eliminating racism
empowering women
ywca

YWCA WINGS Program Application

MISSION STATEMENT

The YWCA is dedicated to eliminating racism, empowering women and promoting peace, justice, freedom and dignity for all.

The YWCA of Helena is committed to providing women with safe, affordable housing and assistance in accessing community resources.

We ask a lot of questions in this application, so we can get to know the women interested in living at the YWCA and learn how we can support participants in achieving life goals.

GENERAL INFORMATION

Name_____ Today's Date_____
First Middle Last

Mailing
Address_____Zip_____

Physical
Address_____ Zip_____

Phone_____ Is it safe to call/leave a message YES NO

Other contact/Message Numbers_____

Email _____

Birth date_____ Social Security Number_____

Who is your Emergency Contact? _____
Phone Number? _____
Where are you coming from? Circle one:
Jail Prison Prerelease Treatment Other_____

Are you currently in Helena? YES No

How long have you been in Helena? _____

How did you hear about the YWCA? _____
Have you lived at the YWCA before? YES NO
If yes:
When did you live at the YWCA: _____
Why did you move out: _____

Please check any agencies you are currently working with or have worked with in the last year:

___AWARE	___Family Promise	___Helena Indian Alliance
___Boyd Andrew	___God's Love	___Prison/prerelease
___Center for Mental Health	___Good Samaritan	___Probation and Parole
___Pure View	___Helena Industries	___St. Peter's Hospital
___Counseling	___Job Service	___Salvation Army
___CTI	___Public Defender/attorney	___Voc-Rehab
___DPHHS/CPS	___Food Share	Other: _____

PERSONAL

Have you experienced violence in any form since you turned 18? YES NO
If yes, did you get any counseling? YES NO

Do you currently feel safe? YES NO
If no, please explain: _____
_____
_____

Are you a single head of household?	YES	NO
Do you have a service animal?	YES	NO
Have you ever served in the military?	YES	NO
If yes, when? _____		
Are you receiving benefits?	YES	NO
Enrolled Tribal member?	YES	NO

VEHICLE

Do you own your own vehicle? YES NO

Do you have auto insurance? YES NO

Do you have a driver's license? YES NO

If no, please explain _____

HOUSING

Are you homeless or about to become homeless? YES NO

Where did you sleep last night? _____

Are you signed up for Helena Housing Authority? YES NO

If yes, when? _____

If no, please explain _____

_____

Please describe your current living situation (where are you living, for how long, circumstances leading up to now) _____

_____

_____

_____

_____

EMPLOYMENT AND INCOME

Do you have the ability to work? YES NO

If no, please explain: _____

_____

Are you currently employed? YES NO

Name of Employer: _____ Phone: _____

How many hours do you work each week? _____ What is your hourly pay? _____

What job skills do you have? _____

_____

Do you have other sources of income? YES NO

Please check all that apply

Other Source of Income	✓	Amount You Get Monthly
Social Security		
SSI		
SSDI		
Unemployment		
SNAP		
TANF		
Child Support		
Other:		

EDUCATION

Mark your highest level of education, including partial completion.

Highest Level of Education	✓
Some High School (please circle the grade) 9 10 11 12	
High School Diploma	
GED	
Some College or Trade School, no degree	
Some College and a Professional Certification	
Associates Degree	
Bachelors Degree	
Masters Degree	
PhD	

Are you currently enrolled in school? YES NO

If yes, what school do you attend? _____

Do you plan on enrolling in school? YES NO

FAMILY SIZE AND INCOME

Please list **yourself and all your children whether or not they have been living with you** Please mark if your children are living with you in the appropriate box. Disregard income for those children who are not currently living with you. For monthly income, indicate the gross amount received (gross income refers to the pre-tax amount; include salary, tips, and state assistant.)

Family Relationship	Name (First, Middle, Last)	Birthday mm/dd/yy Social Security Number	Living with You (Yes or No)	Monthly Income From All Sources
You				

If your child(ren) is school-aged, what school do they attend? _____

_____

Please describe the custody and living arrangements (parenting plan, visitation, etc):

_____
_____
_____
_____
_____
_____

Is CPS/DPHHS involved? YES NO

If yes, for how long? _____

Case worker name _____ Phone _____

Attorney name _____ Phone _____

Will your child(ren) be living with you at YWCA Helena? YES NO

Or, do you plan on reuniting with your child/ren while at YWCA Helena? YES NO

Are you currently pregnant? YES NO

If yes, how far along? _____

Are you currently breastfeeding? YES NO

Are you married? YES NO

If yes, to who and for how long? _____

HEALTH

Have you ever been treated for a mental illness? YES NO

If yes, was/is there a treatment plan? YES NO

Please describe treatment plan and who developed/administered the plan:_____

_____
_____
_____
_____

Are you currently working with a mental health professional? YES NO

For how long? _____ Name _____ Phone _____

If not currently, have you worked with a mental health professional previously? YES NO

Do you have any physical health problems? (seizures, diabetes, etc) YES NO

Please explain: _____

Do you have any disabilities? YES NO Receiving SSDI? YES NO
Please explain: _____

Do you need special accommodations? YES NO
Please explain (ambulatory devices, shower aids, service animal): _____
_____
_____

LEGAL

YWCA Helena serves women who have had legal system involvement, please be as specific as possible as this will not hinder acceptance into the WINGS program.

Charge	County, State	Date	Outcome (incarceration, probation, fines, etc)	Date Resolved

Additional information: _____
_____
_____
_____
_____

Do you have any unresolved legal charges YES NO
If yes, please describe: _____
_____
_____

Do you have legal representation? YES NO
Representing attorney _____ Phone _____
County _____ Scheduled sentencing date _____

Are you on probation or parole? YES NO
Name of Parole/Probation Officer: _____
How long have you been on probation/parole? _____

Are you paying fines or restitution? YES NO
How many hours of community service: _____ Amount of fines/restitution: _____

ALCOHOL AND OTHER DRUGS

Are you currently dependent on alcohol and/or other drugs? YES NO

Substance	Never Used	Age of First	Date of Last Use	Frequency	Typical Amount	Method of Use	System Involved
EXAMPLE: addiction		14	6/26/2017	3x a day	1 gram	snort	PO, Court, CPS
Alcohol							
Tobacco							
Tranquilizers							
Inhalants							
Marijuana							
Hallucinogens (LSD, Mushrooms)							
Amphetamines (Speed)							
Barbiturates (Downers)							
Methamphetamine (Crank, Crystal Meth)							
Opiates (Heroin)							
Cocain							
Prescription Pain Medication							
Adderall							
Suboxone or Naloxone							
Other:							

Other addictions, not alcohol or drugs: examples; work, sex, money: _____
_____
_____

Do you experience withdrawal symptoms when you stop using? YES NO
What are your symptoms (seizures, DT's): _____

Are you currently experiencing withdrawal symptoms? YES NO

Have you attended **inpatient** chemical dependency treatment? YES NO

Treatment facility	City, State	Entry Date	Discharge Date	Still Attending?	Did you complete?	If no, why?

Have you attended **out-patient** chemical dependency treatment? YES NO

Treatment facility or Provider	City, State	Entry Date	Discharge Date	Still Attending?	Did you complete?	If no, why?

Have you ever experienced life difficulties or problems because of alcohol or other drugs?

_____

_____

Has anyone ever expressed concerns about your use of alcohol or other drugs?

_____

_____

Do you attend AA or NA? YES NO
Are you working with an LAC? YES NO
If yes, who? _____ Phone _____

Future Plans

Are your family members supportive of your sobriety at this time? YES NO

Why do you want to come to YWCA Helena?

_____

_____

_____

_____

_____

_____

_____

Why are you seeking treatment at this time?

_____

_____

_____

_____

_____

Please mark the number that best describes your readiness to change your life:
1 being I do not want to change and 5 being I will do whatever it takes

1 2 3 4 5

Do you have a long-term sobriety plan?

_____

_____

_____

_____

_____
_____
_____

Please check all that apply:
___ Signed up for IOP/OP
___ Created a plan with PO
___ Started GED
___ Searching for employment
___ Signed up for SNAP, Medicaid, etc
___ AA or NA groups
___ Working with or signed up with an LAC
___ Working with or signed up with a mental health therapist
___ Applied for housing

Additional items to include with your application:
Releases for ALL applicable agencies
Parenting plan
Chemical dependency evaluation
Mental health evaluation
Presentence Investigation Report (PSI)
Discharge summary/plan

STATICAL INFORMATION

Racial Identification	✓
American Indian/Alaskan Native	
Asian	
Black/African American	
Hispanic	
Native Hawaiian/Other Pacific Islander	
White	
American Indian/Alaskan Native & White	
Asian & White	
Black/African American & White	
American Indian/Alaskan Native & Black/African American	
Other Multi-Racial	

Preferred Not to Answer	

Please make a checkmark in the appropriate box. In some cases, you may need to place a checkmark in more than box. Public use of this information will not be connected to individuals and is YWCA Helena population statistics only.

Where did you sleep last night?	✓
Non-housing (street, park, car, etc.)	
Emergency shelter	
Transitional housing	
Psychiatric facility*	
Substance abuse treatment facility*	
Hospital*	
Jail/prison*	
Domestic violence situation	
Living with relatives/friends	
Rental housing	
Other (please specify)	
Could be kicked out of where you are staying in next 14 days without a place to go?	
Housing History	
Have you been without a home 4 or more times in the last 3 years?	
Age Ranges	
17 and under	
18-30	
31-50	
51-61	
62 and over	

Relationship Status	✓
Single	
In a Relationship	
Married	
Separated	
Divorced	
Widowed	
Medical Information	
Physical Disability	
Developmental Disability	
Chronic Health Condition	
HIV/AIDS	
Would you like information or assistance on any of the following?	
Mental Illness	
Alcohol Abuse	
Drug abuse	
HIV/AIDS and related diseases	
Developmental disability	
Physical disability	
Sexual Assault	
Legal Services	
Accessing SNAP and other Assistance	
Financial Education	
Domestic Violence	
Other (please specify)	

REFERENCES

Please provide three (3) references. Some examples of references include employers, case managers, counselors, landlords, co-workers, and teachers.

Name: _____ Phone _____

Address: _____ City and State _____

How does this person know you? _____ How long?_____

Name: _____ Phone _____

Address: _____ City and State _____

How does this person know you? _____ How long?_____

Name: _____ Phone _____

Address: _____ City and State _____

How does this person know you? _____ How long?_____

Applicant Statement

My signature below certifies that all information on this application is true, correct, and complete to the best of my knowledge, and contains no willful falsifications or misrepresentations. I authorize the YWCA to contact my present and past employers and the references listed above to obtain information deemed appropriate to consider my application for the WINGS program. **I agree to take a drug test, paid for by the YWCA, before being accepted into the WINGS Program.**

_____ _____

Applicant Signature Date

Thank you for taking the time to fill out this application

ACE Survey

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often…
Swear at you, insult you, put you down, or humiliate you? OR Act in a way that made you afraid that you might be physically hurt? Yes No

2. Did a parent or other adult in the household often or very often…
Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? Yes No

3. Did an adult or person at least 5 years older than you ever…
Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you? Yes No

4. Did you often or very often feel that …No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other? Yes No

5. Did you often or very often feel that…You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? Yes No

6. Were your parents ever separated or divorced? Yes No

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife? Yes No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? Yes No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide? Yes No

10. Did a household member go to prison? Yes No

Number of Yes answers: _____

Head Trauma History

Please put “Yes” or “No”

H = Hit on head

Have you ever:

____ Been hit in the face or head? With what?

____ Has your head been slammed into a wall or another object?

____ Been pushed so that you fell and hit your head?

____ Has anyone ever shaken you?

____ Have you ever been strangled or choked, or had anything else that made it hard for you to breathe?

____ Have you ever had an injury to your face, head or throat in any other way?

____ Have you ever been in a car accident?

If yes:

____ Has anything happened more than once?

E = Emergency room treatment

____ Did you ever go to the emergency room after hitting your head? Why?

If yes:

____ Did they ask whether you had been hit on the head or say that they suspected that you had a head injury or concussion?

____ Did you think you got all the treatment you needed?

If no:

____ Was there ever a time when you thought you should go to the ER after an injury to your head, but didn’t go?

L = Loss of consciousness

____ Have you ever lost consciousness or black out as result of a hit to the head or being choked?

P = Problems

____ Have you been having trouble concentrating or remembering things?

____ Are you having trouble finishing things you start to do?

____ Have people told you that you’re not acting like yourself?

____ Have you been having trouble doing what you need to do at work, school, or home?

____ Are you having mood swings that you don’t understand?

____ Has it gotten harder for you to function when you’re under stress?

S = Sickness

____ Have you had any physical problems since your partner assaulted you? What kind?

____ Do you have any recurring headaches or fatigue?

____ Have you had any changes in your vision, hearing, or sense of smell or taste?

____ Do you find yourself dizzy or experiencing a lack of balance?

YWCA OF HELENA

Inter-Agency Authorization to Release Information

1. I, _____, hereby authorize the release and exchange of information to the YWCA of Helena.
(Name of Participant)

2. Information Requested from: _____
(Agency/Department Name)

_____
_____

3. General participation information is requested, including but not limited to, progress reports, enrollment, attendance, participation, other (please list):_____
_____

4. I authorize the YWCA of Helena to obtain confidential personal, employment, medical, financial and other pertinent information for the purpose of facilitating service delivery to my household. The YWCA of Helena will use the acquired information solely for the purpose directly connected with the administration of the YWCA of Helena. It does not authorize release to any other person or agency without further consent. This authorization of release of information will be in effect for one year from the signatory date or until my case closes, whichever is longer. I understand I can revoke this consent in writing at any time. I understand I have a right to receive a copy of the release.

_____	_____
(Signature of Participant)	(Date Signed)

Summary of WINGS Program Expectations

Upon move-in, all WINGS Participants are expected to sign the WINGS Program Agreement which outlines all Program Expectations. Each Program Expectation is in place to help all Participants achieve the overall goal of obtaining permanent housing that she can sustain.

Primary expectations to be aware of **prior to move-in** are as follows:

- Participants are to pay rent on the first business day of every month while in the program.
    - Rent is calculated as **25%** of the Participant's annual gross income.
    - The lowest amount rent can be is $50 and the highest amount rent can be is $388.
    - Participants are expected to give the Agency Coordinator copies of all paystubs and proof of any other income so that appropriate calculations may be completed.
    - **Participants are expected to pay the full amount of rent prior to move-in.**
- Upon move-in, Participants will be provided with four bins to move in personal items.
    - **Two bins are permitted in the new Participant's room** and two bins may be put in a locked storage room in the basement of the building.
    - A Participant that has children will be provided with two extra bins per child. One of these bins will be permitted in the new Participant's room and one bin will be put in locked storage downstairs.
    - Participants **may not** bring in extra furniture, a television, refrigerator, extension cord, or any other unnecessary items.
- Any Participant requesting to have a service animal live with them at YWCA Helena must provide staff with a written prescription from a licensed professional, copies of the animal license, proof of spay/neuter, rabies, and vaccination records **prior to move-in.**

Primary expectations to be aware of as a **current Participant** are as follows:

- Participants must meet with her WINGS Advocate **once a week** to develop goals toward 1) Employment/Education, 2) Housing, 3) Self-Care, 4) Community Connectivity, 5) Mental Health, and 6) Financial Budgeting.
- Participants must attend daily gratitude circle at 9:00 am Monday through Friday. Participants must attend weekly psychotherapy groups every Monday at 6:00 pm. Participants must attend as many scheduled house activities as possible.

- Participants are expected to attend **psychotherapy** sessions **once a week**.
    - There is a therapist in-house who can provide this service for free.
    - With proof of attendance, a different therapist may be used at the Participant's expense.
- **Fourteen (14) days** after a Participant moves in, she must have a job working at least **40 hours per week**.
    - A Participant that is in school or on SSDI must be working or volunteering **20 hours per week** by the end of the 14 days.
- Participants **must not use alcohol or other drugs on or off** YWCA Helena premises.
    - Random urine analyses will be completed with all Participants.
- Participants who have children will be required to sign a child addendum which requires Circle of Security parenting classes, and other expectations to foster the healthiest mother/child relationship.
- Participants **must stay at YWCA Helena every night**.