EDUCATIONAL & TREATMENT COUNCIL, INC.
TRANSITIONAL LIVING PROGRAM
P.O. Box 864
Lake Charles, LA 70602-0864
Fax (337) 433-8638
Telephone (337) 433-8636

Transitional Living Program Application

Name: _____ Date: _____

Address: _____

City, State _____ Zip Code: _____

Cell Phone: _____ Work: _____ Other Contact #: _____

Age: _____ Date of Birth: _____SS# _____ Birthplace: _____

Do you best identify yourself as: ☐ Female ☐ Male ☐ Other _____

Do you best identify yourself as:

- ❑ Heterosexual (straight)
- ❑ Gay
- ❑ Lesbian
- ❑ Bi-Sexual
- ❑ Prefer not to respond

Legal Status

- □ Adult
- □ Minor
- □ Emancipated

Have you ever been in the custody of the Department of Children and Family Services (foster care) or the Office of Juvenile Justice (state juvenile justice system)? Yes No

If you are a minor (17 years old or younger), who is your current Guardian? (Parent, relative, State of Louisiana, etc.) Please indicate below.

Name of Guardian: _____ Phone: _____

Ethnicity (circle all that apply)

African American/ Black
Caucasian / White
Asian
Asian American
Native American
Native Hawaiian
Alaskan Native
Other Pacific Islander
Other_____

Check one:
Hispanic ____
Non-Hispanic ____

Referral Source

Who referred you to the Transitional Living Program or how did you hear about us?

_____

Housing History

Where are you currently living?

_____

Where have you lived over the last year?

_____

Your Relationship Status and Family Composition:

☐ Single ☐ Separated
☐ Married ☐ Divorced
☐ Primary Partner ☐ Widowed

Please fill out the following information for all persons that would be living with you.

Name	Relationship	Gender	Age	Social Security #

Transportation

What is your current means of transportation?

☐ Bus ☐ Personal Vehicle ☐ Friend/Relative ☐ Walk ☐ Bike

Have you ever lived in Lake Charles? ☐ Yes ☐ No Do you know how to get around the city? ☐ Yes ☐ No

Do you know how to use the Lake Charles public bus system?

Resources

Please check the box if you receive financial assistance from the programs listed below; please identify the amount(s) you receive.

☐ Child Support $_____ ☐ Medicaid #_____
☐ Food Stamps $_____ ☐ SSI $_____
☐ WIC $_____
☐ Other Program _____; Amount $_____

Have you applied for any of the following (please circle):

Public Housing? Yes No Date applied: _____
Section 8 Housing? Yes No Date applied: _____
Other Subsidized or Rental Housing? Yes No Date applied: _____

Employment

Are you currently employed? Yes No

If so, how long have you worked there? _____

If so, where do you work? _____Phone_____

How much do you make per hour? _____ How many hours a week do you work? _____

What do you do there? _____

Do you like what you do? Yes No

If not, what would you like to do? _____

If not currently employed, how long has it been since you worked? _____

What kind of work have you done in the past? _____

What led you to unemployment? _____

Would you like to have job training? Yes No

If so, in what? _____

Please check the box if any of the following prevents you from finding work:

- ☐ Transportation
- ☐ Criminal History
- ☐ Child Care Issues
- ☐ No Resume
- ☐ Little work history
- ☐ Health/mental health issues
- ☐ History of drug/ alcohol abuse
- ☐ Other:_____

What kinds of work are you best at? _____

What are your particular abilities and strengths?_____

Please list any particular issues that keep you from maintaining employment or advancing in your career:

_____

_____

_____

Educational History

Are you currently enrolled in high school? Yes No

If so, what school?_____ Grade _____

Did you complete high school? Yes No

Do you have a GED? Yes No

If not, what level of school have you completed?_____

Have you ever attended college (McNeese, Sowela)? Yes No

When and where? _____

What did you study?_____

If you attended a trade or technical school, or have participated in any type of job training program, please list the names of the schools or programs and the subjects you have studied. Please also list any certificates you have received.

_____

_____

Would you like to continue your education? Yes No

If so, in what area?_____

What do you like best about school? _____

What do you dislike about school? _____

What are your particular skills and abilities?

_____

_____

Please check any of the following that prevents you from continuing your education:

- ❑ Financial reasons (can't afford tuition, old loans)
- ❑ Learning disability
- ❑ Transportation
- ❑ Child care issues
- ❑ Lack of time
- ❑ Learning style (please explain): _____
- ❑ Other (please explain) : _____

Independent Living Skills (please circle the answer that best describes you)

I say "yes" to people when I really want to say "no".

Frequently Often Sometimes Seldom Never

I have a hard time making and keeping friends.

Frequently Often Sometimes Seldom Never

I have trouble managing my money.

Frequently Often Sometimes Seldom Never

I find it difficult to manage my time.

Frequently Often Sometimes Seldom Never

I find it difficult to accept the consequences of my actions.

Frequently Often Sometimes Seldom Never

Some ways that I stretch my income in order to provide for myself and my family are:

Would you like to receive more information concerning: (circle all that apply)

Job Skills
Communication
Assertiveness
Coping with Impairments
Stress Management
Dealing with Discrimination
Cooking
Time Management
Decision Making
Coping with Loss/Rejection
Establishing Healthy Relationships
AIDS and other STD's
Budgeting
Smart Shopping
Dealing with Anger/ Depression
Pregnancy Prevention
Human Sexuality
Alcohol /Tobacco/Other Drugs
Health
Parenting
Dealing with Authority Figures
Other (explain) _____

Would you be willing to take classes to increase your skills in these areas? Yes No

Have you ever received education in any of the following? (Circle all those that apply)

Legal Rights and Responsibilities Voting Rights Tenant Rights
HIV/STD prevention Pregnancy Prevention

If so, where? _____

Do you have the following documents? (circle all that apply)

Birth Certificate Social Security Card ID Card Driver's License Immunization Record

I know how to do the following (check all that apply; please be honest as it will help us better serve you):

- ☐ Grocery shop for nutritious meals
- ☐ Prepare more than 5 meals
- ☐ Wash dishes by hand
- ☐ Use a washing machine and dryer
- ☐ Fold and hang clothes
- ☐ Sweep, mop, and vacuum
- ☐ Take out the trash
- ☐ Clean a toilet and bathtub/shower

Rate on a scale of 1-7, your motivation to complete the above tasks ***without being asked*** (circle the number):

1 2 3 4 5 6 7

Must be asked all the time *Will do tasks when I see they need to be done*

Do you know what it means to pay rent? Yes No

Do you know what a savings account is? Yes No

Please rank the following items that <u>you consider to be the most important</u> from highest (#1) to least (#10):
Each item will have a different number (1, 2, 3, 4, etc. from most important to you (#1) to least important to you (#10)

____ Cable ____ Utilities ____Cell Phone ____Rent ____ Cigarettes ____ Entertainment

____ Clothes ____Food _____Transportation (gas, bus, etc.) ____ Helping a family member or friend

Would you be comfortable living by yourself? Yes No

What kinds of things do you like to do in your free time?_____

_____

Do you have spiritual or religious traditions that are important to you? Yes No
Is there anything you would like the program to do to help you practice these traditions?

_____

Parenting

I am the parent of a child under 18 years old. Yes No **If not a parent, skip to "Legal" Section on next page**

I take care of a child under 18 years old. Yes No

I have legal custody of my child/children Yes No

If not, who does? _____

Are you working towards reuniting with your child/ children? Yes No

If so, explain. _____

_____

Relatives and friends help me with my children in the following ways: (please check all that apply)

- ❑ With money
- ❑ Child Care
- ❑ Someone to talk to about being a parent
- ❑ Things for children (toys, clothes, food, diapers, etc)
- ❑ Other (please explain) _____

My child/children is currently enrolled in day care services Yes No

If so, Please list your daycare name and telephone number

_____

I am interested in learning new ways to improve my parenting skills. Yes No

Would you be willing to take classes to improve your parenting skills? Yes No

The form of discipline I use most is (please explain):

_____

_____

The best thing about being a parent is:

_____

_____

_____

The hardest thing about being a parent is:

_____

_____

_____

Legal

Do you have any legal problems (i.e., divorce, child custody, child support, protective order, probation, etc.)?

_____

_____

_____

Are there any warrants out for your arrest? Yes No

If "yes", what are the warrants for?

_____

Do you have any tickets that need to be paid? Yes No

If "yes", what are the tickets for?

_____

Have you ever been convicted of a: Misdemeanor? Felony?

If so, what for?

_____

Date/location of incarceration(s):

_____

Have you ever been on parole or probation? Yes No

For what? _____

Are you currently on probation? Yes No

Are you currently on parole? Yes No

If for a different reason than listed above, please identify reason and for how long:

_____

_____

Do you have any expenses connected to your current probation or parole? Yes No

How much do you pay, and how often?

_____

Who is your probation officer?

_____

Have you been ordered to do community service? Yes No

If "yes", how many hours? _____

How many hours do you still have to complete and by when? _____

Have you ever applied for a protective order? Yes No

Date Protective Order filed: _____

Name and relationship of person order filed against _____

Alcohol/Tobacco/Drug Use – Please be honest as it helps us to better serve you

If you took a drug test today, would you pass? "Pass" means that you would test negative for any prescription medications (unless you have a prescription), Alcohol, and/or Illegal Drugs (including synthetics).

- ☐ **Yes, I could pass a drug test**
- ☐ **No, I could not pass a drug test. I would test positive for** _____

Is there any history of drug addiction or alcoholism in your family? Yes No

Do any of your friends use illegal drugs or drink alcohol? Yes No

Have you ever drunk alcohol? Yes No

If yes, at what age do you remember having your first drink? _____

How many times in the past 30 days have you had a drink? _____

Have you ever used illegal drugs? Yes No

If "yes", what have you experimented with? (Circle all that apply)

Pain killers	amphetamines	Meth
Pot	cocaine/crack	Incense
Hashish	heroin	Bath salts
Barbiturates/sedatives	hallucinogens	Other_____

What is the earliest age that you remember experimenting with illegal drugs? _____

How many times in the past thirty days have you used illegal drugs? _____

Have you ever abused prescription drugs? Yes No

If so, what kind(s)? _____

Have you participated in a drug education course, AA/NA or substance abuse treatment program? Yes No

If "yes", did you complete it? Yes No

What kind of course or treatment was it? _____

Are you in recovery? Yes No

If yes, for how long? _____

Has anyone ever told you to cut down or stop using alcohol? Yes No

Has anyone ever told you to cut down or stop using drugs? Yes No

Have alcohol or drugs ever caused problems for you? Yes No

If yes, please circle all that apply:

☐ School	☐ Financial
☐ Employment/Work	☐ Legal
☐ Family/Relationships	☐ Health
☐ Emotional/Mental	☐ Spiritual
☐ Motivation/Ambition	☐ Social

☐ Other (please explain) _____

Do you smoke cigarettes? Yes No

If yes, approximately how much do you spend on cigarettes in a week: _____

How long have you been smoking: _____

Would you like assistance in trying to quit? Yes No

Medical/ Mental Health (please circle the answer that best describes you)

I feel overwhelmed by my feelings and find it hard to cope.

Frequently Often Sometimes Seldom Never

I experience mood swings

Frequently Often Sometimes Seldom Never

I feel that I don't have control over my life

Frequently Often Sometimes Seldom Never

I do not like myself very much and feel others are judging me.

Frequently Often Sometimes Seldom Never

I feel scared for no apparent reason.

Frequently Often Sometimes Seldom Never

I feel bad (down and out) more days than not

Frequently Often Sometimes Seldom Never

I find myself crying

Frequently Often Sometimes Seldom Never

I no longer enjoy the things that I used to enjoy

Frequently Often Sometimes Seldom Never

I have thought about harming myself

Frequently Often Sometimes Seldom Never

I have attempted to kill myself

Frequently Often Sometimes Seldom Never

Do you have a history of mental illness in your family? Yes No

Do you, any of your children, or other family members have any of the following?

Condition	**Self Presently**	**Child**	**Other family member**
Behavioral problems			
Physical disabilities			
Health problems			
Mental health issues			
Other:			

Have you ever been abused? Yes No Not comfortable answering at this time

Have you ever taken any psychotropic medication (anti-depressants, anti- psychotics, anti anxiety, etc.)?

Yes No

What medications and what for? (Box below)

Type of Medication	Purpose of Medication	Now	Past

Are you being treated for a medical condition? Yes No

If so, what is the condition? _____

Do you think you need medical attention that you are not getting? Yes No

If so, for what? _____

When was the last time you went to the dentist? _____

Who did you see? _____

Do you have a health insurance? Yes No

Which one do you have? _____

Have you ever had an operation or childhood illness? Yes No

If so, what? _____

Please list any important information and history on you and your family including immunizations

_____

Whom do you rely upon when you need financial assistance or child care?

Whom do you rely upon when you need someone to talk to?

_____

_____

What additional supports do you have in your life? (Friends, family, mentors, employers, other community contacts) List all persons you can think of.

_____

_____

_____

_____

Please explain the reasons we should choose you to participate in the Transitional Living Program and tell us what you would hope to accomplish while in the Program.

What questions/concerns do you have about the program?

FOR OFFICE USE ONLY: Date application received:_____ Disposition _____

Notes/Follow Up/Referred To: