

Westmoreland Community Action  
Transitional Housing Program  
114 Pittsburgh Street Greensburg Pa 15601

Date:

Last Name:

First Name:

MI:

DOB:

SSN:

Phone Number:

What are 3 goals you want to achieve while in program?

- 1.
- 2.
- 3.

\*Is the participant on Coordinated Entry?

Yes

No

If not, please do prior to admission.

Is participant currently employed?

Yes

No

If employed, what is your status?

Full-time

Part-time

Temporary/seasonal

If participant is unemployed, are they currently seeking employment?

Yes

No

If yes, what type of employment are they seeking?

If currently unemployed or unable to work/disabled, does participant have an income?

Yes

No

If yes, income source:

Is participant currently active in mental health treatment?

Yes

No

If no, please explain.

Mental Health Diagnosis:

Is consumer currently prescribed medications?

Will consumer have all prescribed medications upon admission?

Yes

No

If no, please explain.

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Greensburg Pa 15601

Participant Name:

DOB:

\* Transitional Housing Program will only accept individuals who are at their baseline and have some source of income and can be independent and self-sufficient.

WCSI Case Manager:

ACTT:

Housing Support:

Other:

Please list current medical issues or physical disabilities:

Is participant able to climb stairs?	Yes	No
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Is participant able to care for self (hygiene, nourishment, etc.)?	Yes	No
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Does participant have a criminal history?	Yes	No
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If yes, please explain.

Does participant have any pending charges?	Yes	No
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If yes, please explain.

Is participant currently on probation?	Yes	No
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Name of PO:

Phone Number:

Does participant have any history of aggressive behaviors, fire setting, or sexual offenses?

Yes	No
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If yes, please explain.

Does participant have a history of substance abuse?	Yes	No
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If yes, please explain.

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Participant Name:

DOB:

When was last usage:

Is participant currently seeking D&A treatment?

Yes

No

If no, please explain.

\*Please note, if a participant has a vehicle there is only permit parking (they would be responsible to get a parking permit from the City of Greensburg).

\*Please attach a list of current prescribed medications, a signed copy of Transitional Program House Rules, and any other pertinent information.

<u>Referred By:</u>	
Representative:	Date:
Phone Number:	
<u>Office Use Only:</u>	
Date Referral was received:	
Disposition of Referral:	
If declined/denied, what is the reason:	

Staff Signature:

Date:

Supervisor Signature:

Date: