[SOP-2059-FORM-005] PARTICIPANT INTAKE & PROGRAM ENROLLMENT APPLICATION

20/59 VENTURES CORP. Supportive Housing Program | Housing Referral Agency
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PARTICIPANT INTAKE & PROGRAM ENROLLMENT APPLICATION

Date of Intake: _____ Referral Agency/ Name of Referrer: _____

PARTICIPANT INFORMATION

Field	Details
Full Name:	_____
Date of Birth:	_____
Age:	_____
Social Security Number (Last 4):	_____
Phone Number:	_____
Email Address:	_____
Gender:	[ ] Male [ ] Female [ ] Non-binary [ ] Prefer not to say
Emergency Contact Name:	_____
Relationship:	_____
Emergency Contact Phone:	_____

CURRENT LIVING SITUATION

[ ] Homeless

[ ] Couchsurfing / Staying with others

[ ] Transitional Housing

[ ] Jail/Prison Release

[ ] Hospital / Rehab

[ ] Other: _____

REFERRAL SOURCE (IF APPLICABLE)

[ ] Self

[ ] Agency: _____

[ ] Parole/Probation

[ ] Hospital or Treatment Center

[ ] Family/Friend

• Referring Contact Name: _____

• Phone/Email: _____

BRIEF SUMMARY OF SITUATION / REASON FOR HOUSING NEED

MEDICAL & MENTAL HEALTH HISTORY

Medical conditions/physical health details:

Mental health diagnosis (if any):

Substance use history (if any):

- [ ] Alcohol [ ] Drugs [ ] None
- If yes, explain: _____

LEGAL BACKGROUND

- Are you currently on parole or probation? (List PO Name/Phone): [ ] Yes [ ] No
- Are you a registered sex offender? [ ] Yes [ ] No

VA CASE MANAGEMENT CAPTURE

VA Case Manager Information

Assigned VA Case Manager Name: _____

VA Case Manager Phone: _____

VA Case Manager Email: _____

[ ] MULTI-AGENCY COORDINATION CHECK: Participant has signed and executed the concurrent SOP-2059-FORM-001 Authorization for Release of Information (ROI).

INCOME INFORMATION

- Do you have a source of income? [ ] Yes [ ] No | [ ] SSI [ ] SSDI [ ] Employment [ ] Other:
- Monthly Income Amount (if any): $ _____

HOUSING PREFERENCES OR NEEDS

- Any disabilities or accommodations needed? [ ] Yes [ ] No — If yes, explain:

- Preferred Room Type: [ ] Shared Room (Affordable) [ ] Private Room (If available)

INDEPENDENT LIVING & FUNCTIONALITY ACKNOWLEDGMENT

Our program is designed for individuals who are high-functioning and capable of living independently. This is not a personal care home, nursing home, or assisted living facility. We do not provide medical care, personal assistance, or 24/7 supervision.

You must be able to manage your own:

- Personal hygiene and grooming
- Meal preparation and eating
- Medication (unless managed by an outside provider)
- Mobility and transportation arrangements
- Housekeeping and laundry
- Daily living responsibilities

If you require medical or personal care services, they must be provided by a licensed outside agency or caregiver, arranged and paid for separately.

Can you live independently and manage your Activities of Daily Living (ADLs) without assistance?

[ ] Yes [ ] No — Please explain: _____

Do you currently have or need a home health care provider or outside support service? [ ] Yes [ ] No

- Agency Name (if applicable): _____

[ ] I understand and agree that this program provides housing only. I will be responsible for my personal care, medical needs, and daily living tasks. I will not hold the program responsible for services outside the scope of independent housing.

Participant Initials: _____ **Date:** _____

PROGRAM AGREEMENT PREVIEW

[ ] I understand that if accepted, 20/59 Ventures Corp. provides housing accommodations only, that the program is entirely voluntary, and that violating house safety rules may result in an immediate strike or administrative discharge. I agree to program check-ins.

APPLICANT DECLARATION

I certify that the above information is true to the best of my knowledge. I understand that this intake does not guarantee placement, and my application will be reviewed by staff.

Participant Name: _____ **Participant Signature:** _____

Date: _____

Staff Name: _____ **Signature:** _____

Date: _____