



# Old Pueblo Community Services Resident Application

Name: \_\_\_\_\_ Case/DOC#: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_ **Circle One:** Single Married Divorced Separated Widowed

Identification: (**Circle**) Driver's License AZ ID Card DD-214 SS Card Birth Certificate Tribal Other: \_\_\_\_\_

Ethnicity \_\_\_\_\_ Gender: \_\_\_\_\_ Are you pregnant? **YES NO** Current Contact Phone \_\_\_\_\_

Have you ever served in the Military/Armed Forces? **YES NO** If Yes, Type of Discharge \_\_\_\_\_

Current Living Situation: (**Circle One**) Streets Shelter Detox Jail/Prison Rental Housing Transitional Living Hospital DV Shelter Family

Other \_\_\_\_\_ Name of current contact: \_\_\_\_\_ Current address: \_\_\_\_\_

Are you receiving county, state, or federal benefits? **YES NO** What? \_\_\_\_\_ Why? \_\_\_\_\_

Have you been homeless for more than a year? **YES NO** Have you had at least 4 episodes of homelessness in the past 3 years? **YES NO**

Do you have children? **YES NO** Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Are you paying child support? **YES NO**

How much? \_\_\_\_\_ In case of emergency notify: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

### ALCOHOL AND DRUG USE (if any)

What was the date the last time you used alcohol or drugs? \_\_\_\_\_ What did you use? \_\_\_\_\_

### EMPLOYMENT HISTORY (List most recent employer)

Employer Name \_\_\_\_\_ Phone \_\_\_\_\_ Position/Title \_\_\_\_\_

Date started \_\_\_\_\_ Date Ended \_\_\_\_\_ Supervisor \_\_\_\_\_ Hourly pay rate \_\_\_\_\_

### EDUCATION HISTORY

Highest Grade Completed \_\_\_\_\_ Education Completed (**Circle all that apply**) High School GED Vocational School Junior College

University Other: \_\_\_\_\_

### BRIEF MEDICAL HISTORY

Are you under a physician's care? **YES NO** If yes, why? \_\_\_\_\_

Dr. Name \_\_\_\_\_ Phone \_\_\_\_\_ Agency \_\_\_\_\_

List ALL Medications Prescribed: \_\_\_\_\_

List all current and chronic physical medical issues: \_\_\_\_\_

Have you ever been diagnosed with a mental illness? **YES NO** Explain: \_\_\_\_\_

Are you under the care of a behavioral health facility? **YES NO** Agency Name \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever attempted suicide? **YES NO** If yes, explain: Date: \_\_\_\_\_ Circumstances: \_\_\_\_\_

### LEGAL HISTORY (if any)

Do you have current charges? **YES NO** If yes, what? \_\_\_\_\_

If yes, next court date: \_\_\_\_\_ Are you on supervision? (**Circle One**) IPS Direct Regular Parole Fed Probation

No Supervision Agency: \_\_\_\_\_ PO Name \_\_\_\_\_ Phone: \_\_\_\_\_ Office Location \_\_\_\_\_

Have you ever been convicted of a sex offense? **YES NO** Have you ever been convicted of an arson offense? **YES NO**

By signing below I provide OPCS authorization to share information included in this application with referring agencies and all information is true to the best of my ability:

Client Name (print) \_\_\_\_\_

(Sign here) \_\_\_\_\_ Date \_\_\_\_\_