

Mercy Center for Women Application for Brandy's Corner

Name: _____ Phone #: _____
 SS#: _____ Alt. Phone #: _____
 Date of Birth: _____ Current Address: _____
 Age: _____
 How long have you been at this address? _____
 Discharge date: _____

Marital Status: _____ Maiden Name: _____

Ethnic Group: Black Asian Middle Eastern
 White Native American Biracial
 Hispanic
 Non-Hispanic

Children

Children **coming** to BC

| Name | Birth date | Age | Sex | SS # |
|------|------------|-----|-----|------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Fathers Name/ Age/ Relationship:

Any special needs or concerns:

Past/ Current Services the Children are Involved With

Childs Name: _____ **Date involved:** _____

Agency & Counselor Name: _____

Phone # _____

Reason for Involvement:

Childs Name: _____ **Date involved:** _____

Agency & Counselor Name: _____

Phone # _____

Reason for Involvement:

Childs Name: _____ **Date involved:** _____

Agency & Counselor Name: _____

Phone # _____

Reason for Involvement:

Childs Name: _____ **Date involved:** _____

Agency & Counselor Name: _____

Phone # _____

Reason for Involvement:

Relationship History

Not currently in a relationship

Currently in a serious relationship

Person's name: _____

How long in relationship: _____

Describe any past or current significant issues such as Domestic Violence in this relationship or past relationships:

Domestic Violence History

Have you ever filed a protection from abuse order against anyone? Yes No

Have you ever had a PFA ordered against you? Yes No

If yes, list date and name of the person involved: _____

Describe the situation of the abuse:

Childhood/ Family History:

Education History

Regular or Learning Support Classes: _____

Highest grade completed: _____ Degree: _____

Where did you go to school: _____

Do you have a GED? Yes _____ No _____ Are you interested in getting your GED? Yes _____ No _____

If applicable, why did you not finish High School:

Employment History

Are you currently employed? Yes or No

If no, are you looking for work? Yes or No

Two Most Recent Jobs

Employer: _____ Dates: _____

Address: _____

Responsibilities: _____

Why did you leave: _____

Employer: _____ Dates: _____

Address: _____

Responsibilities: _____

Why did you leave: _____

Income

No Income ()

Income Information: List amount per month or week

| | |
|----------------------|------------------------|
| SSI/SSDI \$ _____ | Child Support \$ _____ |
| DPW \$ _____ | Other \$ _____ |
| Food Stamps \$ _____ | Other \$ _____ |

Total Monthly Income: _____

Debts / Monthly Expenses:

| | | |
|-----------------------|-----------------------|---------------------------|
| Gas \$ _____ | Telephone \$ _____ | Luxuries \$ _____ |
| Electric \$ _____ | Cell Phone \$ _____ | Fines \$ _____ |
| Rent \$ _____ | School Loans \$ _____ | Medical expenses \$ _____ |
| Credit Cards \$ _____ | Loans \$ _____ | Restitutions \$ _____ |
| Cable \$ _____ | Other \$ _____ | Other \$ _____ |

Total Monthly Expenses: _____

Total Debt: _____

Please complete the attached budget

Medical History

How would you describe current physical health: () Good () Fair () Poor

Primary Care Physician:

Name _____

Phone _____

Address _____

Medical Card / Insurance: _____

Mental Health

Have you ever had a psychiatric evaluation or been diagnosed with an SMI?

Yes No If yes, please give details

Have you ever tried to harm yourself? How many times? _____

If yes, please give details:

Family Mental Health History:

Inpatient Mental Health Treatment

Have you ever had an Inpatient Stay at a BH HOSPITAL?

Yes No If yes, on how many occasions_____.

1. _____ Facility Name
City/State SMI Diagnosis

Dates of Stay Aftercare Plan

2. _____ Facility Name
City/State SMI Diagnosis

Dates of Stay Aftercare Plan

3. _____ Facility Name
City/State SMI Diagnosis

Dates of Stay Aftercare Plan

All current or prior medication usage

| Medications | Dosage | Condition/Reason |
|-------------|--------|------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Drug & Alcohol History

Clean Date: _____

Drug of choice:

Primary: _____ Secondary: _____

What is your longest clean time? _____

When was it? _____

How old were you when you first started getting high? _____

What happened that you started to use drugs or alcohol?

Substances used:

(Check all that apply)

| | First use age | Last use age | Frequency | Amount |
|--|---------------|--------------|-----------|--------|
| <input type="checkbox"/> Alcohol | _____ | _____ | _____ | _____ |
| <input type="checkbox"/> Meth Amphetamines | _____ | _____ | _____ | _____ |
| <input type="checkbox"/> Cocaine | _____ | _____ | _____ | _____ |
| <input type="checkbox"/> Crack cocaine | _____ | _____ | _____ | _____ |
| <input type="checkbox"/> Marijuana/Weed | _____ | _____ | _____ | _____ |
| <input type="checkbox"/> Heroin | _____ | _____ | _____ | _____ |
| <input type="checkbox"/> Benzos | _____ | _____ | _____ | _____ |
| <input type="checkbox"/> Opiate | _____ | _____ | _____ | _____ |
| <input type="checkbox"/> Other _____ | _____ | _____ | _____ | _____ |

List Drug and Alcohol treatment facilities starting with current or most recent

Facility Name: _____ Date involved: _____

Counselor Name: _____ Phone # _____

Did you complete the program? _____

Facility Name: _____ Date involved: _____

Counselor Name: _____ Phone # _____

Did you complete the program? _____

Facility Name: _____ Date involved: _____

Counselor Name: _____ Phone # _____

Did you complete the program? _____

Facility Name: _____ Date involved: _____

Counselor Name: _____ Phone # _____

Did you complete the program? _____

Do you attend meetings (AA/NA)? Yes or No

How often _____

Do you have a sponsor? Yes or No

Why do you want to remain clean and sober? What do you do to focus on your recovery?

Legal / Criminal History

Have you ever been arrested, convicted, and/or incarcerated?

Yes

No

If yes, list dates, where and what for:

Do you have any **pending** charges?

Are you currently or have been on parole or probation? Yes No

If yes, list officer's name and contact phone #: _____

Homeless History

List Shelter Stays for the last 3 years
Dates and Agencies

Rental History / Timeline

Starting with the most recent for the last 3 years
Must give dates

More About You

What goals have you accomplished in the last 6 months?

What/ Who in your life do you look to for support?

What are some of your current/future goals?

1.

2.

3.

4.

5.

In which areas of your life do you feel like you need the most help with?

1.

2.

3.

4.

5.

Why do you want to come to Brandy's Corner?

Contacts / Agency Involvement

List all agencies in which you are currently involved with, e.g. OCY, Family Services, MH Counselors, D/A Counseling, education, law enforcement, etc.:

Agency: _____ Time Period: _____

Case Worker / Counselor: _____

Agency: _____ Time Period: _____

Case Worker / Counselor: _____

Agency: _____ Time Period: _____

Case Worker / Counselor: _____

Agency: _____ Time Period: _____

Case Worker / Counselor: _____

Agency: _____ Time Period: _____

Case Worker / Counselor: _____

Agency: _____ Time Period: _____

Case Worker / Counselor: _____

Currently seeing a Counselor, Psychiatrist or Therapist

Name _____

Agency _____

Dates of contact _____

Phone Number _____

Name _____

Agency _____

Dates of contact _____

Phone Number _____

Prior outpatient counseling

Name _____

Agency _____

Dates of contact _____

Phone Number _____

Do you have a **BCM**?

Name _____

Agency _____

Phone Number _____

List any relatives or friends MCW could contact as a reference:

Name: _____ Relation: _____ Phone # _____

Name: _____ Relation: _____ Phone # _____

Name: _____ Relation: _____ Phone # _____

I certify that the information provided on this application is true, complete, and correctly stated. I understand that any deliberate misstatement or omission can be cause for my application being denied or for my immediate dismissal from the program.

Applicant Signature

Date

Staff Signature

Date

Name:

| ❖ Monthly Income ❖ | | | |
|---------------------------|--------|------------------------|----------|
| Cash Income Source | Amount | Payment Date/Frequency | Comments |
| | | | |
| | | | |
| Total Cash Income: | \$ | | |
| Non-Cash Income Source | Amount | Payment Date/Frequency | Comments |
| | | | |
| | | | |
| Total Non-Cash: | \$ | | |

| ❖ Monthly Expenses ❖ | | | |
|-------------------------------------|--------|-----------|----------|
| Cash Income Amount: | \$ | | |
| Expenses | Amount | New Total | Comments |
| MCW Residency Fee: | -- \$ | \$ | |
| Fines: | -- \$ | \$ | |
| Probation/Parole | -- \$ | | |
| Bills: | -- \$ | \$ | |
| Past Due Utility bills | -- \$ | | |
| Credit Card Bills | -- \$ | | |
| Transportation: | -- \$ | \$ | |
| Car payment | -- \$ | | |
| Gas | -- \$ | | |
| Bus Pass | -- \$ | | |
| Uber | -- \$ | | |
| Phone: | -- \$ | \$ | |
| Medicine/Co-pays: | -- \$ | \$ | |
| Personal Items: | -- \$ | \$ | |
| Cigarettes/Vape | -- \$ | | |
| Fast food | -- \$ | | |
| Clothes/Makeup/Hair/Nails | -- \$ | | |
| Baby | -- \$ | | |
| Other: | -- \$ | \$ | |
| | | | |
| Total Remaining Cash Income: | \$ | | |

| ❖ Monthly Savings ❖ | | | |
|---------------------|------|-------------|----------|
| Savings | Cash | Food Stamps | Comments |
| Current Total | \$ | \$ | |
| Monthly Addition | \$ | \$ | |

| | | | |
|-------------------|----|----|--|
| Next Month's Goal | \$ | \$ | |
| Long Term Goal | \$ | \$ | |
| | | | |

| | | | |
|----------------------------|--|--|--|
| ❖ Notes and Goals ❖ | | | |
| | | | |

USDA Nondiscrimination Statement

SNAP and FDPIR State or local agencies, and their subrecipients, must post the following Nondiscrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race,

color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [How to File a Complaint](#), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

USDA Nondiscrimination Statement (Continued)

For all other FNS nutrition assistance programs, State or local agencies, and their subrecipients, must post the following Nondiscrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race,

color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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USDA Nondiscrimination Statement (Continued)

Joint Application Form (HHS)

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers ([click the link for a listing of hotline numbers by State](#)); found online at: [SNAP Hotline](#).

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

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