



HOUSING APPLICATION
*For A-HOME's Independent Supportive
 Housing Programs*

Creating Homes to Rebuild Lives

Date of application _____

Last Name: _____ First Name: _____ MI: _____

Current Address: _____

City, State, Zip Code: _____

Home phone number: _____ Work phone number: _____

Cell phone number: _____ E-Mail Address: _____

Health Insurance: Medicare# _____ MEDICAID # _____

Other (type) _____ # _____

Ethnicity: _____ (optional)

Marital Status: Never Married Married Widowed

Separated Divorced/Annulled

Family Composition: list all individuals who will be residing in the unit

Name first, last	Relationship	Social Security #	Date of Birth	Gender M or F	Age
	SELF				

Are you a resident of Westchester County? YES NO

Are any of your family Westchester residents? YES NO

How did you learn about A-HOME? _____

Name, Agency and Phone # (if applicable) of person who referred you to A-HOME:

Why are you applying? _____

Check all that apply:

- Economic/ Financial In temporary or time limited housing
 Potentially Homeless More Independence
 Better Living environment Companionship Homeless
 Other (specify) _____

Do you, or anyone who will be living with you, have any needs or disabilities, which would require special accommodations? Yes No

If yes, please explain: _____

Do you own a car? Yes No Do you have use of a Car? Yes No
 If yes, to either Year _____ Make _____ Model _____

Do you have any pets? Yes No

Do you have a Section 8 housing voucher? Yes No

If yes, which Section 8 office?
 (County/ Municipality/ specify) _____

If no, have you applied for Section 8 Housing assistance? Yes No
 With Westchester County? Yes No Other? _____

RESIDENCES: Where have you lived in the past? Start with most recent:

Type of Housing	Rent amount	Location	Dates (From/To)	Reason for moving

Current Landlord: _____ Phone Number: _____

Address: _____

Previous Landlord: _____ Phone Number: _____

Address: _____

Have you ever been evicted or asked to leave a residence? Yes No

If yes, please explain: _____

Have you ever lived in shared living before? Yes No

EMPLOYMENT/EDUCATIONAL INFORMATION

For you and all individuals who will be living with you.

Name	Relationship	Attending School? (Yes or No) Where?	Last education level/grade completed	Employed? Yes or No. Where?
	Self			

FINANCIAL INFORMATION

Income (type) for you and all individuals who will be living with you.

	Name	Amount Monthly
SSI		
SOCIAL SECURITY DISABILITY		
SOCIAL SECURITY RETIREMENT		
PENSION		
EMPLOYMENT WAGES		
PUBLIC ASSISTANCE		
VETERANS BENEFITS		
UNEMPLOYMENT		
ALIMONY		
OTHER		
TOTAL INCOME FROM ALL SOURCES		\$

RESOURCES:

AMOUNT

CASH ON HAND	
BANK ACCOUNT (savings, checking, CD's)	
REAL ESTATE (estimate market value)	
STOCKS, BONDS, MONEY MARKET &/or IRA's	
LIFE INSURANCE (cash value)	
TOTAL FINANCIAL RESOURCES	\$

Liabilities	Name/ Location	Account #	Amount owed
Bank Loan			
Credit card(s)			
Car loan			
Student loan			
Mortgage			
Rent owed			
Medical bills			
Child support Or Alimony			
Utilities (Electric, phone etc.)			
Other			

****Detailed income verification will be required later in the admissions process.****

Do you have any major outstanding debts? Yes No

If yes, please describe: _____

Have you, or anyone who will be living with you, ever been convicted of a crime?

Yes No

If yes, please explain (When, where and what crime): _____

MEDICAL HISTORY for you and all individuals who will be living with you:

<i>Use a separate sheet of paper if necessary</i>	Name:	Name:	Name:	Name:
Medical Problem? Diagnosis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medications Type and dosage:				
Able to take own medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospitalizations (past 5 years) where and why?				
Allergies? Type?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance? Type?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last physical:				
Dr's Name:				

MENTAL HEALTH HISTORY for you and all individuals who will be living with you:

<i>Use a separate sheet of paper if necessary</i>	Name:	Name:	Name:	Name:
Diagnosis:				
Medications Type, dosage and frequency:				
Able to take own medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospitalizations (past 5 years) where, length of stay and reason?				
Seeing a therapist? Who?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seeing a psychiatrist? Who?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
In a day treatment? program? Where?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you, or anyone who will be living with you, have a history of alcohol or drug use? Yes No Who? _____

Are you/they currently in a drug or alcohol treatment program? Yes No

If yes, Where? Contact person?: _____

Date of last use: _____ Substance(s) used: _____

OTHER INFORMATION:

Do you, or anyone who will be living with you, smoke cigarettes? Yes No

Are you able to do any of the following independently without assistance?

Shopping Yes No Cooking Yes No Personal care Yes No

Cleaning Yes No Use public transportation Yes No

Handle your own finances Yes No

If no to any, please explain: _____

Is there anything else you would like us to know about you or anyone else who will be living with you?

Did you complete this application without help? Yes No

If No, please explain _____

Name & relationship of the person helping: _____

How did they help? _____

I hereby affirm that the above information is true and current. Falsification of information can result in termination of the application process or eviction.

Signature: _____ Date: _____

Please return to:

A-HOME
141 Tompkins Avenue Third Floor
Pleasantville, NY 10570

Phone Number: 914-741-0740 Fax: 914-741-0777

E-Mail: a-home@a-homehousing.org Website: a-homehousing.org

