

**COOL TRANSITIONAL HOUSING APPLICATION**

**PLEASE NOTE: If this application is NOT FILLED OUT COMPLETELY, you will not be considered for the program. DO NOT FAX YOUR APPLICATION. Mail application to 800 W. Glen Flora Ave., Waukegan, IL 60085**

**For Office Use Only:**

Date Application Received \_\_\_\_\_ Date receipt of app. sent \_\_\_\_\_

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Date \_\_\_\_\_

Referred By/ Agency \_\_\_\_\_

Case Worker \_\_\_\_\_ Phone \_\_\_\_\_

**Identifying Information**

Full Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_

Other names used \_\_\_\_\_

Social Security Number (last four numbers only ) \_\_\_\_\_ XXX-XX-\_\_\_\_\_

Current Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

Marital Status: (circle one)    Single    Married    Widowed    Divorced    Separated

Spouse's Full Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_

Social Security Number (last four numbers only) \_\_\_\_\_ XXX-XX-\_\_\_\_\_

Children's Full Names

\_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

**(if more room is needed for other children, please list on back of this page)**

Are you pregnant now? Yes No (if yes) Due Date \_\_\_\_\_

Are you or your spouse a Veteran? Yes No Spouse Self Discharge Date \_\_\_\_\_

Have you or your spouse ever been convicted of a felony?

Self Y N (if yes) Date \_\_\_\_\_ Conviction \_\_\_\_\_

Spouse Y N (if yes) Date \_\_\_\_\_ Conviction \_\_\_\_\_

What is the primary reason you are homeless now? \_\_\_\_\_

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**History**

Previous Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Landlord \_\_\_\_\_ Rent/Mortgage \$ \_\_\_\_\_

Phone \_\_\_\_\_ Lease Date (start/end) \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

**Agencies Contacted for Services**

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

**Present Shelter:**

Family  Friend  Motel  PADS  Car  Other \_\_\_\_\_

Move in date? \_\_\_\_\_ Anticipated move out date? \_\_\_\_\_

**BACKGROUND INFORMATION** - Nearest relative/friend (in case of emergency)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street/City/State/Zip

**Education (Years Completed-Please circle) (Applicant)**

1 2 3 4 5 6 7 8 9 10 11 12 or GED

College 1 2 3 4 Post Graduate 1 2 3 4 Degree \_\_\_\_\_

Any plans to continue education? Yes No Field of Interest \_\_\_\_\_

**Education (Years Completed-Please circle) (Spouse)**

1 2 3 4 5 6 7 8 9 10 11 12 or GED

College 1 2 3 4 Post Graduate 1 2 3 4 Degree \_\_\_\_\_

Any plans to continue education? Yes No Field of Interest \_\_\_\_\_

**Employment-Applicant (if unemployed, list last employer)**

Company Name \_\_\_\_\_ Supervisor \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Position \_\_\_\_\_

Date started: \_\_\_\_\_ Date ended: \_\_\_\_\_ Hourly Wage? \_\_\_\_\_

Full Time (35+ hours per week)  Part Time (20 or less hours per week)

**Employment Spouse (if unemployed, list last employer)**

Company Name \_\_\_\_\_ Supervisor \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Position \_\_\_\_\_

Dates started: \_\_\_\_\_ Date ended: \_\_\_\_\_ Hourly Wage? \_\_\_\_\_

- Full Time (35+ hours per week)       Part Time (20 or less hours per week)

**Outstanding Debts**

Please attach a **SEPARATE PAGE** listing all your **OUTSTANDING DEBTS** and amounts of monthly payment to each creditor.

**Present Child Care**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Cost \$ \_\_\_\_\_ per/ (circle one)      day      week      month

<b>Source</b>	<b>Family Member Receiving</b>	<b>Amount</b>
Wages (employment)		
Public Aid		
Social Security/SSI		
Veterans Assistance		
Child Support		
Food Stamps		
Unemployment Compensation		
General Assistance		
Medical Coverage		<b>N/A</b>
Dental Coverage		<b>N/A</b>
Monthly Gross Income	<b>TOTAL MONTHLY GROSS INCOME</b>	<b>\$</b>
Monthly Net Income	<b>TOTAL MONTHLY NET INCOME</b>	<b>\$</b>

**Have you received services from Christian Outreach of Lutherans before?    \_\_\_Y \_\_\_N**

**If yes what year?** \_\_\_\_\_ (check services received)    \_\_\_ Food Pantry    \_\_\_ Housing

**Medical Background (Applicant)**

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Have you been hospitalized within the past 2 years? (circle one) Y N  
Any current/previous illnesses? Y N (if yes, please list)

Diagnosis \_\_\_\_\_

Present medications \_\_\_\_\_

**Medical Background (Spouse)**

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Have you been hospitalized within the past 2 years? (circle one) Y N  
Any current/previous illnesses? Y N (if yes, please list)

Diagnosis \_\_\_\_\_

Present medications \_\_\_\_\_

**Medical Background- Dependent**

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Have you been hospitalized within the past 2 years? (circle one) Y N  
Any current/previous illnesses? Y N (if yes, please list)

Diagnosis \_\_\_\_\_

Present Medications \_\_\_\_\_

**Medical Background- Dependent**

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Have you been hospitalized within the past 2 years? (circle one) Y N  
Any current/previous illnesses? Y N (if yes, please list)

Diagnosis \_\_\_\_\_

Present Medications \_\_\_\_\_

**Medical Background- Dependent**

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Have you been hospitalized within the past 2 years? (circle one) Y N  
Any current/previous illnesses? Y N (if yes, please list)

Diagnosis \_\_\_\_\_

Present Medications \_\_\_\_\_

**(if more room is needed for other children, please list on back of application)**

**Transportation** (Check all that apply)

I own a car       I borrow a car       I take public transportation  
Other (Please Explain) \_\_\_\_\_

**Outline a two year plan for your progress toward self-sufficiency. Explain your goals and how you will accomplish them.**

Goal for Year One \_\_\_\_\_  
Steps to Accomplish Goal \_\_\_\_\_

Goal for Year Two \_\_\_\_\_  
Steps to Accomplish Goal \_\_\_\_\_

**Reason for wanting to be part of the T-H Program** \_\_\_\_\_

**Please list the qualities you possess that make you a good candidate for the COOL Transitional Housing Program**

**What types of help do you think will benefit you in becoming self-sufficient?**

\_\_\_ Budgeting/Finance      \_\_\_ Parenting Skills      \_\_\_ Life Skills  
\_\_\_ Permanent Housing      \_\_\_ Medical/Dental Health      \_\_\_ Ex-Felon

**Have you experienced any of the following?**

\_\_\_ Domestic Violence      \_\_\_ Developmentally Disabled      \_\_\_ Alcohol/Substance Abuse  
\_\_\_ Sexual Abuse      \_\_\_ Mental Health      \_\_\_ Juvenile Delinquency

Other concerns or special needs \_\_\_\_\_

**I verify that the information given in this application is complete, true and correct to the best of my knowledge.**

**I also understand that COOL will do a CRIMINAL BACKGROUND CHECK and drug screening before entry into the Family Housing program is possible.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Social Security Number** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

*It is our policy to award Transitional Housing to families who fit our criteria at the time a housing unit becomes available. All applications are kept on file for six months from the date of receipt. In the event a housing unit becomes available that would suit your needs, a staff member will contact you to set up a time for a formal interview. Submitting an application is not a guarantee for admittance into the COOL Program.*