

**MALACHI HOUSE INTERNATIONAL
DREAM CENTER VETERAN HOUSING PROGRAM
INFORMATION FORM**

(Please Print)

| | | | | | | | | | | |
|--|--|--|---------------------|------------------------------|-----------------------------|---------|-------------------------------|-------------------------------|--------------------------------|----------------------------|
| Date: | | | | | | | | | | |
| RESIDENT'S INFORMATION | | | | | | | | | | |
| Resident's Last Name: | | | First: | | Middle: | | <input type="checkbox"/> Mr. | <input type="checkbox"/> Miss | Marital Status (circle one) | |
| Spouse's Name: | | | | | | | <input type="checkbox"/> Mrs. | <input type="checkbox"/> Ms. | Single / Mar / Div / Sep / Wid | |
| Insurance Name: | | | | Policy Number: | | | Birth Date: | Age: | Sex: | |
| | | | | | | | / / | | <input type="checkbox"/> M | <input type="checkbox"/> F |
| Street Address: | | | | Social Security No.: | | | Home No.: () | | | |
| | | | | | | | Cell No.: () | | | |
| P.O. Box: | | | City: | | | State: | | Zip Code: | | |
| Children Name: | | | | DOB/Age: | | | Name of School | | | |
| Children Name: | | | | DOB/Age: | | | | | | |
| Children Name: | | | | DOB/Age: | | | | | | |
| Children Name: | | | | DOB/Age: | | | | | | |
| Occupation: | | | Employer: | | | | Employer's Phone No.: | | | |
| | | | Employer's Address: | | | | () | | | |
| COUNSELING | | | | | | | | | | |
| SESSION GOALS | | | | PLEASE CHECK BOX | | REMARKS | | | | |
| 1. Housing/Transportation | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| 2. Case Management | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| 3. Substance Abuse Services | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| 4. Life Skills/Self-Esteem | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| 5. Clinical Counseling for Adults | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| 6. Group Counseling–Anger Management | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| 7. Holistic Counseling (body, soul and spirit) | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| 8. Clinical Counseling for Children | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| 9. Job Skills Training | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| 10. Financial Counseling | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| 11. Employability Training | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| 12. Social Services/Social Security Resources | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | |
| Name of Local Friend or Relative (Not Living at Same Address): | | | | | Relationship to Resident: | | Home Phone No.: | | Work Phone No.: | |
| | | | | | | | () | | () | |
| Resident/Guardian signature | | | | | | | Date | | | |

**MALACHI HOUSE INTERNATIONAL DREAM CENTER
HOUSING PROJECT PROGRAM
PRESCREENING FORM FOR VETERANS (CONTINUED)**

I. Current Problems:

| | <u>YES</u> | <u>NO</u> |
|----------------------|------------|-----------|
| Financial | _____ | _____ |
| Unit (Job) | _____ | _____ |
| Child Care | _____ | _____ |
| Recent Move | _____ | _____ |
| Pending Move | _____ | _____ |
| Loneliness/Isolation | _____ | _____ |
| Medical | _____ | _____ |
| Family Disagreements | _____ | _____ |
| Deaths in the Family | _____ | _____ |

Explain any yes answer: _____

II. History of Violence in the Family, if any:

| | <u>YES</u> | <u>NO</u> |
|--------------------------------------|------------|-----------|
| 1. Did you witness abuse as a child? | _____ | _____ |
| 2. Were you abused as a child? | _____ | _____ |
| 3. If you were abused, how? | | |
| a. Physically | _____ | _____ |
| b. Sexually | _____ | _____ |
| c. Emotionally | _____ | _____ |
| d. Needs neglected | _____ | _____ |

**MALACHI HOUSE INTERNATIONAL DREAM CENTER
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4. Have you had any previous involvement with the Family Advocacy Program or the Child Protective Services?

Explain any yes answer: _____

III. Substance Use/Abuse:

YES

NO

A. In the current family does anyone use/abuse alcohol/drugs?

Explain any yes answer: _____

B. In the families of origin did anyone use/abuse alcohol/drugs?

Explain any yes answer: _____

IV. History of Mental Illness (Include Suicide and Homicide Attempts):

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PRESCREENING FORM FOR VETERANS (CONTINUED)**

V. **Answer the following questions relating to your children (if applicable):**

YES

NO

1. Do any of these children have medical problems?

2. Are any of these children difficult or exceptional in any way?

3. Are there any present special problems?

Explain any yes answer: _____

4. How is discipline administered? _____

5. How are problems solved? _____

6. How are emotions/feelings handled in the family? _____

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7. How is spare time? _____

VI. Experience with counseling, if any:

| | <u>YES</u> | <u>NO</u> |
|--------------------------------|------------|-----------|
| Ministers' | _____ | _____ |
| Alcohol/Drug | _____ | _____ |
| School Counselors | _____ | _____ |
| Marriage and Family Counseling | _____ | _____ |
| Social Work Service | _____ | _____ |
| Community Mental Health | _____ | _____ |
| Court Mandated Counseling | _____ | _____ |

Explain any yes answer: _____

