



# PROGRAM APPLICATION

Date Received: \_\_\_\_\_  
 Contact Date 1: \_\_\_\_\_  
 Contact Date 2: \_\_\_\_\_  
 Interview Scheduled: \_\_\_\_\_

**Please return the completed application to the appropriate program**

### Men's/Veterans/Young Adults

Email: info@appletoncots.org  
 Fax: 920-734-4732  
 Drop box: 819 S. West Avenue | Appleton, WI  
 US Mail: P.O. Box 1645 | Appleton, WI 54912

Questions? Call 920-809-8434 or 920-475-8341

### Women's

Email: jjanness@appletoncots.org  
 Fax: 920-831-6593  
 Drop box: 1003 W. College Avenue | Appleton, WI  
 US Mail: P.O. Box 1645 | Appleton, WI 54912

Questions? Call 920-843-7269 or 920-475-8434

## COTS PROGRAM FEES

	<b>Program Name</b> <i>(please indicate the program to which you're applying)</i>	<b>Security Deposit</b>	<b>Monthly Fee (first year)</b>
<input type="checkbox"/>	Men	\$100	\$285
<input type="checkbox"/>	Veterans	\$100	\$285
<input type="checkbox"/>	Young Adults (18-24)	\$100	\$285
<input type="checkbox"/>	Women	\$100	\$285
<input type="checkbox"/>	Single Mothers with Young Children	\$100	\$285 (plus \$25 per child)

Referred by \_\_\_\_\_

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

Other Names/Aliases Used \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

Current Address \_\_\_\_\_  
 Street City State ZIP How long

Employer \_\_\_\_\_ Date Started \_\_\_\_\_

Hourly Wage \_\_\_\_\_ Hours per week \_\_\_\_\_

Do you receive:  SSI  SSDI  Unemployment What is your total monthly income? \$ \_\_\_\_\_

### **Please check the items that apply to you:**

- Homeless as defined by HUD:
  - An individual that lacks a fixed, regular, and adequate nighttime residence; or
  - An individual that has a primary nighttime residence that is:
    - A supervised publicly or privately-operated shelter designed to provide temporary living accommodations (including welfare motels, congregate shelters, and transitional housing for the mentally ill)
    - An institution that provides a temporary residence for individuals intended to be institutionalized; or
    - A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This term does not include any individual imprisoned or otherwise detained under an Act of the Congress or a State Law
- Able to pay the program fee and security deposit upon intake
- Employed or have a legal source of income (ongoing ability to pay monthly program fees)
- Committed to remaining alcohol/drug free while in the COTS program and willing to submit to screening if suspected of use
- Committed to participating in COTS' programs, working with COTS staff, and setting up/working toward individualized goals as agreed upon with the COTS staff



- Yes  No Do you require special accommodations?
- Yes  No If yes, are you able to care for yourself?
- Yes  No Does someone help care for you (Clarity Care, etc.)?
- Yes  No Have you stayed at COTS before? If yes, when? \_\_\_\_\_
- Yes  No Are you a veteran? If yes, what branch? \_\_\_\_\_
- Yes  No Are you on probation/parole? If yes, please provide agent name and phone number.  
Agent name: \_\_\_\_\_ Phone number \_\_\_\_\_
- Yes  No Do you have any special conditions of probation/parole?  
If yes, explain: \_\_\_\_\_
- Yes  No Do you have any pending court cases or warrants?  
If yes, explain: \_\_\_\_\_
- Yes  No Are you under a civil commitment (mental health, etc.)?  
If yes, for what/with whom: \_\_\_\_\_  
\_\_\_\_\_

**Please answer the following questions to further the interview:**

1. Why do you want to live at COTS? \_\_\_\_\_  
\_\_\_\_\_
2. How would you be a good COTS community member? \_\_\_\_\_  
\_\_\_\_\_
3. What goals do you want to achieve at COTS? \_\_\_\_\_  
\_\_\_\_\_

**List three references (previous landlord, counselor, probation officer, employer, etc.):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State ZIP

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State ZIP

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State ZIP

***By signing, I verify the above information is accurate to the best of my knowledge, and I request to be considered for the COTS, Inc. program. I give permission for COTS, Inc. representatives to obtain and/or release information to/from the references listed above regarding my application to COTS, Inc.***

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_