

Application for Residency at C.A.L.M. House



CALM ORGANIZATION INC.
CALM House Niceville
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Application for Residency at CALM House Niceville

1. C.A.L.M. Organization defines single moms as follows:
 - A mother to at least one young child they have biologically birthed that will be living with them.
 - They may have legal custody of another young child that is legally adopted by them or in their legal custody. All applicants are decided on a case by case basis for acceptance into the CALM program. The decision is made by the Executive Board and stands as such.
2. We will serve single moms that want to change their lives and want to learn life skills to keep their family together and who meet our criteria for entrance to CALM House Niceville.
3. A small room fee deposit is required at move in. This will be returned to you if your room is cleaned and free of items upon move out. A checklist will be given for move out.
4. There is \$100 room deposit that can be paid installment plan. The room deposit will be returned upon inspection of room when resident leaves.
5. While leaving at Calm, Residents will be attending life skills classes, devotionals, cooking classes as needed, parenting classes, budgeting, household management and etc. The moms also MUST work a minimum of 20 hours a week. The moms MUST also follow the daily schedule and adhere to all rules while in our care. All rules, classes, church attendance, and curfew must be followed as set.
6. We expect you to be drug and alcohol free and this includes ALL illegal substances in the state of Florida and also includes medical marijuana and all the substances obtained from the plant even if you have an approved card for use.
7. You will be provided a safe and loving home for up to 5 months, with a possible one-month extension, and taught essential life skills to be successful as a mom. We have a transitional program to help you move to independent living once you complete our program.
8. Daycare will be available in our facility with a very small cost while moms are working. The moms will set daycare up with our assistance from our list of available friends that have had background checks completed.
9. **Please read all the house rules, daily schedule, and Phase Program. Then decide if you can abide by our guidelines before applying. Resident may be ejected from CALM House if not following the rules or the program.**
10. If you meet the above criteria you are welcome to apply to our program. We have room for 4 moms and their young children in this program.
11. **This program is fluid and subject to change at any time.**

Please note: Incomplete applications will not be processed. Please make sure to answer all questions as thoroughly as possible to the best of your ability.

Name: _____ Today's Date: _____

(Must Sign and date application to be considered)

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Street Address: _____ City, State, Zip: _____

Length of Time at Address _____ Telephone #(s): _____

Email Address: _____

Is it OK to call? *Please circle:* YES NO Is it OK to leave a message? YES NO

Are you a US Citizen? *Please circle:* YES NO

Date of Birth _____ Age _____

Marital Status (*Please circle*): Single Married Separated Divorced Widowed

Relationship Status: Are you currently involved in a relationship (either casual or serious)? Yes or No

Total # of Children: _____ Total # of Children living with You: _____

Are you currently pregnant? *Please circle:* YES NO Anticipated Due Date: _____

Race (*Please circle*): White Black Asian Native American Black/White Other

Ethnic background (*Please circle*): Hispanic Non-Hispanic

Who referred you? (*Agency, friend, online, etc.*) _____

Have you resided here or in similar housing before? *Please circle:* YES NO

If YES, please list program name(s) and dates: _____

EMERGENCY CONTACT INFO:

Name: _____ Relationship to you: _____

Address, City, State: _____ Contact Phone: _____

Is there anyone you wish we NOT contact or leave a message with? ____ YES ____ NO

Name: _____

CHILDREN

Child Name: (First, Last)	Date of Birth:	Age:	Race W-White, B - Black N-Native American A- Asian O-Other	School status (home, daycare, grade)	Father's Name	Custody of Child (Yes or No)	Do you have a SS card in your possession Yes or No

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EMPLOYMENT (From most recent to past):

Employer/Address	Position	Amount per hr.	Start/End Dates	Reason for Leaving

EDUCATION (From most recent to past):

Name of School/City	Dates Attended	Highest Level of Education Completed (Degree, Grade, etc.)	Course of Study
Do you have a GED? Yes No If yes, please list location obtained:	Have you ever been diagnosed or suspected to have a Learning issue? Yes No	State diagnosis _____ _____ When were you diagnosed? _____	Were you ever in remedial reading or math classes? Yes No

TRANSPORTATION (Calm needs a copy of a valid Driver's License or ID)

Do you have a valid driver's license? Yes No State? _____ Expiration Date: _____	If no, please explain:
Do you own a car? Yes No License Plate # _____	Make _____ Color _____ Model _____ Year _____
Is it registered in your name? Yes No	Do you have auto insurance? Yes No
Copy of Driver's License ___ Yes ___ No	Copy of Car Insurance ___ Yes ___ No

HOUSING

Please List Last Three Addresses (not including your current address)	Length of Time:	Reason for Leaving

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CRIMINAL HISTORY INFORMATION

Have you ever been arrested/ convicted of a crime?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please Explain:	Where the charges dropped? Circle: Yes No
Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please Explain:	Where & When did you serve time in jail?
Do you have a parole or probation officer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please List Name & Contact #:	Length of Time Remaining
Is there currently a restraining order on/against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please List Name & Contact #:	Describe:
Do you currently have a restraining order in place on/against someone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please List Name & Contact #:	Describe:
Are you or have you ever experienced domestic violence or sexual assault against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	No explanation needed here....	

MEDICAL HISTORY-SELF

Do you have medical insurance? Yes No Insurance Co. Name _____

Primary Care Physician _____ Address _____

Phone Number _____ Date of Last Physical: _____

OB/GYN _____ Address _____

Phone Number _____ Date of Last Visit: _____

Do you have any allergies (Please list them)? _____

Please list any present health concerns:

Do you have your Social Security Card in your possession? Yes No

Do you have your Birth Certificate in your possession? Yes No

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Please list any prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs: **Schedule 2, 3, or 4 medicines will be stored in locked cabinet in House's office.**

Medication	Dosage as Prescribed	Start Date	Reason for Medication

MENTAL HEALTH

Are you or have you ever been involved in any counseling or therapy? Yes No

Name of Therapist: _____ Address: _____

Phone Number: _____ Dates: _____

Name of Psychiatrist: _____ Address: _____

Phone Number: _____ Dates: _____

Are you or have you ever been diagnosed with a mental illness? Yes No

Diagnosis: _____

Have you ever been hospitalized for mental health? Yes No

Date of Hospitalization	Reason	Outcome

SUBSTANCE/ALCOHOL HISTORY

Are you or have you ever used any narcotic or illegal drug including marijuana? Yes No

If yes, list drug of choice and last time used: _____

Have you ever been treated for substance or alcohol abuse? Yes No

If yes, list dates of Treatment: _____ Successfully graduate? Yes No

Are you in recovery? Yes No If so, how long have you been in recovery? _____

Do you currently have a sponsor? Yes No Name Sponsor: _____

Are you currently drinking alcohol? Yes No

Are you currently taking suboxone or methadone? Yes No

Please list anything else we should know about past drug or alcohol use _____

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CHILDREN - MEDICAL HISTORY

Child's Name	Age	Is Child up to date with immunizations?	Name & Address of Pediatrician	Date of last immunization or well child visit	If the child is receiving any therapeutic support? (Occupational, speech, etc.) If yes, please list dates & provider	List any health concerns or dates of any hospitalizations

Please list any prescription and non-prescription medicines, vitamins, home remedies, herbs: (please use back side if necessary). Please list any prescription and non-prescription medicines, vitamins, home remedies, herbs: (please use back side if necessary)

Child's Name	Name of Medication	Dosage	Name of Physician Who Prescribed:	Length of Time on Medication (# of months or years)	Purpose for Medications

Do your children have medical insurance? Yes No Insurance Co. Name _____

Primary Care Physician _____ Address _____

Phone Number _____ Date of Last Physical: _____

Please list any present health concerns: _____

SUPPORTS (please use other side if needed)

Who do you consider are supports in your life? (parents, siblings, friends, etc.) _____

Describe the relationships you have and/or have had with child(ren) father(s) (good and bad)

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PARENTING (please use other side if needed) _____

What do you think are your strengths as a parent? (Use back for additional space) _____

What do you think you could improve upon in your parenting? _____

Have you ever attended a parenting group, course or have had individual parenting assistance? _____
Yes _____ No

If so, please list dates and where: _____

Do you have a current religious or spiritual practice or preference? _____ Yes _____ No

If yes, please list your religious or spiritual practice or preference: _____

What are your specific education/career goals? _____

The C.A.L.M. Organization, Inc. does not discriminate against any applicant on the basis of race, color, religion, creed, national origin, or sexual orientation. The C.A.L.M. Organization will provide reasonable accommodations at the C.A.L.M. House for persons with disabilities. Reasonable accommodations in rules, policies, practices, and services will be allowed to give persons with disabilities an equal program, provided such accommodations do not impose an undue hardship to the agency. Applicants with disabilities seeking entry into our program and who can complete the program requirements with reasonable accommodations must notify the interviewer to make an accommodation request.

If you are currently working with any city or town welfare department please realize we will give them any information they request, relating to your application during the intake process.

The information I, _____, provided the C.A.L.M. Organization, Inc. is true, accurate, and honest. If any information that I have provided as actual and truthful is indeed false and untrue and has been deliberately lied about by myself, the C.A.L.M. Organization may ask me to leave the program immediately. I also absolve the C.A.L.M. Organization, Inc. from any liability of any actions they may take based on this information that I have provided as truth.

I release C.A.L.M. House Niceville and other authorized C.A.L.M. Organization, Inc. representatives or stakeholders from any and all liability. Furthermore, I fully understand that I am provided transitional housing and do not have a permanent domicile at C.A.L.M. House, and thereby may be asked to leave at any time if I fail to follow the rules or schedule or are found to be using an illegal substance, drinking alcohol or commit other infractions that violate C.A.L.M. House rules that place me and my children, or other residents and volunteers in jeopardy.

Applicant Signature

Date

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I, _____ give the C.A.L.M. Organization, Inc. permission to speak to the individuals/companies listed in this application for the purposes of gaining more information and verification to make an informed decision about my possible entry into the program.

Applicant Signature

Date

Briefly explain why you feel you should be accepted into the C.A.L.M. House 5-month residential program: _____

Please explain anything else you feel C.A.L.M. House staff and volunteers should know about your children. _____

INCOME	
Salary/Earnings	
Worker's Comp	
Child Support	
TANF	
SNAP	
EBT Card Monthly Amount	
Other Income Not Previously Listed:	
TOTAL MONTHLY INCOME	\$

EXPENSES	
Cell Phone	
Medications/Vitamins	
Child Care	
School Lunches	
Clothing	
Credit Cards	
Car Payment	
Gasoline/Oil & General Maintenance on car	
Car Insurance	

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Car Registration	
Other Transportation – Uber, Taxi	
What do you spend your money on	
Other: _____	
TOTAL MONTHLY INCOME	\$

Outstanding Debt	
Back Rent Due	
Outstanding Bills	
Student Loan in Default	
Debt of any kind	
Other Expense Not Previously Listed:	
Subtotal for Outstanding Debt:	
TOAL MONTHLY EXPENSES:	\$

We need a copy of the most recent copy of the Bank Statement and Savings Account.

Additional questions:

1. In your own words explain how you got into this situation that you need CALM? _____

2. Why should you be accepted in the CALM House? _____
