

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: Thao Ngo, CHSP Program Manager
1085 Montreal Avenue
St. Paul, MN 55116
Thao.Ngo@stpha.org**

**Fax: 651-695-3725
Phone: 651-292-6035**