

Dear Applicant,

We are glad that you have chosen CHRIS 180 TransitionZ Program. Our mission is to help young adults learn skills associated with a successful transition into adulthood and to provide supportive and affordable housing. Some of our services include assistance with: completing and obtaining a high school diploma or GED; enrolling in and completing post-secondary education; interviewing and resume writing skills; asset attainment and money management and daily living skills to include, but is not limited to utilizing community resources, food preparation and transportation.

Young adults will be selected to enroll in the program based on objective criteria listed below. To enroll in the program the young adult must be:

1. Between the ages of 17-24;

**Exception:** If applicant is under age of 18, a legal guardian is required to sign a lease.

1. Willing to complete a mental health assessment;
2. Willing to submit to a criminal background check;
3. Employed and working at the minimum, 30 hours per week; or
4. In an educational program and working a minimum of 20 hours per week; and
5. Willing to participate in services.
6. Must qualify within the Income Limits for the household size

Young adults enrolled in our program receive support from TransitionZ program staff to ensure that they reach their future goals. Each young adult will be provided individualized attention by their assigned TransitionZ Case Manager who will ensure that a plan is developed to ensure successful completion of the Individualized Service Plan. All young adults are further supported by Resident Advisors, who conduct daily living skills and ensure the safety of all residents enrolled in the TransitionZ Program. Program participants are also expected to participate in therapeutic services that may include individual or group counseling, expressive therapies or participation in community support groups.

You should expect from us a mutual relationship of collaboration, accountability, and transparency to ensure that the young adult’s needs are met and that all opportunities for independence are explored. We look forward to your participation in the service planning process and an ongoing dialogue to discuss strengths and needs. Your commitment to ensuring that necessary skills that exhibit independence are learned is critical to their success in the program.

After you review the information and complete the application and attached documents, please fax to 404-564-4719 or email to janikqua.cutno@chris180.org to begin the application process.

If your application is not accepted, you will be provided a written explanation of the grounds for rejection.

If your application is accepted and depending on the availability of units, your application will be placed on the approved waiting list, which is maintained in the chronological order of application. Vacant units are filled based on the current resident transfer requests as well as the waiting list. Once a unit becomes vacant, the approved applicant will be contacted based on your chronological position within the waiting list.

If you have any questions, concerns, or information you would like to share, please feel free to reach me by e-mail at janikqua.cuton@chris180.org or by phone at 404-564-3420. Thank you in advance for your partnership with CHRIS 180 and the TransitionZ program.

Janikqua Cutno Alfred Garner

TransitionZ Intake Coordinator TransitionZ Program Manager



Application for Admission for CHRIS 180 TransitionZ

|  |  |
| --- | --- |
| **Full Name (include middle initial):**  | **Application Date:** |
| **Medicaid #** | **SS #:** |
| **DOB:**  | **Age:** | **Gender:** ❑ **Male** ❑ **Female**  |
| **Sexual orientation:** The Fair Housing Act prohibits "any preference, limitation, or discrimination because of race, color, religion, sex, handicap, familial status, or national origin, or intention to make such preference, limitation or discrimination" in connection with any aspect of a residential real estate transaction. CHRIS 180 encourages and supports the equal housing practices of the Fair Housing Act in the conduct of its business and we encourage users of our site to follow appropriate guidelines to comply with the Federal Housing Act, as well as any applicable state and local regulations. All applicants are hereby informed that all property offers are available on an equal opportunity basis. |
| **Address:** |
| **Phone Number:** | **Email Address:** |
| **City:** | **County:** | **State:** | **Zip Code:** |
| **Payor/Funding: (Select all that apply)** |
| ❑ Self-Pay | ❑ State Contracted Svcs. | ❑ SSI | ❑ DJJ | ❑ DFCS |
| **Leasing Information:**  |
| Have you ever been evicted from an apartment or home? **Yes** ❑ **No** ❑If yes, Name of Property\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Evicted:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Household Income per year:❒ 0-$9,999 ❒ $10,000 – $19,999 ❒ $20,000 - 29,000 ❒ over $30,000 |
| Do you have a checking or savings account?**Yes** ❑ **No** ❑If yes, what is the current balance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (checking)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (savings) |
| **Are there any other persons who will occupy the apartment? Yes** ❑ **No** ❑If yes, complete below:Name Gender (M/F) Date of Birth Relationship to Applicant  |
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| **Insurance Provider** |
| ❑ Medicaid | ❑ Private Insurance | ❒ Other (please explain): | ❑ Self-Pay |  |
| Insurance Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group or ID # Expiration date:­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Type of Coverage:  |
| **Ethnicity:** | ❒ American Indian | ❒ White/Caucasian |
|  | ❒ Hispanic | ❒ Asian  |
|  | ❒ Black/African American | ❒ Multi-racial |
|  | ❒ Other single race: |
| **Religion:** | ❒ Protestant/Catholic | ❒ Christian |
|  | ❒ Muslim | ❒ Other: |
| **English Proficiency:**  | ❒ Proficient | ❒ Limited-Spanish Primary Language | ❒ Limited-Primary Language Other |
| **Referral Source:** (C*heck all that apply.)* |
| ❑ Self | ❑ DFCS | ❑ MAAC | ❑ Other |
| ❑ Family | ❑ State Hospital | ❑ Juvenile Justice - Region:  |
|  |
| **Special Population** (C*heck all that apply.)* |
| ❑ Vision impairment ❑ HIV + ❑ Pregnant ❑ Hearing impairment ❑ None |
| **Psychological Assessment Information:** Date of Assessment: Full Scale IQ: Name of Assessment: Achievement Scores: Math: Reading:  |

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| **DSM Multi-Axial Assessment** |
| Axis I Primary | Axis I Secondary | Axis II Primary | Axis II Secondary | Axis III Primary | Axis III Secondary |
|  |  |  |  |  |  |
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| **Service History** within past 18 months |
| Number of Impatient Hospitalizations: |
| Number of Crisis placements: |
| Number of ER/Crisis Team Involvements: |
| AllegationsHas there been any allegations against staff? **❑** No **❑** Yes  if yes: **❑** Pending **❑** substantiated **❑** unsubstantiated |
| Medications | No **❑** | Yes **❑** | If ‘Yes’ please list. |
| **Medications** (*List* *primary psychiatric first.)* |
| Name |  | Purpose |
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| Active medical diagnosis? No **❑** Yes **❑** If ‘yes’, please describe: |
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| **ALLERGIES**: |
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|  |
| **Living Situation:** |  |  |
| ❑ Parent/relative/friend | ❑ Jail/Correctional Facility ❑ Group Home | ❑ Supported Living |
| ❑ Foster Home ❑ Residential Program | ❑ Non Housing (such as car, park, sidewalk, street) | ❑ Emergency Shelter  |
| ❑ Psychiatric Hospital (PRTF) ❑ Other: (please explain) |
| **Reason for Homelessness (if homeless):** |
| **Last Permanent Address (if homeless; zip code, nearest major crossword, or city):** |
| **Employment Status:**A. Employment: Employed Yes **❑** No **❑** If yes: Name of Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Employed: Hrs worked during a typical week: Hourly or monthly wage: Hourly Wage Monthly Wage  |
| B. Volunteer: Volunteer Yes **❑** No **❑** If yes: Location or Volunteer Organization\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Average volunteer hours:  |
| **School:**❑ Regular school programming ❑ Enrolled in an alternative school (IEP) ❑ Pursuing GED❑ No longer in school |
| Number of days absent from school in past month if enrolled:  |
| Years of Education: What is the highest level of education that the applicant has completed?  |
| Name of Last or Current School Attended\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Legal Status (current or past):**1. Date youth entered Care: ❑ N/A

County Case Plan Expiration Date: ❑ N/A Custody Order Expiration Date: ❑ N/A1. Legal Custody (*Check any that apply)* ❑ Parental custody ❑ DFCS Custody

❑ Other Court-Appointed Guardian 1. Legal Involvement (*Check any that apply.)*

❑ DFCS ❑ Juvenile Justice ❑ Probation ❑ Jail/Law Enforcement 1. Juvenile Justice System Involvement:

Has client been involved with juvenile justice system in the past year? ❑ Yes ❑ No(*Includes arrests, probation, commitments, adjudications, diversions, or awaiting sentencing)*1. Arrests: Number of arrests, regardless of nature of offense or outcome, in the past 30 days:
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Addiction and Substance Abuse**Has this youth ever used/abused substances? ❑ Yes ❑ No

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| --- | --- |
| Type of Substance(s) Used: | ❑ None |
| ❑ Marijuana | Frequency:  | ❑ Tobacco | Frequency:  |
| ❑ Alcohol  | Frequency:  | ❑ Huffing | Frequency:  |
| ❑ Amphetamines | Frequency:  | ❑ prescription drug abuse  | Frequency:  |
| ❑ Crack/cocaine | Frequency:  |  |  |
| ❑ other (please describe)  |

Age at First Use: Is there a history of family drug/alcohol abuse? Yes ❑ No ❑ If yes, please describe:  Has applicant ever received in-patient treatment for substance use? ❑ Yes ❑ NoIf so, when and where?  |
| Are there pending or recent charges? Yes ❑ No ❑ If yes, please describe: |
| **Custodial Agency/Custodian (present or past):**  | County: (if DJJ, include Region)  |
| Case Worker/Court Service Worker:  | Title: | Agency:  |
| Address:   |
| **Phone #:**  Cell #: | **\*Additional means of communicating w/custodian required:**Fax:  |
| After Hours #: | Email: |
| **Supervisor’s Name:** (required): | Phone: |
| Email : |
| Family Contact(s): Name: | Relationship:  |
| Address:  Street City, state, zip  |
| Phone Number: | Email Address: |
| Phone contact? Yes ❑ No ❑Face-to-face? Yes ❑ No ❑Supervision Required? Yes ❑ No ❑ | Who provides supervision?  |
| Add’l Family Contact(s):Name: | Relationship: |
| Address:  Street  City, state, zip |
| Phone: (home) | (work) |
| Legal Restrictions regarding family contact? Yes ❑ No ❑ If yes, please describe:   |
| Are there family members or other individuals not currently involved who are potential resources for this youth? Yes ❑ No ❑ If so, please list:   |

**PRESENTING AND HISTORICAL ISSUES**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| History | Presenting |  | History | Presenting |  | History | Presenting |  |
|  |  | Alcohol |  |  | Fire Setting |  |  | Psych Hospitalization |
|  |  | Animal Abuse |  |  | Gang/Cult |  |  | Runaway |
|  |  | Enuresis/ Encopresis |  |  | Juvenile Court |  |  | Self Mutilation |
|  |  | Depression  |  |  | Medical/Illness |  |  | Sex Offense |
|  |  | DFCS  |  |  | Violence re peers |  |  | Sexual Abuse |
|  |  | DJJ |  |  | Weapons |  |  | Sexual Acting Out |
|  |  | Drugs |  |  | Medication |  |  | Suicidal |
|  |  | Emotional Abuse |  |  | Neglect  |  |  | Violence re: authority |
|  |  | Family D/A  |  |  | Physical Abuse |  |  | Other (explain below) |
|  |
| Most recent high risk incident:    |
| If incident reports regarding high risk behaviors (as requested on the first page) are not available, please describe any incident involving the following behaviors within the last 90 days – physical aggression, AWOL, substance/alcohol use, school suspension or expulsion, sexual acting out, self-harm or police involvement:    |
| Strengths and Skills:   |
| Positive behaviors the applicant seeks to practice: (examples: emotional regulation, independence/life skills)    |
| Please document any need for special consideration of sexual, cultural, religious, national, racial or ethnic identity issues:   |
| Will it be possible for the applicant to have a pre-placement visit? Yes ❑ No ❑ |

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| --- |
| **References:** |
| Please list three personal and/or professional references that CHRIS 180 may contact on the applicant’s behalf. |
| Name | Contact Number or Email | Relationship |
|  |  |  |
|  |  |  |
|  |  |  |

Name: (please print)

Signature: Date:

***\*\*Please note that incomplete applications will not be processed and may delay approval time\*\****

**Please email this document to** **janikqua.cutno@chris180.org** **or fax to** 404-564-4719.

**when completed.**

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| --- |
| **Office Use Only** |
| **Date Application Received:**  |
| **Application Complete** (circle one) **:Yes / No** |
| **System Checks:**Department of Pardons & Parole Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_National Sex Offender Registry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Application Status: Denied\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) Reason:**  |
| **Application Status: Pending \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) Reason:** |
| **Application Status: Approved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) Additional Info:** |
| **Date of Move In: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Additional Information:** |



**TransitionZ Consent for Release of Information**

 **\_\_\_\_\_\_**

Consumer’s Full Name Date of Birth

 Social Security Number Identification #

The following agencies, organizations and stakeholders have my permission to exchange/give/receive/ share/re-disclose information regarding service delivery planning for the purpose of securing, coordinating and/or providing services for the above named person. Please identify by checkmark all that apply.

|  |  |
| --- | --- |
| ❑ Adults serving in Foster Care or other caretaking roles | ❑ MAAC |
| ❑ Department of Family and Children/Youth Services | ❑ Mental Health (Public/Private) |
| ❑ Department of Juvenile Justice/Probation | ❑ Public/Private Hospitals |
| ❑ Juvenile Courts | ❑ CHRIS Counseling Center\*\* |
| ❑ Other | ❑ Relatives of the Youth (please specify) |
|  ❑  |  |

\*\*Please select if you wish to receive clinical services through CHRIS Counseling Center.

I authorize exchanging/giving/receiving/sharing/re-disclosing of the following information if needed by the receiving organization to secure, coordinate or provide services to the individual. *Check yes or no and initial.*

Check one Initial

❑ Yes ❑ No Identifying information: name, birth date, sex, ethnicity, address, and telephone #.

❑ Yes ❑ No Social Security Number

❑ Yes ❑ No Case Information:

• The above identifying information • Social history

• Treatment/service history • Psychological evaluations

• Individualized Education Plans (IEPs) • Transition plans

• Individualized Service Plans (ISPs) • Grades/Work schedule

• Medical (except for HIV, AIDS, and drug and alcohol treatment records)

• Other personal information regarding the individual named above.

**Information regarding the following shall *not* be released unless initialed below:**

Check one Initial

❑ Yes ❑ No HIV and AIDS related diagnoses

❑ Yes ❑ No Substance abuse diagnosis and treatment

❑ Yes ❑ No Other, specify:

I understand that the Consent for Release of Informationexpires one year from the date below unless otherwise indicated herein by the consumer or his/her representative. I also understand that I may cancel my Consent for Release of Information at any time by stating so in writing with the date and my signature, and delivering it to Chris 180. The revocation does not include any information which has been shared between the time that I gave permission to share information and the time that it was revoked.

**I understand that this authorization will remain in effect for:**

* **Ninety (90) days unless I specify an earlier expiration date here:**
* **One (l) year from signed date**

 / /

Young Adult, Guardian, Custodial Parent Date

 / /

Witness/Agency Representative Date

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 **APPLICATION CHECKLIST**

**The following information should be included in your application and emailed to**

**janikqua.cutno @chris180.org** **or faxed to** 404-546-3419 **when completed**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Date:** |  |
|  |
| **These documents are required to be considered for an interview:**  | **Included** | **Reviewed** | **Pending(Date)** |
| CHRIS 180 TransitionZ Application |  |  |  |
| TransitionZ Consent for Release of Information |  |  |  |
| Mental Health Evaluation or Psychological (as recent as 2 yrs).  |  |  |  |
| Current Social Assessment or CCFA (DFCS/DJJ only) |  |  |  |
| Current Placement monthly notes and summaries (DFCS/DJJ only) |  |  |  |
| **These documents will be required at the time of the interview:**  |  |  |  |
|  HorizonZ Application for Rental (Summit Trail Application) |  |  |  |
|  Employment Verification Form (sign only, if employed) |  |  |  |
|  Tenant Release & Consent Form |  |  |  |
|  HUD-Authorization to Release Information Form |  |  |  |
| Copy of Valid Georgia I.D.  |  |  |  |
| Copy of Birth Certificate |  |  |  |
| Copy of Social Security Card |  |  |  |
| Copies of Recent Pay Stubs (last 6 weeks) |  |  |  |
| Copies of Recent Bank Statements-Checking & Savings (last 2 months) |  |  |  |
| **These documents will be required for approval of application:**  |  |  |  |
| Criminal Background Check (local) |  |  |  |
| Completed Mental Health Assessment or Psychological Evaluation |  |  |  |
| Copies of Recent Pay Stubs (last 6 weeks) |  |  |  |
| Copies of Recent Bank Statements-Checking & Savings (last 2 months) |  |  |  |

**\*\*\*Please note: If you are not accepted into TransitionZ @ Summit Trail your personal information will be shredded.**