HEALING HOMES
Social Impact and Community Investment (SICI) Initiative
Pre-Screening Application- 2024

Please complete the Pre-Screening Application so that we can better determine your eligibility for participating in Healing Homes Transitional Housing Initiative. Full application will be required if applicant is determined potentially eligible from this pre-screening.

Applicant's Information: **Date:**

Legal Name:	**Preferred Name:**
Sex assigned at birth:	**Gender Identity:** **Pronouns:**
Date of Birth:	
Phone Number- P:	**S:**
Email Address:	
Do you have a Social Security card?	☐Yes ☐No
Are you a US Citizen?	☐Yes ☐No
If no, please indicate residence status: _____	
Do you reside in Somerset County?	☐Yes **☐No**
If yes, please indicate town:_____	**Address:**
What is your household size?	☐1 ☐2 ☐3 ☐4 ☐ 5 ☐6
Are you presently Homeless?	☐Yes ☐No
Are you currently residing in:	☐Permanent Housing ☐With friends or family
☐ Place not meant for habitation	☐ Emergency Shelter (motel/hotel)
☐ Safe haven/transitional housing	☐Other_____

INCOME

Do you have income? ☐Yes ☐No Monthly Income Amount: $_____

Is your household income combine under the following income limits for the household? ☐Yes ☐No

1 Person - $73,400 **2 People -** $83,850 **3 People -** $94,350 **4 People -** $104,800

What is your source of income? ☐Earned income (from employment) ☐Unemployment ☐SSI ☐SSDI
☐ Retirement Income from Social Security ☐Pension or retirement income from a job ☐Worker's Compensation
☐TANF ☐General Assistance (GA) ☐Child Support ☐Alimony or Spousal Support
☐ VA-Service-Disability Compensation ☐VA Non-Service Disability Pension ☐No Income

HEALTH CONDITION

Do you or a household member have any of the following? (check all that apply)

☐ **Physical Disability** ☐ **Mental Illness**

Nature of Disability:_____ Nature of Illness:_____

Substance Abuse (Alcohol) ☐Yes ☐No **Substance Abuse (Drugs)** ☐Yes ☐No

Medical Condition (s)? ☐ Yes ☐No (State medical condition):_____

Can you provide medical documentation from your medical doctor? ☐Yes ☐No

Are you taking any prescription medications? ☐ Yes ☐ No

Do you or a household member require special accommodation? ☐Yes ☐No
If, yes, please describe:

Are you on a medical marijuana program?	☐Yes ☐No
Do you have any pet(s)?	☐Yes ☐No

How to submit form: Download form, answer all questions, save form, and attach form to email. Send form to Cynthia.Walker2@rwjbh.org. For additional information contact 908-704-3746.

RWJBarnabas HEALTH | Robert Wood Johnson University Hospital Somerset