

Shaping Your Future Homes Screening Form

Our Mission is to provide those in need affordable and quality all- inclusive living environment

* Required

Please enter information below and we will contact you within 24 hours

1. Client Full Name *

2. Current Address *

3. Phone Number *

4. Email *

5. Date of Birth *

Example: January 7, 2019

6. Age *

7. Ethnicity *

8. Religious Preference *

9. Sexual Preference

10. Funding Source

Mark only one oval.

- SSDI
- SSI
- Voucher
- Private Pay

11. Person Referring *

12. Reason for referral *

Mark only one oval.

- Emergency Shelter
- Transitional Housing
- Permanent Housing
- Other

13. Case Manager/ Social Worker *

14. Outpatient Mental Health Agency *

15. Primary Care Provider *

16. Current Mental Health Diagnosis *

17. Current Medical Conditions *

18. What Medications are you currently taking? *

19. Veteran *

Mark only one oval.

Yes

No

20. Services needed and expected outcomes

21. Is the Client able to do own personal hygiene – bathing/showering, grooming, nail care, and oral care? *

Mark only one oval.

Yes

No

22. Is the Client able to make appropriate clothing decisions and physically dress and undress oneself? *

Mark only one oval.

Yes

No

23. Is the client has the ability to feed oneself, though not necessarily the capability to prepare food.

Mark only one oval.

Yes

No

24. Is the Client able to Maintain continence – being able to mentally and physically use a restroom. This includes the ability to get on and off the toilet and cleaning oneself. *

Mark only one oval.

Yes

No

25. Move in date preferred *

Example: January 7, 2019

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