



APPLICATION FORM
GETTING AHEAD IN A JUST-GETTIN-BY-WORLD

CONTACT INFORMATION

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Best contact phone #: _____ SSN: _____

Email: _____ Date of Birth: _____ Gender: _____

Emergency Contact: _____ Phone Number: _____

Race: _____ African American _____ Caucasian _____ Hispanic _____ Native American
_____ Pacific Islander _____ Asian _____ Other

PROGRAM INFORMATION

The Class will meet for 10 weeks. Can you commit to attending all 10 sessions?

_____ YES _____ NO

Do you have any conflicts with other standing appointments that might keep you from attending?

_____ YES _____ NO

Will transportation be an issue for you, give the location of the class, the meetings days/times?

_____ YES _____ NO

Will you use the free childcare that will be provided during the class sessions?

_____ YES _____ NO

If yes, please provide the names and ages of the children who will need childcare while you are in class:

1. Name/Age/Gender: _____
2. Name/Age/Gender: _____
3. Name/Age/Gender: _____

EMPLOYMENT

Place of employment: _____

Job Title: _____ How Long have you been employed there? _____

What is your annual household family income?

_____ \$0 - \$12,000 _____ \$12,201 - \$20,000 _____ \$20,201 - \$40,000 _____ \$40,000+

Please check all sources of income:

_____ Wages _____ SSI _____ TANF _____ Unemployment _____ Child Support

EDUCATION

Highest grade completed: _____ 1-6 _____ 7-8 _____ 9 _____ 10 _____ 11 _____ 12

_____ GED _____ Associate _____ Bachelor _____ Master

Currently enrolled in (Education program): _____

Date Enrolled: _____ Anticipated Completion Date: _____

TRANSPORTATION

Do you have a working vehicle? _____ Yes _____ No **OR** Are you on a bus route? _____ Yes _____ No

CURRENT SERVICE AGENCIES

Please provide names of organizations, professionals or case managers that you receive ongoing supportive services from: (Examples: Energy Assistance, Food Stamps/SNAP, Head Start, Academic Financial Aid, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Place a check next to the areas where you are experiencing difficulties:

- | | |
|---|---|
| <input type="checkbox"/> Employment | <input type="checkbox"/> Isolation |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Training/Education | <input type="checkbox"/> Alcohol/Drugs |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Childcare Costs |
| <input type="checkbox"/> Parenting | <input type="checkbox"/> Healthcare Costs |
| <input type="checkbox"/> Budget | |

I certify that the following are true (check):

- I do not receive disability assistance, or I want to discontinue disability assistance
- I am not in a major crisis (untreated mental illness or drug/alcohol addiction, domestic violence situation, homeless); I am stabilized
- You give permission for us to contact any of the organizations or case managers you listed to discuss your life situation, strengths and barriers
- I am willing to work with others to become self-sufficient, i.e. independent of assistance
- I am willing to participate in a phone interview to determine my eligibility and willingness to participate in this program
- I am willing to participate in a 10-week class, approximately 2 ½ hours per class

Thank you for your interest and for taking the time to complete this application. The information you provide will be used to determine eligibility for the Bridges program and track progress towards goals. Completing this application does not guarantee you will be accepted.

SIGNATURE

Signature: _____ Date: _____

Please return completed application to:

One Body Collaboratives
PO Box 1633
Rockford, IL 61110

If you were referred to us by another agency, please list the agency name here:

Referring Agency: _____

Contact Name/Phone: _____

