Date:__/__/____

Fee: _____ $50 Deferred

St Ambrose Homesharing
Homeseeker Interview Form

Name_____ Phone: (H)_____
(W)_____
Address_____ (C)_____
Street Zip

Email_____ D.O.B._____

PLEASE NOTE THAT ALL PERSONAL INFORMATION DISCLOSED DURING THIS INTERVIEW IS NOT CONSIDERED CONFIDENTIAL AND MAY BE SHARED WITH POTENTIAL MATCHES.

A. Your Profile

Female Male
Your age_____
Your race_____
# of children at home_____
Name _____age_____
Do you smoke?_____
Do you drink?_____
Do you have a pet?_____

Ideal HP Profile:
(circle all possibilities)

Female Male Couple Single Parent/Child Family

Smoker Occ. Drinker Pet

__ Outdoor OK ___ Dog ___ Cat

B. HS Space Preferences:

Desired Location:_____

Public Transportation Needed? Yes No If YES, which: Bus, #_____ Subway Lightrail

Space (*circle all desired*): Room 2 Rooms Apartment Private Entrance Private Bath

Handicap Accessible First Floor/Minimal Stairs

Furnished / unfurnished Furniture you will be bringing & **your bed size**:_____
_____

Storage space needed:_____

Do you require: Internet / Cable Are you willing to contribute financially for these things? Y N

C. Rent/Income:

Desired rent_____ Maximum rent_____ Utilities included?_____

Source of income:_____Amount:_____ Verification: **Provided** **Will Send**

D. Timeline:

Date you would like to move:_____ Date by which you must move:_____

How long do you expect your homesharing match to last?_____

E. Personal Background:

1. How did you hear about St. Ambrose Homesharing?_____
2. Why are you moving now?_____
3. Why have you chosen Homesharing rather than living with family/getting an apt?_____
4. Are you under any unusual stress that you'd like to share?_____
5. List the past addresses you have resided for the previous 5 years:

Number and street	City and state	How long?

6. Most recent landlord: _____ Phone: _____

7. Are you attending school? Y N If yes: Full-Time Part- Time
   School Attending: _____
8. Are you currently employed? Full-Time Part- Time Seeking Job Not Working

Present (or Most Recent) Employer_____

Position_____ Date began_____

Address_____

Supervisor's Name_____ Phone_____

9. Employment History for the past 5 years:

Employer Name	Address	Dates of Employment

10. What is your work/ school schedule?_____

Are you at home in the evenings?_____ Are you ever gone overnight? Y N

Weekends?_____ Do you eat most of your meals: At Home / Out

IF CHILD: What time does s/he go to bed?_____ Weekly schedule?_____

11. In case of an emergency, person(s) to be contacted (family / friend):

1)	H	W
2)	H	W

F. Services: Would you like to provide any service? Y / N Do you need any services? Y / N

Meal prep_____
Housekeeping_____
Grocery Shopping_____
Childcare_____
Other_____
_____

Companionship_____
Laundry_____
Yard work_____
Transportation _____
* Do you have a license? Y N

G. Habits and Preferences:

1. What qualities in a person are most important when you think of living with someone?
   _____
   _____
   _____

2. Would you consider someone with an addiction you have been in recovery for at least one year?
   Y/N (Please circle) Drugs Alcohol

   Would you consider someone with a non-violent criminal background? Y/N
   If YES, for how long ago: 1-5 yrs 5-10 yrs 10+ yrs

3. A) What would someone like about you? _____
   _____

   B) What might irritate someone about you?_____

4. Where do you fall on the spectrum of tidiness?_____

5. What would an "ideal" Homesharing situation look like for you?_____
   _____

6. What are your Hobbies/Activities? _____
   _____

7. Do you have visitors? Often Sometimes Never Would you have overnight guests? Y / N

   If overnight, who would they be? Family? Y / N Friend? Y / N Intimate guests? Y / N

8. In Homesharing, disagreements do arise. How would you expect to handle conflict or miscommunication?
   _____

H. Health Data:

1. Are there any health conditions – or are you using any medications – that we need to know about for your (or your homesharer's) safety in the home? Y N

If yes, what are they? _____

2. Do you regularly see a physician, psychiatrist or professional counselor? Y N

Name:
Address:
Phone:

3. Have you ever had a drug or alcohol problem? Y N
If yes, explain:_____

Reference verifying sobriety:_____
Name phone #

4. Have you ever been convicted of a crime? Y N
If yes, explain:_____

6. NOTICE: We customarily run a background check on all participants in the Homesharing program using Maryland Judiciary Records or any other public records maintained by another state or jurisdiction. Any information we receive through our background check may be shared with a potential homesharer. Do you consent to this background check?

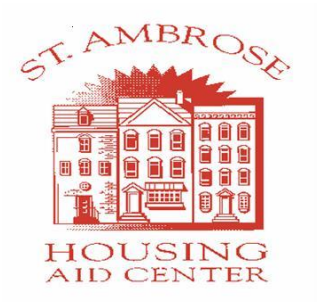
Yes No

I have honestly answered all of the questions during this interview, and agree that any of the above information can be shared with a prospective homesharer. I understand that St. Ambrose requires 1/3 of the monthly rent for a match fee, which I agree to pay if a suitable match is found for me.

_____ _____
Signature of Participant Staff Member, SAHAC, Inc

_____
Date

HSInterv 3/18



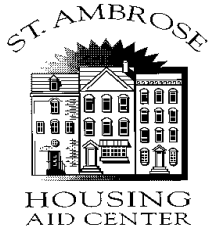
In order to insure quality service through our Homesharing Program, we ask that you read and understand the following.

HOMESHARING PROGRAM'S RESPONSIBILITIES TO YOU:

1. Check your references within a reasonable amount of time.
2. Present your situation clearly to prospective homeowners/homeseekers.
3. Call you regarding possible matches.
4. Follow-up with a match meeting after you have finalized arrangements.
5. Keep in touch to facilitate any problems that might develop.
6. Find you another arrangement if the match doesn't work for acceptable reasons.

HOMESHARERS' RESPONSIBILITY TO THE HOMESHARING PROGRAM:

1. Be willing to speak truthfully during the interview.
2. Provide references with day phone numbers/ sign required forms.
3. Respond in a timely manner to any calls from staff.
4. Contact the agreed upon homeowners/seekers in a timely fashion.
5. Call St. Ambrose with an update after each contact.
6. Agree to a match meeting at an agreed-upon date and pay the stated fee.



AGREEMENT OF NON-LIABILITY

The staff of St. Ambrose Housing Aid Center, Inc. will use their training and experience to bring together those who have housing and those who are seeking housing, either in a peer relationship or through an intergenerational match. St. Ambrose Housing Aid Center, Inc. adheres to a policy of non-discrimination in housing on the basis of any individual's race, gender, age, religion, national origin, disability, or any other characteristic protected under applicable federal, state, and local laws.

I acknowledge and agree that St. Ambrose Housing Aid Center, Inc., is not the agent of any party (homeowners or homeseekers) but acts as a facilitator providing the opportunity for the parties involved to come together and work out an acceptable housing arrangement. I further acknowledge that the decision to participate in a homesharing arrangement is solely within the discretion of the applicant, and St. Ambrose Housing Aid Center, Inc. does not require any applicant to cohabitate under its homesharing program.

Any and all homesharing agreements shall be made solely by the parties involved in the homesharing arrangement. St. Ambrose Housing Aid Center, Inc., its staff and volunteers, will not be held responsible, either individually or jointly, and will not assume any liability for claims, damages or other consequences which may arise from the homesharing arrangement.

I have read and understand the above statement.

_____ _____

Signature of Applicant Date

_____ _____

Staff/Volunteer, SAHAC, Inc. Date

INFORMED CONSENT TO SHARE A HOME

Home Providers and Home Seekers may have health concerns about sharing a home during the COVID-19 pandemic and with regard to other contagious or communicable illnesses. While there are many benefits to sharing a home- financial, practical assistance, and companionship- there are also risks. Home Providers and Seekers should educate themselves about the COVID-19 pandemic and any other contagious or communicable illnesses that may be of concern and document below.

_____

I hereby certify that I:

_____ Reviewed the CDC health and safety information regarding COVID-19.
(Initial)

Date Reviewed _____

How Reviewed _____
(online website, printed material, other-specify)

_____ Reviewed the Md.gov health and safety information regarding COVID-19.
(Initial)

Date Reviewed _____

How Reviewed _____
(online website, printed material, other-specify)

_____ Understand that HomeSharing cannot make any representations about or know the
(Initial) health status of the Provider(s) or Seeker(s).

_____Understand the risks of sharing a home and want to do so.
(Initial)

CLIENT:

_____
NAME

_____
SIGNATURE

_____
DATE

WITNESS:

_____
NAME

_____
SIGNATURE

_____
DATE

REFERENCE FORM

Verification of employment

Name of employee: _____

Name of employer:_____

Years worked:_____

Is this employee: part-time, full-time, temporary, permanent or terminated

If terminated last day of work/employment _____

Is the person in good standing? _____

Would you recommend him/her for a homesharing situation? (This would be sharing an available room and common areas in their home)._____

Why?/Why not? _____

_____

The above information is correct with the following exceptions:

_____ (if none, write "none.")

If terminated last day of work/employment _____

Name _____ Title_____

Signed: _____ Date _____

Thank you for your prompt attention to this matter.

Sincerely,

Tamia Smith
PSY Baltimore Host Home Program
321 E. 25th Street
Baltimore, MD 21218
Phone: 410-366-6180

ST. AMBROSE HOUSING AID CENTER

Client Health Evaluation

PLEASE NOTE

This form is relevant to the application your client has made to participate in a ROOMMATE MATCHING PROGRAM. This is NOT an application for an apartment or efficiency – we are assessing suitability to live in close quarters with another individual.

Name of Prospective Homesharer: _____

How long have you known the patient? _____

Are there any psychoses or other mental health issues that might interfere with the patient's ability to live independently or effectively with another person? _____

_____

_____

Please describe any physical/mental health conditions and related medications s/he takes:

Health Conditions	Medications
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are there any physical limitations of which we should know? (e.g. unable to climb stairs, incontinence, etc.) _____

_____

_____

Does confusion or forgetfulness interfere with the patient's ability to live independently?

_____

_____

Describe this person's overall mental/emotional health: _____

_____

_____

Is there any evidence of drug or alcohol abuse (current or past)? Please explain.

_____

_____

_____

Please share your personal impressions of this person: _____
_____
_____
_____
_____

Please evaluate: (1=poor; 2=below average; 3=average; 4=above average; 5=excellent)

General Health……	**1**	**2**	**3**	**4**	**5**
Emotional Stability……	**1**	**2**	**3**	**4**	**5**
Life Stability/Continuity……	**1**	**2**	**3**	**4**	**5**
Interpersonal/Communication Skills……	**1**	**2**	**3**	**4**	**5**
Flexibility……	**1**	**2**	**3**	**4**	**5**
Support Systems……	**1**	**2**	**3**	**4**	**5**
Social Involvement…….....	**1**	**2**	**3**	**4**	**5**

Is there any condition that makes it <u>probable</u> that an emergency would occur for which the homesharer might need to call 9-1-1? _____
_____

Would you recommend that this person have a homesharer who could cope with physical or mental health emergencies? _____

Would you recommend this person to share a home with someone you know and care about? _____

****

Provider's name: _____ Date: _____

Signature: _____

Phone #: _____

Please return to:
St. Ambrose Homesharing Program
321 East 25th Street
Baltimore, MD 21218
Phone 410-366-6180 Fax 410-366-8795

HEALTH 03/11

Resident Name: _____

Date of Birth: _____

MENTAL ILLNESS DISABILITY FORM

Please have physician use this form to verify resident's Mental Illness disability status

Medical History and Hospitalization(s)

1. Name: _____

2. Age: _____ 3. Gender: _____ 4. Race: _____

5. Current Medical Diagnosis/Disability Condition:

_____

_____

_____

_____

6. Hospitalizations and Psychiatric History:

Facility Name	Diagnosis (State Axis)	Admission/Discharge Dates

Psychiatric Diagnosis:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

7. Social and Developmental History:

_____

_____

_____

_____

_____

Resident Name: _____
Date of Birth: _____

8. Medications:

_____

_____

_____

_____

9. Initial Level of Functioning:
Mark each item below, using the appropriate corresponding number:

Key: 0-10 Above Average
11-20 Average Functioning
21-30 Slight Dysfunction
31-40 Moderate Dysfunction
41-50 Severe Dysfunction

a. Thinking/Mental Processes _____
b. Feeling/Mood/Affective Process _____
c. General Medical/Physical _____
d. Substance Use _____
e. Family/Living Situation _____
f. Interpersonal Relations _____
g. Role Performance _____
h. Socio-Legal _____
i. Self-care/Basic Needs _____

Physician's Name: _____
PLEASE PRINT

Physician's Signature: _____

Address: _____

_____

_____

Phone Number: _____

Date of Evaluation: _____