

SAN MARCOS HOUSING AUTHORITY FAMILY SELF-SUFFICIENCY PROGRAM APPLICATION

For Office Use Only	Housing Program: _____	Housing Site: _____
----------------------------	-------------------------------	----------------------------

All information will be kept confidential in accordance with Housing Authority guidelines. This information will be reviewed by a Family Self-Sufficiency Service Coordinator. Please be as honest as possible. This information will be used to help us determine if we have access to sufficient resources to help you reach your goals. Answer ALL questions. If a question does not apply to you, please put "not applicable" or "N/A." If you need help with this application or have any questions, call the FSS Office at 512-396-3364.

Head of Household: _____ SSN: _____

Address: _____ Cell #: _____
(Include unit # & zip code)

Mailing address if different from above: _____

E-mail Address: _____

Phone Number: (____) _____ - _____ Alternate Phone Number: (____) _____ - _____

Please check one of the following:

- SINGLE
 MARRIED
 SEPARATED
 COMMON-LAW MARRIED

Including yourself, please list all of the people who live with you:

	NAME	RELATION TO YOU	DATE OF BIRTH	RACE
1.)	_____	SELF	_____	_____
2.)	_____	_____	_____	_____
3.)	_____	_____	_____	_____
4.)	_____	_____	_____	_____
5.)	_____	_____	_____	_____

What is your current employment status?

- | | | |
|---|---|---|
| <input type="checkbox"/> Employment Full-time | <input type="checkbox"/> Employed Part-time | <input type="checkbox"/> Waiting to start job |
| <input type="checkbox"/> On Lay-Off | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Enrolled in School |
| <input type="checkbox"/> Looking for Work | <input type="checkbox"/> Disabled | <input type="checkbox"/> Retired: age _____ |
| <input type="checkbox"/> In Job-training | <input type="checkbox"/> Leave of Absence | <input type="checkbox"/> Other _____ |

Employer: _____ Start Date: _____

Address: _____ Work #: _____

Please list your work history for the last 3 years:

Do you have any other source of income?

Yes _____ No _____

If yes, how much and where does it come from? _____

EDUCATIONAL BACKGROUND

Do you have a high school diploma or GED? If yes, what year did you obtain it? _____

If you do not have a high school diploma or GED, have you ever enrolled or participated in a program to obtain it? _____ If yes, when and where? _____

Have you ever enrolled in a university, community college, trade school or any other higher education program? _____ If yes, when and where? _____

Major / Trade: _____ Date began: _____ Expected date of Graduation: _____

List skills, certificates, special training or experience (CNA, CMA, MA, HA, Welding, Forklift, etc.): _____

CRIMINAL BACKGROUND:

Do you have any criminal records in your background?

Yes _____ No _____

If yes, please explain in detail: _____

Transportation: Check all boxes that apply:

<input type="checkbox"/> I have a valid driver's license	<input type="checkbox"/> I have a reliable vehicle	<input type="checkbox"/> I use public transportation
<input type="checkbox"/> I have car insurance	<input type="checkbox"/> I have a non-working car	<input type="checkbox"/> I walk
	<input type="checkbox"/> I ride a bicycle	<input type="checkbox"/> I depend on others: _____

Who Cares for Your Children?: List all children

Dependent's Name	Age	Grade	Care-giver or School

Please tell us about any challenges with regard to parenting your children.

Are you getting assistance from any of the following programs? Check all boxes that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> TANF/Cash Assistance | <input type="checkbox"/> Domestic Violence/Sexual Assault | <input type="checkbox"/> Child Protective Services |
| <input type="checkbox"/> Earned Income Tax Credit | <input type="checkbox"/> Rehabilitation Services | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Utilities: _____ | <input type="checkbox"/> Veterans Administration | <input type="checkbox"/> Food Bank |
| <input type="checkbox"/> Food Stamps | | <input type="checkbox"/> Other: _____ |

Are you interested in receiving any of the following services? Check all boxes that apply.:

- | | | |
|---|--|---|
| <input type="checkbox"/> GED | <input type="checkbox"/> High School | <input type="checkbox"/> Job Search/Placement |
| <input type="checkbox"/> Vocational /Job Training | <input type="checkbox"/> Resume | <input type="checkbox"/> Alcohol/Drug Issues |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Medical Referral _____ | <input type="checkbox"/> Food Assistance |
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Child Care | <input type="checkbox"/> Budgeting |
| <input type="checkbox"/> First-time Home Buyer | <input type="checkbox"/> Credit Repair | <input type="checkbox"/> Support Group |
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> Health or Nutritional Info. | <input type="checkbox"/> Parent Training |
| <input type="checkbox"/> Legal Issues | <input type="checkbox"/> College | |

Finances: Check all boxes that apply:

<input type="checkbox"/> I have a checking account	<input type="checkbox"/> I have a written budget	<input type="checkbox"/> I owe a lot of money
<input type="checkbox"/> I have a saving account	<input type="checkbox"/> I do not follow a budget	<input type="checkbox"/> I have a poor credit rating
<input type="checkbox"/> I have been turned down for a checking account	<input type="checkbox"/> I overspend	<input type="checkbox"/> I have credit issues that
	<input type="checkbox"/> I use credit cards	<input type="checkbox"/> have become legal issues

Support:

Who do you go to when you need help? _____

Have you received any type of case management services from any agency? ___Yes ___No

If yes, please list the agencies and provide the name of your case manager: _____

Current Status and Goals:

List the 3 biggest problems YOU are facing now: _____

How would you like things to be in the future? _____

What do you want most from life? _____

What changes would you want to see in your life 6 months from now? _____

What changes would you want to see in your life 1 year from now? _____

What changes would you want to see in your life 5 years from now? _____

What is your greatest strength?

What is your greatest weakness?

What does success look like for you?

What are your goals?

Education: _____

Financial: _____

Family: _____

Personal: _____

What is preventing you from reaching your goals? _____

Additional Information

How did you hear about the FSS Program? (If you heard about the FSS Program from a current or former client, please list their name.)

Have you been enrolled in any self-sufficiency or similar programs anywhere else?

If yes please explain where and why you are no longer enrolled: _____

Have you ever applied for the FSS Program before? Yes _____ No _____

If yes, please give the date you last applied: _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS APPLICATION. ONE OF OUR FSS COORDINATORS WILL CONTACT YOU AS SOON AS POSSIBLE.

SIGNATURE OF APPLICANT

DATE SIGNED

San Marcos Housing Authority Family Self-Sufficiency Program
701 South LBJ Drive
San Marcos, TX 78666
Crystal Wilson, FSS Coordinator
Stewart Dale Spencer, Resident Services Asst. Director
512-396-3364