TRANSITIONAL FOOD & SHELTER

Medically Fragile Homeless
APPLICATION
FAX to: 805-462-8901

Date:_____ Referring Case Worker: _____ Agency:_____ Phone:_____

Client First Name:_____ Nickname:_____ Last Name:_____

Client Phone Number:_____ Preferred Language:_____ Gender: M F T Other

Date of Birth:_____ Age:_____ Ethnicity: Latino ☐ Non- Latino ☐

Type of ID:_____ ID #:_____ SSN:_____

Race: American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐
Native American/Pacific Islander ☐ Afghanistan (2001-Present) ☐ White ☐

Is client currently homeless? Yes ☐ No ☐ # of Months Homeless: 0-12 ☐ More than 12 ☐ 3 years or more ☐

If homeless less than 12 months, how many times has he/she been homeless in the last 3 years? _____

Does the client have income? Yes ☐ No ☐ If yes, Source:_____ Amount:_____

Names of Other Adults in HH: _____

Relationship:_____ Type of ID:_____ ID #:_____
(*must list for each adult in HH)*
Age:_____ Gender: M F T Other

Relationship:_____ Type of ID:_____ ID #:_____
(*must list for each adult in HH*)
Age:_____ Gender: M F T Other

Number of Children that will reside with client:_____ Pets: Yes ☐ No ☐ Service Animal ☐ Type:_____
(one animal allowed)

Name of current Case Manager:_____ Agency:_____ Phone:_____

_____ _____
Client (Signature) Date Referring Case Worker (Signature) Date

[Release of Information (DSS 815); Verification of Medical Need by medical professional and Referral must be included with application. Forms available at www.nowheretogo.com under Agency tab]