# The HER Foundation, Inc.

*"Providing a Helping Hand, Love and Hope to other Sisters in Arms."*

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## CONFIDENTIAL APPLICATION

All questions must be answered completely. Failure to disclose any information or provide false information will result in being denied admission or dismissal from the program.

Today's Date _____/_____/_____

Last Name: _____First Name: _____ Middle Initial: ___

SSN: _____-_____-_____ Date of Birth: _____/_____/____ Age: ____

Citizenship: U.S._____ Other_____ Email: _____

Last Permanent Address:

How long since you lived at this address? _____

Reason for Leaving: _____

Contact/Landlord Name: _____

Email address: _____ Phone number: _____-_____-_____

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone number: _____-_____-_____

Address: _____ City_____ State_____ Zipcode _____

Race (circle all that apply): American Indian/Alaskan Asian Hawaiian/Other Pacific Islander

Black/African American White/Caucasian

Are you of Hispanic/Latino heritage? (circle): Yes No

Marital Status (circle): Single Married Separated Divorced Widowed

Highest Level of Education: (circle) HS Diploma GED Vocational Certificate

Associate's Degree Bachelor's Degree Master's Degree Other:

Are you able to read and write in English well? ◯ Yes ◯ No

## Armed Forces Status:

What branch(s) of the U.S Armed Forces did you serve? (circle)

Army ◯ Marines ◯ ◯Navy ◯Coast Guard ◯ Air Force

Did you serve in the National Guard or Reserves? (circle)

No ◯ ◯Yes, National Guard ◯ Yes, Reserves

Did you serve in combat zone? (circle)

Yes ◯ No ◯

Military service begin date: _____/_____/_____ Military service end date _____/_____/_____

Military Rank/Pay Grade at Separation/Retirement_____

What type of discharge did you receive? (circle)

Honorable ◯ ◯ General (Under Honorable Conditions) ◯ Other than Honorable (OTH)

Bad Conduct ◯ Dishonorable ◯

## Veteran Administration:

Are you enrolled in the Veteran Administration Healthcare System? (circle)

Yes ◯ No ◯ Don't Know ◯

Are you receiving benefits from Veteran Administration? (circle)

Yes ◯ No ◯ Don't Know ◯

If yes, what type of benefits? _____

If you are receiving service-connected disability compensation, what is your rating?

Disability Percentage _____ Don't Know ◯

## Employment:

Current Employer: _____ Occupation_____

Employer address_____

Date hired_____

Salary $ _____ (circle one): hourly; weekly; bi-weekly; twice a month; monthly; yearly; other

Previous Employer: _____ Occupation_____

Employer address_____

Date hired_____

Salary $ _____ (circle one): hourly; weekly; bi-weekly; twice a month; monthly; yearly; other

Unemployed: Yes ◯ No ◯ If no, last date of employment: _____

Work experience_____

Are you presently receiving any benefits or income? (Alimony, Social Security Disability, Unemployment, Child Support, Food Stamps, other?)

If so, what and how much per month?

Are you disabled? Yes ◯ No ◯

Drivers' License? Yes ◯ No ◯ State Number

Do you have a vehicle? Yes ◯ No ◯ Make/Year?

## Medical:

Doctor _____ Phone _____

Medical Insurance_____ Medical Policy #_____

Pharmacy_____

Dentist_____ Phone _____

Dental Insurance _____ Dental Policy #_____

Height: _____ Weight: _____ Blood Type_____

Medications: _____

Allergies: _____

Special Conditions: _____

Do you have any Medical Limitations? (circle) Yes ◯ No ◯

_____

_____

_____

_____

Are you being treated for Mental Health reasons? Yes ◯ No ◯

_____

_____

Are you limited in any physical activity? (circle) Yes ◯ No ◯

Have you had any serious illness or recent surgery? (circle) Yes No
Explain

Do you smoke? Yes No How much: Drink? Yes No How much:

## Drug & Alcohol History:

| Type | Amount/Frequency | Last Day Used | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever been in treatment for alcohol/chemical abuse? (circle) Yes No

## Clothing Sizes:

Shirt_____ Sweater_____ Dress_____

Pants_____ Shoes_____

## Legal:

Have you **ever** been convicted of a misdemeanor? ◯ Yes ◯ No

Have you **ever** been convicted of a felony? ◯ Yes ◯ No

If yes, what? _____

When? _____

Dept. of Corrections Number _____

Are you currently on probation? ◯ Yes ◯ No

If Yes, what is the date your probation expires? _____/_____/_____

Probation Officer Name. _____ Phone Number _____

## Income:

*Monthly household income. Give income for yourself and attach proof of income.*

**Received any income from any source in the past 30 days? ◯ No (◯) Yes ◯ ) Don't Know (◯) Refused**

| **Income Sources and Amount** | **No/Yes** | **Amount/pay period** | **Date Started** |
|---|---|---|---|
| ( ) Earned Income | ◯ No ◯ Yes | _____ | _____/_____/_____ |
| ( ) Unemployment Insurance | ◯ No ◯ Yes | _____ | _____/_____/_____ |
| ( ) Supplemental Insurance Security (SSI) | ◯ No ◯ Yes | _____ | _____/_____/_____ |
| ( ) Social Security Disability Income (SSDI | ◯ No ◯ Yes | _____ | _____/_____/_____ |
| ( ) Veteran Disability Payment | ◯ No ◯ Yes | _____ | _____/_____/_____ |
| ( ) Retirement Income from SS | ◯ No ◯ Yes | _____ | _____/_____/_____ |
| ( ) Veteran's Pension | ◯ No ◯ Yes | _____ | _____/_____/_____ |
| ( ) Pension from former job | ◯ No ◯ Yes | _____ | _____/_____/_____ |
| ( ) Other source | ◯ No ◯ Yes | _____ | _____/_____/_____ |

**Non-Cash Benefits received from any source in past 30 days: (◯) No (◯) Yes (◯) Don't Know (◯) Refused**

| **Source of Non-Cash Benefit** | **No/Yes** | **Amount** | **Date Started** |
|---|---|---|---|
| Sup. Nutrition Ass. Program (SNAP): **Food Stamps** | ◯ No ◯ Yes | _____ | _____/_____/_____ |
| Medicaid Health Insurance Program | ◯ No ◯ Yes | _____ | _____/_____/_____ |
| Medicare Health Insurance | ◯ No ◯ Yes | _____ | _____/_____/_____ |
| Veterans Administration (VA) Medical Services | ◯ No ◯ Yes | _____ | _____/_____/_____ |
| Other Source | ◯ No ◯ Yes | _____ | _____/_____/_____ |

**Additional comments regarding your financial status:**

_____
_____
_____
_____
_____

**Financial Disclaimer:** I understand that the information provided will be used only to determine my responsibility for financial costs of the housing ***at Faith House*** sponsored by ***The HER Foundation, Inc***. I understand that any documents I provide as proof of status will be returned. I understand that the information provided is subject to verification. I certify that all information provided is true and accurate to the best of my knowledge.

**Print Signature** **Date**

**Applicant Signature**