**APPLICATION**
**Congregate Housing Services Program (CHSP)**
**Public Housing Agency of the City of St. Paul**

Applicant's Name: _____

Current Address: _____ Apt: _____

City_____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Social Security Number: _____

Medical Assistance Number (if applicable): _____

Case Manager (if applicable): Name: _____ Phone:_____

Current or Former Occupation: _____

Status: Single: _____ Married: _____ Widowed: _____ Divorced: _____

Person to be contacted regarding admission if other than applicant:

Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Phone: _____ Relationship: _____

State reason(s) for requesting CHSP: _____

_____

_____

Do you have a location preference? Yes: _____ No: _____

If yes, what building(s) do you prefer?

1. _____

2. _____

When was your last medical examination? _____

Physician: _____

Address: _____

Phone: _____ Hospital Preference: _____

Do you have difficulty walking?

Yes _____ No _____ Sometimes _____

Do you use a wheelchair? _____ Walker? _____ Cane? _____ Brace? _____

How often? Always _____ Sometimes _____

Do you experience falls? Yes_____ No_____

Have you ever had a problem with bladder or bowel control?

Yes _____ No _____ Sometimes _____

Does someone help you to set up your medications?

Yes _____ No _____ Sometimes _____

How is your appetite?

Good _____ Fair _____ Poor _____

What services are you currently receiving?

| Services | Yes or No | How Often | Who provides the service? (Agency, family , friend) |
|---|---|---|---|
| Meals | | | |
| Housekeeping | | | |
| Personal Care (assistance with bathing, dressing, transferring) | | | |
| Health Services (Therapy, medication administration) | | | |
| Transportation | | | |
| Counseling/ Friendly Support | | | |

Which services do you think you will need from CHSP to remain living independently?

-Daily Meals Increase _____ Decrease _____

Why? _____

-Housekeeping Increase _____ Decrease _____

Why? _____

-Personal Care Increase _____ Decrease _____

Why? _____

-Health Services Increase _____ Decrease _____

Why? _____

-Transportation Increase _____ Decrease _____

Why? _____

-Counseling/Support Increase _____ Decrease _____

Why? _____

-Escort to medical appointments Increase _____ Decrease _____

Why? _____

Is there any other information we should know that would help determine your eligibility?

_____

_____

I hereby state that the information given by me is true, correct and complete to the best of my knowledge.

Applicant Signature: _____

Date: _____

****Please send application to:** **Melonie Hagman, CHSP Program Manager**
**1085 Montreal Avenue** **Fax: 651-695-3725**
**St. Paul, MN 55116** **Phone: 651-292-6035**
**melonie.hagman@stpha.org**