East Providence Housing Authority
Family Self Sufficiency Program
APPLICATION

NAME: ______________________________________DATE:_______________________
ADDRESS: ____
PHONE: __________________________Email:____________________________________

1. Please list all family and household members living with you.

Name of Family Member	Relationship to Head of Household	AGE	SEX	Ethnicity*
	H of H			

*Ethnic groups include: White, African American, Hispanic, Latino, American Indian Alaskan Native, Asian/Pacific Islander, and Other.

2. Are **you** (Head of Household) employed? **YES / NO**
   Full-time /part-time (circle one)

If yes, list your job and rate of pay:
Employer:____________________________**Type of Work**:_________________________
Approximate Starting Date:___________________**Wages**: $__________________ per month.

Do you receive the following benefits through your employer? (Circle all that apply)
Medical **Dental** **Retirement**

If unemployed, what type of income do you receive? (CIRCLE)
WELFARE SSI UNEMPLOYMENT WORKERS COMP. CHILD SUPPORT
OTHER:____

Are any other family members employed? **YES/NO**

Do the other adults in the household wish to participate in the FSS Program? **YES/NO**

3. What is the highest level of education completed? (circle)
   Grade School
   Some High School: 9 10 11 12
   HS Diploma
   GED
   Some College: 1 2 3 4 **What Curriculum & School**?______________________

College Degree: Certificate Associate's Bachelor's Master's

Are you currently enrolled in a GED Program? **YES/NO**

If so, what tests have you taken and passed?

Reading **Math** **Writing** **Science** **Social Studies**

Other Training/Certification:________________________________When?________

Have you ever volunteered? **YES/NO**

If yes, where? ____

4. Please check any items below that you consider a current need.
   (Check as many as apply)

___Need a better job ___Need better transportation

___Need childcare ___Need health care/ health insurance

___Need more income to pay bills ___Need parenting help

___Want to start/finish school ___Counseling

___Need food/heating assistance ___Need money management/ credit help

___Want job training ___Need legal assistance

List any other services, goals and other needs you may have:

____
____
____
____
____

5. Please check the agencies where you have visited or received services in the last 6 months.

___Health Dept., doctor, or clinic ___Community action agency

___Job training program ___Welfare department

___Mental health clinic ___Alcohol or drug program

___Food pantry ___Child care /DHS

___Community College ___Vocational/Tech. School

___Shelters ___Children services programs

___Other ___None of the above

List Other: ____

6. What is your primary language? **English Portuguese Spanish Other**________________

7. Do you need help finding someone to watch your children (childcare) if you get a job or start school? **YES/NO**

8. Do you have a driver's license? **YES/NO**

Do you have your own vehicle? **YES/NO**

Do you have access to a vehicle? **YES/NO**

Do you rely on public transportation? **YES/NO**

9. Do you now work with a welfare case manager, counselor or church member who helps you find services? **YES/NO**

IF yes, please list person's name: ______________________________________
What agency does she/he work for: ______________________________________

10. Explain why you would like to join the FSS program What do you expect to gain from this program?
____
____
____
____

11. What are the biggest problems/barriers that **YOU and your FAMILY** are facing now?
____
____
____
____

12.What **goals** do you want reach over the next 5 years?
____
____
____
____

Signature___________________________________ Date______________________

Please RETURN TO:

Jennifer Brightman
Family Self-Sufficiency Coordinator
East Providence Housing Authority
99 Goldsmith Avenue
East Providence, RI 02914

401-434-7645 ext. 108

(OPTIONAL)

PARTICIPANT'S NAME:

____

Participant Program Access Assessment Intake Form

Assessment question #1: Some people have difficulty completing tasks in their daily living because of physical, mental or emotional conditions. Which of the following tasks, if any, are ***difficult*** for you to accomplish ***on your own*** in your daily life because of an underlying condition?

Question #1: Please Check (ü) All That Apply			
	Physical tasks like walking or sitting		Understanding directions
	Hearing/understanding spoken words		Staying focused or keeping on track
	Reading newspaper sized print		Managing a schedule
	Seeing faces across the room		Making decisions
	Breathing (due to allergies, etc.)		Remembering things
	Speaking		Dealing with relationships
	Holding a pen or typing		Other
	Expressing yourself on paper		None of the above

Assessment question #2: In this program, you will need to understand and complete required paperwork, attend required meetings and complete assigned activities. If you need assistance with any program related activities because of a physical, mental or emotional condition, please indicate all of the types of assistance that you require.

Question #2: Please Check(ü) All Needed Accommodation			
	Wheelchair accessible facilities		Flexibility because of chronic fatigue
	Special seating arrangements		Audio-taped materials
	Sign language interpreting		Personal coaching
	Materials in Braille		Meeting reminders
	Materials in large print		Note-takers for regular meetings
	Scent free environment		Special considerations for medication
	Materials on disk		Other
	Assistance with writing		None of the above

If you need assistance or accommodation at any time in the course of the program, please inform FSS Coordinator, Jennifer Brightman (401) 434-7645 ext. 108. She will discuss how best to provide you with the assistance you need.