

TEEN TRANSITIONAL LIVING PROGRAM (TTLP)

Catholic Charities of Broome County

232 Main St.

Binghamton, NY (revised 2025)

Application for Residency/ Initial Comprehensive Assessment

Please complete this application honestly and as completely as you can. Once complete and received by TTLP staff we will contact you to schedule an interview to review your application. If there are any questions, please call TTLP staff to assist you with the application. TTLP staff can be reached at 729-9166. **While filling out the application and after meeting with staff please keep in mind that we are Mandated Reporters and anything that we feel should get reported we will do so.** Thank you.

Applicant Information

Date of Application: _____

Name: _____

Current Address: _____

Name of individual you are staying with and relationship: _____

What is the best number to reach you at? _____ Home Cell

Whose phone is this & relationship to you: _____

Additional Phone Number (if applicable): _____

Whose phone is this & relationship to you: _____

Social Security No.: _____

Age: _____ Date of Birth: ____/____/____ Marital status: _____

Gender: male female transgender male transgender female Non-binary

Sexual Orientation: Gay, Lesbian Bisexual Pansexual Straight Queer
 Questioning, unsure other

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Race:

- | | |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American and White |
| <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian or Alaska Native and Black or African American |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other multiple race combinations greater than one percent: _____ |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | |
| <input type="checkbox"/> White | |
| <input type="checkbox"/> American Indian or Alaska Native and White | |
| <input type="checkbox"/> Asian and White | |

For staff use only please

Where did youth sleep the night prior to the admission?

Date and time of admission: _____

Dependent Information

Do you have any children? Yes No If yes, how many? _____ Who has custody? _____

Do you currently have Child Care? Yes No

Are you pregnant? Yes No Unsure If yes, what is your due date? ____/____/____

Are you pregnant with, or parenting a child that will be coming to the program with you?

Yes No* *If no, please go to page 3

1.) _____
1st Child's First and Last Name Age DOB Biological Parents' First and Last Name

_____ _____
Child's Address Other Parent's Address

Child's Primary Doctor: _____ Telephone number: _____

Physical state of this child

Does your child have any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> physical disabilities | <input type="checkbox"/> doctor | <input type="checkbox"/> learning disabilities |
| <input type="checkbox"/> health alerts | <input type="checkbox"/> dentist | <input type="checkbox"/> allergies |
| <input type="checkbox"/> medications | <input type="checkbox"/> special dietary needs | <input type="checkbox"/> _____ |

If you checked any of the following please explain: _____

Emotional state of this child

Does your child have any of the following?

- | | | |
|---|---|--------------------------------|
| <input type="checkbox"/> temperament issues | <input type="checkbox"/> mental diagnoses | <input type="checkbox"/> _____ |
| <input type="checkbox"/> behavioral issues | <input type="checkbox"/> counselor | <input type="checkbox"/> _____ |

If you checked any of the following please explain: _____

2.) _____
2nd Child's First and Last Name Age DOB Biological Parents' First and Last Name

_____ _____
Child's Address Other Parent's Address

Physical state of this child

Does your child have any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> physical disabilities | <input type="checkbox"/> doctor | <input type="checkbox"/> learning disabilities |
| <input type="checkbox"/> health alerts | <input type="checkbox"/> dentist | <input type="checkbox"/> allergies |
| <input type="checkbox"/> medications | <input type="checkbox"/> special dietary needs | <input type="checkbox"/> _____ |

If you checked any of the following please explain: _____

Emotional state of this child

Does your child have any of the following?

- | | | |
|---|---|--------------------------------|
| <input type="checkbox"/> temperament issues | <input type="checkbox"/> mental diagnoses | <input type="checkbox"/> _____ |
| <input type="checkbox"/> behavioral issues | <input type="checkbox"/> counselor | <input type="checkbox"/> _____ |

If you checked any of the following please explain: _____

Parent/ Legal Guardian and Family Information

Your Birth Father's Name _____

Address _____

Phone No. _____

Do you have contact with him? Yes No

Are you able to live with them? Yes No

Your Step-Father's Name if applicable _____

Address _____

Phone No. _____

Do you have contact with him? Yes No

Are you able to live with them? Yes No

Your Birth Mother's Name _____

Mother's Maiden Name _____

Address _____

Phone No. _____

Do you have contact with her? Yes No

Are you able to live with them? Yes No

Your Step-Mother's Name if applicable _____

Step Mother's Maiden Name _____

Address _____

Phone No. _____

Do you have contact with her? Yes No

Are you able to live with them? Yes No

Name of Legal Guardian (if different than parent) _____

Address _____

Phone No.: _____

Do you have contact with them? Yes No

Are you able to live with them? Yes No

Did you have religious or spiritual beliefs different from your parent or legal guardian? Yes No

Please explain why you are unable to live at home with your parents/family? Please be specific. If you have moved out, please state when you moved out.

Have you looked into any other programs and if so what programs? Yes No

How did you find out about our program? _____

Has anyone ever had custody of you other than your birth parents? Yes No Unsure

Do you have any siblings? Yes No

Sibling's Name	Age	Where do they live?	Do you have contact?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For staff use only please

Questions to determine eligibility:

- Is the person under the age of 21? YES or NO If NO, then the person is not eligible
- Does the person have a relative to stay with? YES or NO If YES, then the person is not eligible
- If the person doesn't have a relative to stay with, do they have a safe alternative? YES or NO If YES, then the person is not eligible
- Is the person without proper supervision and care? YES or NO If NO, then the person is not eligible

After answering these questions, does the youth meet the criteria for being homeless? YES or NO

Do your Parents/ Family know you are applying to TTLP? Yes No

If yes, how do they feel about it?

Personal Information

Are you now or have you ever been involved in any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Arrested | <input type="checkbox"/> Emergency Shelter | <input type="checkbox"/> Group Home/
Residential |
| <input type="checkbox"/> Probation | <input type="checkbox"/> Homeless Shelter | <input type="checkbox"/> ACR |
| <input type="checkbox"/> PINS | <input type="checkbox"/> Counseling | <input type="checkbox"/> Gangs |
| <input type="checkbox"/> Lawyer | <input type="checkbox"/> Mental Health
Facility/Hospital | <input type="checkbox"/> CPS |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Foster Care/Home | |
| <input type="checkbox"/> Order of Protection | | |

If you checked any of the following please explain: _____

Criminal Involvement

Do you have a criminal history? _____

Please list charges: _____

Have you been in placement/detention/ secure facility/jail before? Yes No

If yes, please explain when and where: _____

Have you had any court involvement? Yes No

Family Court Criminal Court

If yes, please explain: _____

Are there any current charges pending? Yes No

If yes, please explain: _____

Are you on probation or parole? Yes No

Dates of Probation/parole: _____ PINS/JD/OTHER _____

Probation Officer: _____ County: _____ phone number: _____

Parole Officer: _____ County: _____ phone number: _____

Child Protective Involvement-Self Applicant

Are there any **present/current** abuse or neglect allegations: Yes No

If yes, what is the date of the CPS hotline call? _____

Is there any **past history** of CPS involvement? Yes No

If yes when? _____ Was it founded? Yes No

Please list all of your closest friends and the people you associate with:

First and Last name

Age

How do you know your friends? _____

What do you do when you are hanging out with your friends? _____

What are some activities you are involved in currently? _____

Are you currently involved in any school activities and if so what? (If applicable) _____

What do you like to do on your free time? _____

What are some of your goals that you would like to achieve? _____

What are some of your hobbies? _____

What is something that you are proud of? _____

What is something that you would like to improve on? _____

What do you want to do or be when you get older? _____

What are some areas that you feel you may need extra help with? _____

For staff use only please

Comments: _____

Educational Information

- 1.) **Are you currently enrolled in school?** Yes No
If no, are you interested in re-enrolling in school? Yes No
What is the last grade you completed: _____
Have you graduated high school or have you received your GED? Yes No
 High school Diploma GED
Are you planning on receiving your GED? Yes No
Anticipated Graduation/GED date _____
- 2.) **Name of School/Last School attended** _____
Address _____
Current grade _____ Special Programs / Trainings _____
Name of Guidance Counselor _____ School Social Worker _____
Can we speak with school staff & counselor? Yes No
If yes, what is the best number to reach either your guidance counselor or school social worker?

- 3.) **Do you have an IEP/504 Plan?** Yes No
- 4.) **Are you currently having problems in school?** Yes No
If yes, please explain: _____

- Have you ever had any problems in school?** Yes No
If yes, please explain: _____

- Have you ever had unauthorized absences?** Yes No
- 5.) **What is your educational goal?** _____

- 6.) **Do you plan on attending college or have a career in the Military?** Yes No
Which one? _____
Have you already taken steps to enroll? _____
Did you complete your Financial Aid? _____

For staff use only please

Comments: _____

Medical/Mental Health History

Do you have/have you had: *Please check all that apply*

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> prescribed medications | <input type="checkbox"/> itching/irritation in genital area | <input type="checkbox"/> depression | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> over the counter medications | <input type="checkbox"/> genitals painful/sore | <input type="checkbox"/> anxiety | <input type="checkbox"/> migraines |
| <input type="checkbox"/> vitamins, mineral, food supplements | <input type="checkbox"/> respiratory disease | <input type="checkbox"/> anger problems | <input type="checkbox"/> obesity |
| <input type="checkbox"/> rash due to medication | <input type="checkbox"/> liver disease | <input type="checkbox"/> severe mood swings | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> rash due to food | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> health concerns | <input type="checkbox"/> medication allergies |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> any chronic diseases | <input type="checkbox"/> medical problem | <input type="checkbox"/> food allergies |
| <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> pregnancies | <input type="checkbox"/> serious illness | <input type="checkbox"/> birth defect |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> STD's/STI's | <input type="checkbox"/> serious accident | <input type="checkbox"/> epilepsy, seizures, convulsions |
| <input type="checkbox"/> heart medication | <input type="checkbox"/> unexplained weight loss | <input type="checkbox"/> glasses, contacts | <input type="checkbox"/> drug abuse |
| <input type="checkbox"/> blood disorder | <input type="checkbox"/> unexplained weight gain | <input type="checkbox"/> trouble seeing | <input type="checkbox"/> Glandular/Thyroid problem |
| <input type="checkbox"/> bladder control problem | <input type="checkbox"/> special diet | <input type="checkbox"/> dental problem | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> burning when urinating | <input type="checkbox"/> physical disability | <input type="checkbox"/> trouble sleeping | <input type="checkbox"/> mental illness |
| <input type="checkbox"/> blood in urine | <input type="checkbox"/> mental disability | <input type="checkbox"/> sleep walk | <input type="checkbox"/> anemia |
| <input type="checkbox"/> bladder infection | <input type="checkbox"/> learning disability | <input type="checkbox"/> sleeping medication | |
| | | <input type="checkbox"/> asthma | |
| | | <input type="checkbox"/> cancer | |
| | | <input type="checkbox"/> diabetes | |
| | | <input type="checkbox"/> eating disorder | |

If you checked off any please explain each: _____

Are you current with immunizations? Yes No

Can you provide a copy of your immunization record? Yes No

Do you currently have a primary doctor? Yes No **who is it?** _____

When was your last physical exam? _____

Do you currently have a dentist? Yes No **who is it?** _____

When was your last dental exam? _____

Do you currently have a counselor/therapist? Yes No **who is it?** _____

When was your last appointment? _____

Do you currently have a psychiatrist? Yes No **who is it?** _____

When was your last appointment? _____

Have you had a history with any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Suicide Attempts | <input type="checkbox"/> Verbally Aggressive/Abusive | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Suicide Threats | <input type="checkbox"/> Fire Setting | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Self Injuries | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mental/Emotional Abuse |
| <input type="checkbox"/> Physically Aggressive Behavior | <input type="checkbox"/> Family Violence | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Sexually Aggressive Behavior | <input type="checkbox"/> Hurting Animals | |
| | <input type="checkbox"/> Anger | |

If you checked off any of the following please explain each: _____

Safety/Risk

Danger from others

Have you ever been physically abused? Yes No

If yes, by whom? _____ When? _____

Have you ever been sexually abused? Yes No

If yes, by whom? _____ When? _____

Have you ever been exposed to domestic violence? Yes No

If yes, by whom? _____ When? _____

Have you ever had anyone in your household abusing alcohol or drugs? Yes No

If yes, by whom? _____ When? _____

Have you ever been left alone for 2 or more days? Yes No

With food Without food

If yes, by whom? _____ When? _____

Have you ever been hospitalized for medical reasons? Yes No

If yes please explain: _____

Have you ever been to CPEP or hospitalized for mental health reasons? Yes No

If yes please explain: _____

Have you ever had medical problems not attend to? Yes No

If yes please explain: _____

Have you ever not felt safe? Yes No

If yes please explain: _____

Have you ever ran away from home? Yes No How old were you? _____

Were you ever homeless in the past? Yes No

Where did you sleep last night? _____

Danger from self

Have you ever seriously threatened to harm anyone? Yes No

If yes, please explain _____

Where there charges against you? Yes No

If yes, please explain? _____

Drug and Alcohol History

Have you ever used/tried:

- | | | | |
|-------------------------------------|---------------------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Prescription | <input type="checkbox"/> Cocaine | <input type="checkbox"/> LSD |
| <input type="checkbox"/> Tobacco | drugs for fun | <input type="checkbox"/> Heroin | <input type="checkbox"/> Other |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Crack | |

How old were you when you first tried drugs or alcohol? _____

When was the last time you used drugs or alcohol? _____

Have you ever been treated for substance use/abuse? Yes No

If you checked off any of the following please explain each: _____

Medical Information

Are you sexually active? Yes No
Do you have any children? Yes (please complete page 2) No
Do you suspect that you or your partner may be pregnant? Yes No Maybe
Have you or your partner had a pregnancy test? Yes No
Are you currently receiving prenatal care? Yes No
If you or your partner are pregnant, how far along are you? _____
Have you ever been pregnant or fathered a child? Yes No
How many times? _____

Females only

How old were you when you had your first period? _____
Are your periods regular? Yes No
Have you ever had an internal pelvic exam? Yes No
Have you ever had a PAP smear in the past? Yes No
If yes, when was your last exam? _____
Do you have a regular OBGYN? Yes No
If yes, who is it? _____

Males only

Have you had a yearly physical exam? Yes No
If yes, when was your last exam? _____

Financial & Employment

1.) Do you receive any of the following as income?

- | | |
|---|---|
| <input type="checkbox"/> Public Assistance | <input type="checkbox"/> Child Support |
| <input type="checkbox"/> Social Security Income (SSI) | <input type="checkbox"/> Wages |
| <input type="checkbox"/> Survivor Benefits | <input type="checkbox"/> Other Income (other than work) |

2.) Do you have a bank account? Yes No

If yes where: _____ Type of account: _____ Balance: _____

3.) Work History

Have you ever had a job? Yes No
If yes, Where? _____

Have you ever been fired from a job? Yes No
If yes, please explain? _____

4.) Do you currently have employment? Yes No

Place of Employment _____
How long have you worked there _____
Pay per hour _____ How many hours do you work a week? _____

5.) Do you currently receive Medical Assistance or Temporary Assistance? Yes No

If yes, please explain? _____

6.) Do you receive SSD or SSI? Yes No

Who currently is your rep payee? _____
How much do you currently receive? _____

7.) If you receive Child Support payments how much do you currently receive? _____

This page to be completed by TTLP Staff

Referred by: _____ Date of Screening: _____
Agency: _____ Date of Admission: _____
Phone No.: _____ Time of Admission: _____

Has youth called CES? Yes No
Has referral been received? Yes No

Screening Committee Results: _____

To Do:

- _____
- _____
- _____
- _____
- _____
- _____

TEEN TRANSITIONAL LIVING PROGRAM
Professional Referral Questionnaire

Name of Applicant: _____

Name of Reference: _____ Relationship to Applicant: _____

- Give a brief history, including the applicant's involvement with any agencies/services:

- What information can you provide about this applicant's peers? Please include names:

- What important relationships does the applicant have? Please include people the applicant relies on for emotional support:

- What, if any, are some goals the applicant has set, and which ones are you assisting them with?

- What are some of the applicant's strengths?

- What are some things the applicant needs to work on or improve?

- What support services does this applicant use or need?

- What is the applicant's need for substance abuse counseling? low med high unknown
Please provide additional information:

- Will you be continuing with this applicant if he/she is accepted in to the program? Yes No
If no, what are your suggestions for continuing contact with existing service providers?

- Have you reviewed our program rules and guidelines? Yes No
Do you feel that the applicant will have any problems following any of our rules? If yes, which ones?

Signature of Referral: _____ Date: _____

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Professional Referral Questionnaire

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Do you feel that the applicant will have any problems following any of our rules? If yes, which ones?

Signature of Referral: _____ Date: _____

TEEN TRANSITIONAL LIVING PROGRAM
Personal Referral Questionnaire

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Name of Reference: _____ Relationship to Applicant: _____

- Give a brief history, including the applicant's involvement with any agencies/services:

- What information can you provide about this applicant's peers? Please include names:

- What important relationships does the applicant have? Please include people the applicant relies on for emotional support:

- What, if any, are some goals the applicant has set, and which ones are you assisting them with?

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