

Women In Transition

PROGRAM APPLICATION

CASEWORKERS: Your referral must include a copy of the Consent for Release of Information, a completed application, coordinated assessment date (if applicable), and a summary of your client's presenting issues (including health, mental health, substance abuse, and criminal history), strengths, areas of concern, employer, and salary or source of income and amount, *on your agency's letterhead*. Please e-mail completed referrals to witreferral@ywcacentralcarolinas.org or fax to 704-521-9684.

FULL NAME (FIRST, MIDDLE INITIAL, LAST)				TODAY'S DATE	
NAME YOU PREFER			GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER		
CURRENT ADDRESS			CITY/STATE/ZIP		
COUNTY NAME			HOW LONG AT THIS ADDRESS?		
SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY)		DATE OF BIRTH (MM / DD / YYYY)		AGE	
CELL / HOME PHONE				BEST TIME TO REACH YOU	
OTHER PHONE				BEST PHONE # TO LEAVE A MESSAGE	
E-MAIL ADDRESS					
DRIVER'S LICENSE OR ID NUMBER			ISSUING STATE		
ETHNICITY (OPTIONAL) <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> NON-HISPANIC/NON-LATINO					
RACE (OPTIONAL) <input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK/AFRICAN-AMERICAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER <input type="checkbox"/> OTHER (PLEASE STATE)					
NEXT OF KIN			RELATIONSHIP		
ADDRESS			CITY/STATE/ZIP		
CELL/HOME PHONE			WORK PHONE		
EMERGENCY CONTACT NAME			SAME AS NEXT OF KIN		PHONE
CAR MAKE (EXAMPLE: HONDA)			MODEL (EXAMPLE: CIVIC)		
COLOR	YEAR	TAG #		STATE	EXP. DATE (MO / YR)

HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES NO
(ANSWERING 'YES' DOES NOT DISQUALIFY YOU FROM ENTERING THE WIT PROGRAM)

HAVE YOU EVER SERVED IN THE MILITARY? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU A VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF DISCHARGE
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HIGHEST LEVEL OF EDUCATION ATTAINED

<input type="checkbox"/> NURSERY – 4TH GRADE	<input type="checkbox"/> 10TH GRADE	<input type="checkbox"/> GED	<input type="checkbox"/> UNDERGRADUATE
<input type="checkbox"/> 5TH – 6TH GRADE	<input type="checkbox"/> 11TH GRADE	<input type="checkbox"/> SOME COLLEGE	<input type="checkbox"/> GRADUATE DEGREE
<input type="checkbox"/> 7TH – 8TH GRADE	<input type="checkbox"/> 12TH GRADE, NO DIPLOMA	<input type="checkbox"/> TECHNICAL SCHOOL	<input type="checkbox"/> POST-SECONDARY
<input type="checkbox"/> 9TH GRADE	<input type="checkbox"/> HIGH SCHOOL DIPLOMA	<input type="checkbox"/> ASSOCIATE DEGREE / 2 YR.	<input type="checkbox"/> POST GRADUATE

ARE YOU CURRENTLY ENROLLED IN SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHERE?
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EMPLOYMENT STATUS

<input type="checkbox"/> FULL TIME, <u>NOT</u> LOOKING FOR ADDITIONAL HOURS	<input type="checkbox"/> PART TIME, <u>NOT</u> LOOKING FOR ADDITIONAL HOURS
<input type="checkbox"/> FULL TIME, LOOKING FOR ADDITIONAL HOURS	<input type="checkbox"/> PART TIME, LOOKING FOR ADDITIONAL HOURS
<input type="checkbox"/> DISABLED, RECEIVING DISABILITY SERVICES	<input type="checkbox"/> EMPLOYED SEASONALLY/INTERMITTENTLY
<input type="checkbox"/> DISABLED, <u>NOT</u> RECEIVING DISABILITY SERVICES	<input type="checkbox"/> OTHER - PARTICIPATING IN UNPAID JOB EXPERIENCE
<input type="checkbox"/> RETIRED	<input type="checkbox"/> UNEMPLOYED

PLEASE INDICATE HOW MUCH YOU RECEIVE MONTHLY.

<input type="checkbox"/> EMPLOYMENT	\$ _____	<input type="checkbox"/> ALIMONY OR SPOUSAL SUPPORT	\$ _____
<input type="checkbox"/> SOCIAL SECURITY – RETIREMENT	\$ _____	<input type="checkbox"/> CHILD SUPPORT	\$ _____
<input type="checkbox"/> PENSION FROM A FORMER JOB	\$ _____	<input type="checkbox"/> WORKER'S COMP	\$ _____
<input type="checkbox"/> SSDI	\$ _____	<input type="checkbox"/> PRIVATE DISABILITY	\$ _____
<input type="checkbox"/> SSI	\$ _____	<input type="checkbox"/> VETERAN'S DISABILITY	\$ _____
<input type="checkbox"/> UNEMPLOYMENT	\$ _____	<input type="checkbox"/> OTHER _____	\$ _____

HAVE YOU RECEIVED ASSISTANCE FROM ANY OF THESE SOURCES IN THE PAST 30 DAYS?

<input type="checkbox"/> FOOD STAMPS	\$ _____	<input type="checkbox"/> SECTION 8 PUBLIC HOUSING OR RENTAL	\$ _____
<input type="checkbox"/> MEDICAID	\$ _____	<input type="checkbox"/> TEMPORARY RENTAL ASSISTANCE	\$ _____
<input type="checkbox"/> MEDICARE	\$ _____	<input type="checkbox"/> OTHER _____	\$ _____
<input type="checkbox"/> VA MEDICAL	\$ _____		

ESTIMATED MONTHLY EXPENSES

<input type="checkbox"/> FOOD	\$ _____	<input type="checkbox"/> PRESCRIPTIONS	\$ _____
<input type="checkbox"/> CELL PHONE	\$ _____	<input type="checkbox"/> LOANS	\$ _____
<input type="checkbox"/> PERSONAL CARE	\$ _____	<input type="checkbox"/> MEALS OUT	\$ _____
<input type="checkbox"/> CIGARETTES	\$ _____	<input type="checkbox"/> ENTERTAINMENT	\$ _____
<input type="checkbox"/> BUS FARE	\$ _____	<input type="checkbox"/> TITHING	\$ _____
<input type="checkbox"/> GAS	\$ _____	<input type="checkbox"/> LIFE INSURANCE	\$ _____
<input type="checkbox"/> CAR PAYMENT	\$ _____	<input type="checkbox"/> HEALTH INSURANCE	\$ _____
<input type="checkbox"/> CAR INSURANCE	\$ _____	<input type="checkbox"/> CHILD SUPPORT	\$ _____
<input type="checkbox"/> STORAGE	\$ _____	<input type="checkbox"/> TOTAL ESTIMATED MONTHLY EXPENSES	\$ _____

HOW DID YOU HEAR ABOUT THE WOMEN IN TRANSITION PROGRAM?

HAVE YOU EVER PARTICIPATED IN A YWCA HOUSING PROGRAM BEFORE (WIT OR FAMILIES TOGETHER)? **YES** **NO**

APPLICANT SIGNATURE _____