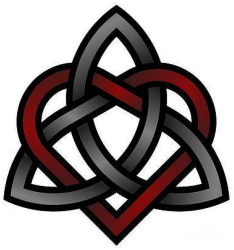

**Trinity Transitional Housing**

**Office (509) 674-6972**

**Email: jeffery@trinitytransitionalhousing.com**

**Personal**-

First Name Middle Last

D.O.B Sex ( ) M ( )F

D.O.C# Ethnicity Race

Email Address Phone #

Social Security Number WDL or ID #

Marital Status - Single ( ) Married ( ) Children ( ) Yes ( ) No

If Yes How Many _____ Education of Completion ____

Are you a US Veteran Yes ( ) No ( )

Current Living Status : ( ) Incarceration ( ) Inpatient ( )Shelter ( ) Other

**Background**

What were your last charges_____

Are you a registered sex offender ( ) Yes ( ) No

Have you been convicted of Arson ( ) Yes ( ) No

Pending Charges or Warrants Yes ( ) No ( ) If Yes, explain _____

Are you on DOC Supervision ( ) Yes ( )No If Yes CCO Name_____

Email Address,_____ Phone

Number_____

Have you been convicted of any violent offenses including Assault or DV?

( ) Yes ( ) No  If Yes, Explain

Are you on DOSA? Yes ( ) No ( ) If Yes, for how long?__ County _____ Status ____

**Work Status**-

Are you planning on working 40 hours a week Yes ( ) No ( )

Do you want to go to school or special training Yes ( ) No ( )

**If you are Working**-

Business Name

Address

Phone Number _____Managers Name _____

**Income/Source of Rent Payment-**

Self Pay ( ) Yes ( ) No

SSI ( ) Yes ( ) No

Voucher ( ) Yes ( ) No  How Long_____

Other ( ) Yes ( ) No Explain:

_____

**Housing-**

What date do you need housing _____

Agencies that work with you for housing _____

Case Manager _____ Phone_____

Have you lived in transitional housing before Yes ( ) No ( )
When_____

Organization_____ Please share your experience there_____

**Medical/Health Care**

Do you require medical treatment Yes ( ) No ( )

Do you require mental health treatment Yes ( ) No ( )

Are you currently receiving mental health treatment Yes ( ) No ( )

Do you require daily assistance from a provider Yes ( ) No ( )

Have you been prescribed any medication Yes ( ) No ( )

Are you taking your medication as directed Yes ( ) No ( )

Are you enrolled in a MAT Program Yes ( ) No ( )

If Yes, List each medication and dosage (add list if needed)

_____

_____

_____

Physician Name_____ Phone Number_____

Mental Health Provider Name_____ Phone_____

Drug(s) of choice_____

Any chemical dependency treatment (IOP, OP) past or present Yes ( ) No ( )

If Yes, do you receive services Yes ( ) No ( ) If Yes where_____

How many NA/AA meetings do you attend per week____ Last Used Date_____

Current Step_____ Sponsor Name_____

Do you Plan to attend 90 meetings in 90 days Yes ( ) No ( )

Personal Statement – Tell us about yourself

With limited beds available, what makes you the best fit for this House

**Emergency Contacts/Family or friends**-

**1.Name:**

Relation:

Address:

City:

State:

Zip: Phone:

**2.Name:**

Relation:

Address:

City:

State:

Zip: Phone:

**All information provided above is true to the best of my knowledge and is not intentionally Mis-leading in any way.**

**Signature:** **Date:**

**First Name** **Last Name**

**Preferred House**

**( ) Hutton House 1927 W. Eighth Ave., Spokane, WA.**

**( ) Mission House 2108 E. Mission Ave., Spokane, WA.**

**( ) Boone House 1819 W. Boone Ave., Spokane, WA.**

**If your preferred House is full, would you consider another Yes ( ) No ( )**

**Please email this application to jeffery@trinitytransitionalhousing.com**

**Our goal is to have application approved in 48 hours.**