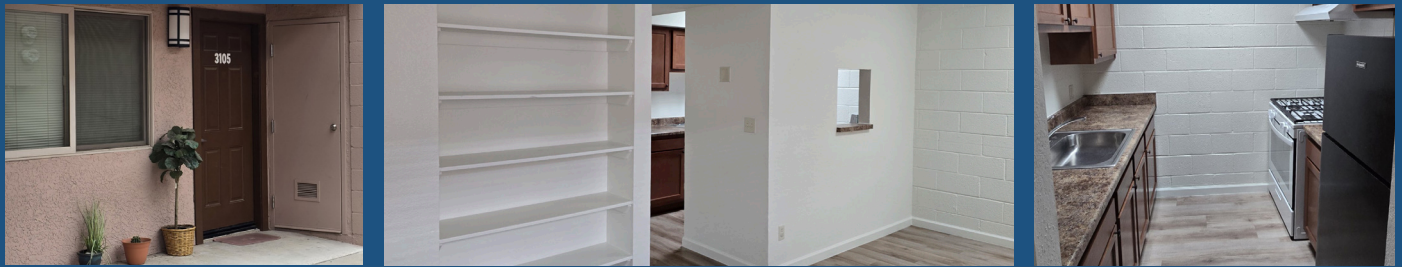




CATHOLIC COMMUNITY SERVICES  
OF SOUTHERN ARIZONA, INC.

# TRANSITIONAL HOUSING PROGRAM



## Families in CCS' Transitional Housing receive person-centered, trauma-informed wrap-around support services through:

- + Individualized Service Planning
- + Case Management
- + Peer Support
- + Life Skills Training
- + Budgeting
- + Parent Groups
- + Therapy/Counseling (Optional)
- + Employment Assistance
- + Community Engagement

Since 1997, Catholic Community Services of Southern Arizona (CCS) has been providing Transitional Housing to low-income families who are experiencing housing instability and homelessness.

The program offers affordable two and three-bedroom apartments for low-income families, with at least one minor dependent in the household. Participants can remain in the program for up to 12 months, while they work on achieving their goals.

### Program requirements include:

- Family income does not exceed 60% Area Median Income (\$51,900 for a family of 3)
- Families are required to actively participate in Case Management Services
- Adults must attend Financial Literacy and Parenting groups (1x per month)
- Families must save 10% of their Adjusted Net Income each month
- Families must pay 10% of their Adjusted Net Income towards paying debts each month

**For apply for the program, please complete the attached documents and email them to: [th@ccs-soaz.org](mailto:th@ccs-soaz.org)**



## CASITAS ESPERANZA: TRANSITIONAL HOUSING

### Interest Form for Transitional Housing

Today's Date: \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_

DOB \_\_\_\_\_ Are you currently homeless? Yes or No

Address 1: \_\_\_\_\_ Zip: \_\_\_\_\_

City, State: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

#### HOUSEHOLD COMPOSITION –

How many occupants – Adults: \_\_\_\_\_ Children: \_\_\_\_\_ (under age of 18)

#### DO YOU HAVE MONTHLY INCOME?

Monthly income from work:	
Social Security:	
Child Support	
Other:	
<b>Total Income:</b>	

Have you (or any member of your immediate family) ever been convicted of a felony or any other criminal activity including a violation of the Controlled Substance Act? Yes or No

If yes, please explain:

\_\_\_\_\_

Applicant Signature:

\_\_\_\_\_

Email completed application to: [th@ccs-soaz.org](mailto:th@ccs-soaz.org)



## Housing Intake and Supportive Services Screening

### Purpose Statement

This document is used to determine housing eligibility. This process is not a behavioral health assessment and does not establish eligibility for behavioral health services. Referrals to supportive services may be offered based on identified needs.

### Applicant Demographics

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

Monthly Income: \_\_\_\_\_

Veteran:  Yes  No

AHCCCS Enrolled:  Yes  No

### 1. What is your current living situation?

- Staying or living in a family member's room, apartment, or house
- Staying or living in a friend's room, apartment, or house
- Room, apartment, or house that you rent
- Homeless shelter
- Domestic violence shelter
- Homeless
- Other: \_\_\_\_\_

### 2. How do you feel about your current living situation? (*Check all that apply*)

- Safe  Unsafe  Scared  Isolated  Happy  Neutral  Other: \_\_\_\_\_

### 3. Do you have any barriers to Housing? (*Check all that apply*)

- No rental history  Past due rent or Eviction history  Insufficient income  Lack of Support
- Criminal background  Unemployment or Underemployment  Lack of ID/documents
- Credit issues  Repeated or chronic homelessness  Substance use
- Adult or child with behavioral health needs  Limited independent living skills

### 4. What is your ideal living situation? (i.e., what housing type, any specific location, community).

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### 5. Number of people in household? Adults: \_\_\_\_\_ Children under 18: \_\_\_\_\_

Name	DOB	Relationship

6. Are there any specific needs or accommodations for anyone in the household?  Yes  No

7. Do you participate in any of the following programs? (Check all that apply.)

- Food Stamps
- MEDICAID health insurance program
- MEDICARE health insurance program
- State Children's Health Insurance Program (KidsCare)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Veteran's Administration (VA) Medical Services
- TANF Child Care Services

8. Do you receive any of the following financial benefits?

- SSI  SSDI  VA Disability  Unemployment

a. If yes, how much per month? \_\_\_\_\_

9. Do you have transportation to get from place to place?  Yes  No

10. Do you or other members of your household have access to Health Care?  Yes  No

a. If yes, where: \_\_\_\_\_

11. Do you or any member of your household have any chronic medical conditions that impact housing stability?  Yes  No a. If yes, what is the condition: \_\_\_\_\_

12. What is your employment status?

- Full-Time Employer: \_\_\_\_\_
- Part-Time Employer: \_\_\_\_\_
- Unemployed/Disabled
- Unemployed, looking for work

a. What area of employment do you wish to work? \_\_\_\_\_

b. What support would you need to obtain employment in your desired occupation? (i.e., training, education, resume, interview supports, certifications, etc.) \_\_\_\_\_

13. Have you ever received or are you currently receiving behavioral health services?  Yes  No

a. If yes, when and where? \_\_\_\_\_

14. Have you ever participated in or are currently receiving substance use services?  Yes  No

a. If yes, when and where? \_\_\_\_\_

### Participant Acknowledgement

Participant understands that they are applying to participate in a social services program administered by Catholic Community Services of Southern Arizona, and enrollment in the program will require active participation in services

Printed Name

Signature

Date