Welcome Home Housing
816 Elm Street
Woodland, CA 95695

APPLICATION

PERSONAL INFORMATION:

Name_____

Address_____

Date of Birth_____ Social Security Number_____

Home Phone _____ Cell Phone_____

Email _____

Do you need or want a cooking coach? Yes____ No____

Do you need or want a cleaning coach? Yes____ No____

Do you smoke? Yes____ No____

Do you drink alcoholic beverages? Yes____ No____

Do you use illegal drugs? Yes____ No____

Explain any alcohol or illegal drug use (what, when, and how often, etc.):

_____

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What are your interests, hobbies, and/or goals?

What can Welcome Home Housing do to support you in your goals?

MEDICAL INFORMATION:

List ALL medical professionals and facilities from which you are receiving treatment.

Social / Case Worker:

Name_____ Phone_____

Address_____

Clinic where you are receiving psychiatric assistance:

Name_____ Phone_____

Address_____

Psychiatrist:

Name_____ Phone_____

Address_____

Diagnosis_____

Medications and/or treatments prescribed by this doctor_____

_____

_____

Psychiatrist:

Name_____ Phone_____

Address_____

Diagnosis_____

Medications and/or treatments prescribed by this doctor_____

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_____

Primary Physician:

Name_____ Phone_____

Address_____

Diagnosis_____

Medications and/or treatments prescribed by this doctor_____

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Other Medical Doctor:

Name_____ Phone_____

Address_____

Diagnosis_____

Medications and/or treatments prescribed by this doctor_____

_____

_____

Other Medical Doctor:

Name_____ Phone_____

Address_____

Diagnosis_____

Medications and/or treatments prescribed by this doctor_____

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_____

Other Health Care Professional :

Profession (nurse, physical therapist, etc.)_____

Name_____ Phone_____

Address_____

Diagnosis_____

Medications and/or treatments prescribed by this professional_____

_____

_____

Other Health Care Professional :

Profession (nurse, physical therapist, etc.)_____

Name_____ Phone_____

Address_____

Diagnosis_____

Medications and/or treatments prescribed by this professional_____

_____

_____

Additional Comments:

_____

_____

_____

May the above named professionals discuss your health issues with us so we can work as a team?

Yes_____ No_____

EMERGENCY CONTACT INFORMATION:

Name_____ Relationship_____

Address_____

Home Phone _____ Cell Phone_____

Email _____

Name_____ Relationship_____

Address_____

Home Phone _____ Cell Phone_____

Email _____

May we contact your family, worker, or doctor in an emergency?

Yes_____ No_____

INCOME SOURCES:

SSI: $_____ SSDI: $_____ VA: $_____ Pension: $_____

Job: $_____

Employer:

Name_____ Phone_____

Address_____

Applicant: _____
Print Name Signature Date