social services if you are looking for housing within W.I.S.H housing units.

Must be willing to be as honest as your comfort zone allows you to be in regards to providing vital in an attempt to help W.I.S.H help you, and/ or family. (*Please keep in mind the more information you can provide regarding the need for social services the better we can assist*).

Understand you must complete a program enrollment form to access any of W.I.S.H services

Understand W.I.S.H is willing to do our best to assist yourself, or family , (granted the proper documentation is provided). None of W.I.S.H's programs provided by W.I.S.H, or its partners, guarantee a positive or negative outcome.

Understand you do not hold W.I.S.H or any of its partners responsible for any undesired outcome.

Understand you have the right to file a grievance. (*Please see W.I.S.H Management in regards to filing a formal grievance*)

Personal Information

First Name

Last Name

Social Security Number : Birth Date:

Gender:

Referring Care Provider/ HSP:

Email (example@example.com):_____

Home/Work/Cell Phone:_____

Address/ Residing location:_____

Do you have a DL or State I.D?: State:

Housing Compensation:

Head of Household

First Name Last Name

Social Security Number

Birth Date Gender Referring Care Provider/ HSP:

Email (example@example.com)

Cell / Home Phone:

Household member 2

First Name Last Name Social Security Number

Birth Date Gender Referring Care Provider/ HSP:

Email (example@example.com):

Cell / Home Phone:

Household Member 2

First Name Last Name Social Security Number

Birth Date Gender Referring Care Provider/ HSP:

Email (example@example.com):

Cell / Home Phone:

Household member 3

First Name Last Name Social Security Number

Birth Date Gender Referring Care Provider/ HSP:

Email (example@example.com):

Cell / Home Phone:

Household Member 4

First Name Last Name Social Security Number

Birth Date Gender Referring Care Provider/ HSP:

Email (example@example.com): Cell / Home Phone:

Household member 5

First Name Last Name Social Security Number

Birth Date Gender Referring Care Provider/ HSP:

Email (example@example.com):

Cell / Home Phone:

Homeless/ Low Income Information

Current Homeless Status (Check One):

-Homeless

-Chronically Homeless (Homeless with a Chronic physical disability/ mental health Issue)

-Housed but member of low income population

How long have you been homeless / or in the low income population?:

_____

Are you residing from another city or state other than Los Angeles California?

(If Yes Please identify):_____

Any Mental Health Status Information:

Any Physical Health STatus Information:

Any Family Mental Health Information:

Family Mental health information

Income information:

Do you have proof of income:

Income Source:

Income amount:

Circle One
Weekly

BI-Weekly

Monthly

Yearly

Providers:

Are you or any member of your family connected to any non profit , homeless services, medical or Mental health organization?
(*If ye please identify your service team contact information*)

Name of Organization:

Social Service Case Manager/ Clunitian Contact Information:
Phone:
EMail:
Next of Ken Information

Name:

Contact information:

Relation: