



Resident Information

Applicant Information

Applicant Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (____) ____-____ Email: _____

Preferred Name/Nickname: _____

Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Trans Male ☐ Trans Female ☐ Prefer not to say

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) ____-____ Cell Phone: (____) ____-____

Student Status/Goals

☐ Current High School Student ☐ Graduated High School ☐ Not currently a student

Last Grade Completed: _____

Please list all High Schools You Have Attended: _____

What are your educational goals? Select all that apply:

☐ HS Diploma ☐ GED ☐ Trade School ☐ Professional Certification ☐ Associate's Degree ☐ Bachelor's Degree

☐ Other: _____

Are you currently enrolled in an educational program? If so, where?

If not, do you wish to be enrolled, either now or in the future?

Have you participated in any vocational or employment training programs?

What are your career fields of interest? Please list below.

Health Information

Do you have any diagnosed medical conditions? Please list.

Do you have any medical concerns that you would like addressed immediately that have gone unaddressed in the past? Please list.

Have you ever been diagnosed with any of the following?

☐ Depression ☐ Substance Addiction ☐ Alcohol Addiction ☐ HIV/AIDS ☐ Developmental Disability

☐ Physical Disability ☐ Intellectual Disability ☐ Anxiety ☐ OCD ☐ PTSD ☐ Other: _____

Please let us know if you currently or in the past have experienced any of these symptoms:

Symptom:	Current:	History of:
Homicidal Ideation/Attempts		
Assaultive/Aggressive Behavior		
Delusions/Hallucinations		
Severe Depression		
Fire Setting		
Suicidal Ideation/Attempts		
Cognitive Impairment		
Victim of Sexual Assault		
Victim of Sexual Trafficking		
Victim of Trauma		

Please let us know if you have been hospitalized because of any of the above symptoms:

List of Current Medications:

Medication:	Dose:	Purpose:

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What are your thoughts about your current medications? Please detail what you like/dislike about your medications.

How often do you take your medications as prescribed? (Circle One):

- a. Everyday as prescribed b. Most of the time c. When I can remember d. I don't take them.

Are you allergic to any medications and/or environmental stimuli?

Yes (Please detail): _____

No, not to my knowledge.

Date last attended:

Primary Care _____ OB/GYN _____ Specialist _____ Psych _____

Social

Please list any social networks or recreational activities that you enjoy:

Are you active or would you like to participate in any faith-based activities? If so, please detail below:

Vocational/Financial

Do you currently receive any of the below benefits? (Please identify which benefit and amount).

SSI/SSDI: _____

Survivors Benefits: _____

Food Stamps: _____

Other: _____

Have you ever opened a bank account? If so, are all your accounts in good standing? Please detail below:

Have you ever been employed? If so, where and for how long? What did you like or dislike about your employment?

Legal

Do you currently have any legal issues? Yes: _____ No: _____

If yes, are you currently on probation? Yes: _____ No: _____

Please list probation officer contact info: _____

Do you have any prior arrests or incarceration? If yes, please detail below:

Do you have legal counsel? If yes, please list contact information: _____

Do you have a guardian/conservator? If yes, please list contact information: _____

ADL/Supports

Please mark a + below for the areas of strength and a – for areas of need:

ADL	Strength (+) or Area of Need (-)
Paying rent/utilities/bills on time	
Complying with home rules	
Housekeeping	
Money management	
Using public transportation	
Scheduling/Requesting home repairs	
Use of mental health services	
Use of health services	
Meal preparation	
Obtaining/Maintaining benefits	
Shopping for food and other necessities	
Taking medication as prescribed	
Filling prescriptions	
Socialization	
Hygiene	
Maintaining healthy relationships	

Support System/Important People

Please list the people you maintain contact with within your support system that you want ALL OUT HOUSING to connect with and provide updates to in the future. ALL OUT HOUSING will only release information to those listed below.

_____	_____	_____
Name	Relationship	Telephone Number
_____	_____	_____
Name	Relationship	Telephone Number
_____	_____	_____
Name	Relationship	Telephone Number

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) ____-____ Cell Phone: (____) ____-____



Standard Photo and Video Release Form

I hereby authorize TSI Cares Foundation, INC to publish the photographs and videos taken of me and our names, for use in TSI Cares Foundation, INC's printed publications, website and other social networks (Facebook, Twitter, Google+, LinkedIn, and others). I release TSI Cares Foundation, INC from any expectation of confidentiality and and that I have the authority to authorize TSI Cares Foundation, INC to use their photographs, videos and names. I acknowledge that since participation in publications, websites, and other social networks (Facebook, Twitter, Google+, LinkedIn, and others) produced by TSI Cares Foundation, INC is voluntary, and I will not receive financial compensation. I further agree that participation in any publication, website, and other social networks (Facebook, Twitter, Google+, LinkedIn, and others) produced by TSI Cares Foundation, INC confers no rights of ownership whatsoever. I release TSI Cares Foundation, INC, its contractors, and its employees from liability for any claims by me or any third party in connection with my participation.

Signature: _____ Date: _____

Name: _____

Street Address: _____

City, State, Zip Code: _____

Phone number & email address: _____



TSI Cares Foundation

WATER WAIVER AND RELEASE OF LIABILITY

I, _____, agree to participate in water related activities (water safety training, swimming, and water play), escorted by TSI CARES FOUNDATION, INC as well as its directors, officers, administrators, employees, or other agents. Activities include, but are not limited to, public pools, beach and ocean outings, splash parks and outings near water (rivers, ponds, lakes).

PLEASE READ CAREFULLY BEFORE ACCEPTING THIS A RELEASE OF LIABILITY AND WAIVER OF CERTAIN LEGAL RIGHTS

I agree and understand that swimming is a HAZARDOUS activity. I recognize that there are risks inherent in use of the pool and ocean as well as the sport of swimming, including, but not limited to paralyzing injuries and death.

I hereby voluntarily agree to participate in water activities (pool or ocean) which may include swimming, swimming instruction, water safety training, boat trips, fishing trips, and free play time in the water and hereby agree to defend, indemnity and hold harmless TSI CARES FOUNDATION, INC as well as its directors, officers, administrators, employees, or other agents against any liability resulting from injury that may occur to the enrolled participant while participating in water activities. The enrolled participant agrees to defend, indemnify, and hold harmless TSI CARES FOUNDATION, INC as well as its directors, officers, administrators, employees, or other agents for any damages or injuries claimed or incurred arising from any claims, demands, actions, or causes of action by enrolled participant.

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I also authorize any representative of TSI CARES FOUNDATION, INC to provide/seek treatment in any medical emergency during participation in water activities. Further, I agree to pay all costs associated with medical care and medical transportation if such medical care is needed for any reason while participating in TSI CARES FOUNDATION, INC water activities.

I HAVE CAREFULLY READ THE ABOVE WAIVER & RELEASE OF LIABILITY AND ACCEPT IT WITH FULL KNOWLEDGE OF ITS CONTENTS AND SIGNIFICANCE.

Printed Name

Date

Signature

Date



PERMISSION TO TRANSPORT AND RELEASE OF LIABILITY AGREEMENT

Please read this form carefully and be aware in signing this waiver to be transported by automobile by TSI CARES FOUNDATION, INC and any activities associated therewith, you will be waiving your rights to all claims for injuries you and/or your minor child/ward might sustain arising out of being transported by automobile by a TSI CARES FOUNDATION, INC employee and you will be required to indemnify, hold harmless and defend TSI CARES FOUNDATION, INC for any claims arising out of you being transported by automobile by TSI CARES FOUNDATION, INC employees.

By signing this form, I hereby release TSI CARES FOUNDATION, INC, as well as its directors, officers, administrators, employees, or other agents from all liability or damages for any and all injuries arising from the negligence of any of the above while traveling to activities via private transportation, including personal injury, death, (and especially including, but not limited to, bodily injury or death from any motor vehicle accident) and for any other damages (including actual, compensatory, consequential, or incidental), arising from or relating to activities which take place during a field trip or in the travel to and from said scheduled community activity.

In consideration of being allowed to be transported by automobile by a TSI CARES FOUNDATION, INC Staff member, as a participant over 18 years of age, I recognize and acknowledge that there are certain risks of physical injury associated with being transported by automobile by a TSI CARES FOUNDATION, INC staff member. I agree to assume the full risk of injuries that may be sustained, as a result of being transported by automobile by a TSI CARES FOUNDATION, INC staff member and all activities connected or associated therewith.

Printed Name

Date

Signature

Date



TSI Cares Foundation

RELEASE OF INFORMATION

READ FIRST: Before you decide whether or not to let TSI Cares Foundation, INC share some of your confidential information with another agency or person, an advocate at TSI Cares Foundation, INC will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want TSI Cares Foundation, INC to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom,

I understand that TSI Cares Foundation, INC has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow TSI Cares Foundation, INC to release some of my personal information to certain individuals or agencies.

I, _____, authorize TSI Cares Foundation, INC to share the following specific information with:
(Name)

Who I want to have my information:	Name: Specific Office at Agency: Phone Number:
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The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail

☐ I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

What info about me will be shared:	(List as specifically as possible, for example: name, dates of service, any documents).
Why I want my info shared: (purpose)	(List as specifically as possible, for example: to receive benefits).

Please Note: there is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by TSI Cares Foundation, INC

I understand:

- ☐ That I do not have to sign a release form. I do not have to allow TSI Cares Foundation, INC to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like TSI Cares Foundation, INC to release information about me in the future, I will need to sign another written, time-limited release.
- ☐ That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from TSI Cares Foundation, INC.
- ☐ That TSI Cares Foundation, INC and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

This release expires on _____
Date Time

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Signature: _____ **Printed Name:** _____

Date: _____ **Time:** _____

Witness Signature: _____ **Printed Name:** _____

Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)

I confirm that this release is still valid, and I would like to extend the release until _____
New Date New Time

Signed: _____ **Date:** _____ **Witness:** _____

Roommate Questionnaire

My roommate preference(s) is: _____

Sleep Habits: ☐ Got bed early ☐ Get up early ☐ Flexible Some Light Irregular
 ☐ Go to bed late Get up late Schedule driven No Light I prefer a roommate who matches

Cleanliness: ☐ Everything has a place & goes there ☐ Some things just don't have a place
 ☐ Everything has a place & that place is the floor I prefer a roommate who matches

Socializing: I like to go out with friends on ☐ Weekends only ☐ Weeknights only
 ☐ Weekends & Weeknights ☐ Hardly Ever

Study Habits: ☐ Outside my room (i.e. Library) ☐ Quietly in my room
 ☐ with music (TV, etc) in my room

Smoking/Vaping (all common areas are smoke free):

☐ I am a nonsmoker, and I am not bothered by a roommate who smokes/vapes outside

☐ I am a nonsmoker, but I am allergic to smoke/vape or bothered by a roommate
Who smokes/vapes outside

☐ I am a smoker/vaper

Guests: (check all that apply)

I'm okay with my roommate: (check all that apply)

☐ I frequently have day guests

☐ Having frequent day guests

☐ I rarely have day guests

☐ Rarely have day guests

☐ I frequently have overnight guests

☐ Having frequent overnight guests

☐ I rarely have overnight guests

☐ Having some overnight guests

How do you feel about your roommate borrowing your personal belongings (clothes, food, toiletries...)? (Check all that apply)

☐ What's mine is yours; use whatever you want

☐ You can usually use my things; just ask first

☐ I prefer it if people not use my things

☐ I have a few things I prefer personal, but the rest is fair game

I consider myself in community (or solidarity) with LGBTQIA students and I believe I would be a good roommate for other LGBTQIA allies and/or members of the LGBTQIA community.

☐ yes ☐ no ☐ unsure

Are you registered for an emotional support animal? Yes No

If so, what is your animal: _____

Are you comfortable living with someone who has an emotional support animal? Yes No

What three words best describe you? _____

Optional Word Bank:

Productive Outgoing Meditative Direct Sociable Opinionated Traditional Tolerant Emotional

Shy Leader Creative Athletic Mature Introverted Friendly Assertive Studious Patient Consistent

Racy Artistic Modest Unconventional Organized Easy going Funny Open-minded

Do you have any medical concerns, allergies, or physical limitations that would be helpful to know for placement purposes?
If yes, please explain:

If you have any other preferences, please explain:

I attest that the above information is true to the best of my knowledge. I acknowledge that I have a right to change or update this information at any time by submitting a request to staff to do so.

Printed Name: _____ Signature/Date: _____

Staff Name: _____ Signature/Date: _____