

**Ocean Housing Alliance, Inc.
Valentine House / Angie's House
Resident Application**



Date of Application: _____ Date Application Received: _____

Name: First	Middle	Last
Date of Birth	Gender	Mental Health Diagnosis
Height	Weight	Other Diagnosis
Social Security number	Insurance (Please include a copy of all insurance cards)	Secondary insurance

Legal Guardian: _____ Phone number: _____

Please include proof of guardianship. Guardian's Email: _____

Applicant's Email: _____

Present Address: _____

*In case of emergency call

Contact Name: _____

Contact phone number: _____

Address: _____

Email: _____

Relationship to applicant: _____

* Applicant recognizes that by providing this information he/she is giving Ocean Housing Alliance the authority to contact the person and to provide him/her with relevant information to the applicant. The applicant has the right to withdraw this authorization/permission at any time.

Please state the reason for seeking new housing:

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Name of Psychiatrist: _____ Phone # _____

Address: _____ City _____ State _____ zip _____

Please attach a recent (last 6 months) Psychiatric Evaluation which must be signed and dated by the Psychiatrist. Applications will not be reviewed if information is not attached.

The following sections should be completed by a case manager/social worker, guardian or applicant. A recent (within the past 2 months) psychosocial evaluation may be attached. Please print.

Brief History of Applicants Psychiatric Illness

History of using tobacco? YES No History of using illegal drugs? YES No
When was the last time you used illegal drugs? _____
How often do you consume alcohol? Daily Weekly Monthly Occasionally Never

History of: (Mark all that apply)

Suicide Ideation	Suicide Attempt	Assaultive Behavior	Psychiatric In-patient treatment
Illegal Drug Use	Arson	Alcohol Use	When was the last time you drank alcohol: _____

If any of the above are checked please provide dates past and present, treatment received and related details below: (Please print neatly)

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Name of General Practitioner: _____ Phone: _____

Address _____ City _____ State: _____ Zip _____

List any Medical Problems/diagnosis (high blood pressure, diabetes, asthma, seizures, headaches. etc.) and medications prescribed.

Condition/Diagnosis	Name of Medication	Dosage and frequency

List significant medical history of; surgeries, injuries, or serious illness:

Surgeries		Date
Surgeries		Date
Surgeries		Date
Injuries		Date
Injuries		Date
Injuries		Date
Type of illness		Date
Type of illness		Date
Type of illness		Date

If necessary, provide additional documentation of a separate sheet

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Applicant Income from:	Income Amount (\$) <i>Please include copy of any award letters and/or supporting documents and annual tax return *</i>	Documentation provided with application
Public Assistance		
SSI		
SSD		
Pension		
Trust fund		
Inheritance		
All other sources		

**Board of trustees requires that upon acceptance the applicant must agree to have all government checks directly deposited into Ocean Housing Alliance account.*

I, _____ understand that with acceptance into the program, I agree to have all government/pension checks directly deposited into OHA bank account.

Signature: _____ Date: _____

Please attach a copy of:

Insurance Card(s)	Proof of Guardianship	Pension statement	Inheritance letter
Tax Return	Government income award letter	Driver's License or other identification card	Social Security Card
Recent Psychiatric Evaluation	Recent Psychosocial Evaluation (if available)	Income Documentation	

**Please Note: Only completed applications will be reviewed.
Reminder: Please include all supportive documents
and your Medical Clearance form.**