



Dottie's House is a two -year transitional housing program for women survivors of domestic violence and their children.

A candidate's acceptance into the program is based on a number of factors including, but not limited to, their willingness and ability to complete the program, their need for safe housing and their desire to be self-sufficient. While each candidate is looked at on an individual basis, they must meet the enclosed outlined selection criteria.

The decision for acceptance into Dottie's House is a collaborative effort. Once a referral is made to Dottie's House, the application is reviewed to make a preliminary determination as to eligibility of the applicant if the selection criteria are met. If it is met, an initial interview with the Director and staff will take place. A second interview may follow to determine acceptance. The referral source's assessment of the client's ability to succeed in the program is an important part of the decision making process.

Enclosed please find our program description, selection criteria and referral forms.

For further information, please feel free to contact us at 732-262-2009.

Sincerely,  
The Staff of Dottie's House

**732-262-2009 (Telephone) ~ 1-732-377-7901 (Fax)**



## **SELECTION CRITERIA FOR THE TRANSITIONAL HOUSING PROGRAM**

Candidates must meet the following criteria:

- Be homeless.
- The survivor of domestic violence must have left her abuser or is unable to leave the abuse without the support of the Transitional Housing Program.
- Be eighteen years or older.
- Have primary residential custody of any children who would be living at Dottie's House.
- Demonstrate a desire to be self-sufficient (independent from abuser).
- Be alcohol and drug free for a minimum of one year.
- Willing to conform to the rules and regulations outlined in the Program Manual.
- Willing to sign all necessary documents.
- Able to participate in all capacities during residency.
- Working full-time.
- Comply with a background check.
- Have own transportation or can arrange for transportation if needed.

**We will begin the interview process with applicants who meet the criteria for the program in accordance with our policy manual.**

**Dottie's House**  
**732-262-2009**  
**1-732-377-7901 (Fax)**  
**Pre-screening Questionnaire for Referrals**  
**\*\*To be completed by referring agency\*\***

Name of Client: \_\_\_\_\_ Date: \_\_\_\_\_

How long has the client been affiliated with your agency? \_\_\_\_\_

Prior address of the client (please specify with abuser/family/friends/other program, etc):  
\_\_\_\_\_

Is there any substance abuse history? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, please explain:

\_\_\_\_\_

Is there any significant mental health history and/or hospitalizations? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, please explain:

\_\_\_\_\_

Is the client receiving and/or applied for Social Services, TANF, Child support and/or other programs? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please list:

\_\_\_\_\_

\_\_\_\_\_

Is the client willing and able to work full time? No \_\_\_\_\_ Yes \_\_\_\_\_

What do you feel the client's chances are of succeeding in a 2-year transitional housing program? (Based on a desire for self-sufficiency, commitment to being independent from abuser, ability to work, etc). Circle one:

Not at all confident   1   2   3   4   5   Confident

**\*\*\*\* Please provide a detailed letter recommending the client for admission into Dottie's House and its affiliated program services. Indicate her readiness to participate in the Dottie's House program. This letter should be on agency letterhead and signed by the referring counselor.**

\_\_\_\_\_  
Counselor/Social Worker Signature & Title

\_\_\_\_\_  
Date

**Dottie's House Referral Information Sheet**  
**\*\*To be completed by referring agency\*\***

Previous contact with this and /or referring agency? No\_\_\_\_ Yes\_\_\_\_

Advocate's name & title: \_\_\_\_\_ Agency: \_\_\_\_\_

Advocate's phone number: \_\_\_\_\_ Advocate's email address: \_\_\_\_\_

Is it safe to call survivor at home? No\_\_\_\_ Yes\_\_\_\_ Leave messages? No\_\_ Yes\_\_

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**Survivor Information**

Age: \_\_\_\_\_ Marital Status: M \_\_\_ S \_\_\_ SEP \_\_\_ D \_\_\_ W \_\_\_ Years: \_\_\_\_\_

Children:           Age \_\_\_\_\_ Sex \_\_\_\_\_  
                          Age \_\_\_\_\_ Sex \_\_\_\_\_  
                          Age \_\_\_\_\_ Sex \_\_\_\_\_  
                          Age \_\_\_\_\_ Sex \_\_\_\_\_

Level of education: GED \_\_\_\_\_ HS \_\_\_\_\_ College \_\_\_\_\_ Other \_\_\_\_\_

Currently Employed: No \_\_\_ Yes \_\_\_ Where? \_\_\_\_\_

Current income: None\_\_\_ TANF\_\_\_ Work\_\_\_ Unemployment\_\_\_ Monthly income: \$\_\_\_\_\_

Does client have a current RO? No \_\_\_ Yes \_\_\_ Past RO's? No \_\_\_ Yes \_\_\_ Dates: \_\_\_\_\_

Description of current situation:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

# DOTTIE'S HOUSE

## CLIENT HISTORY/SELF REPORT

Who referred you to Dottie's House? \_\_\_\_\_

Today's date: \_\_\_\_\_ Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Street Town State Zip

**Safe** email address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Is it safe to call you at home? \_\_\_\_\_ Work? \_\_\_\_\_ At which number(s) can we leave a voicemail? \_\_\_\_\_

If none of the above, how can we contact you? \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Your ethnicity (please circle):

- |                           |                         |
|---------------------------|-------------------------|
| A. American Indian/Alaska | E. White (non-Hispanic) |
| B. Asian Pacific          | F. Bi-Racial            |
| C. Black (non-Hispanic)   | G. Other                |
| D. Hispanic               |                         |

Last grade completed: \_\_\_\_\_ Other training or college: \_\_\_\_\_

Are you employed? \_\_\_\_\_ If so, where? \_\_\_\_\_

Full-time: \_\_\_\_\_ Part-time: \_\_\_\_\_ Income per month (include TANF, unemployment, consistent child support, and other social services): \$ \_\_\_\_\_ Savings: \$ \_\_\_\_\_

Medicaid Number (if applicable): \_\_\_\_\_

Other Insurance Information: \_\_\_\_\_

Do you have your own transportation? \_\_\_\_\_

Marital Status: \_\_\_\_\_ Number of years together: \_\_\_\_\_

Is this your first marriage? \_\_\_\_\_ Number of significant others: \_\_\_\_\_

Significant Other/Partner's name: \_\_\_\_\_

\_\_\_\_\_

Their employer: \_\_\_\_\_ Income per month: \$ \_\_\_\_\_

Description of Abuser:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

Car make and model: \_\_\_\_\_

License Plate #: \_\_\_\_\_

Race: \_\_\_\_\_

Level of Education: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Hair: \_\_\_\_\_

Eye Color: \_\_\_\_\_

Any distinguishing features such as tattoos, beard, mustache, scars, please describe:

History of mental illness? Yes \_\_\_\_\_ No \_\_\_\_\_

Describe: \_\_\_\_\_

History of Substance Abuse? Yes \_\_\_\_\_ No \_\_\_\_\_

Describe: \_\_\_\_\_

Does he/she/they have a criminal record? Yes \_\_\_\_\_ No \_\_\_\_\_

Describe: \_\_\_\_\_

Is he/she/they the biological parent or legal guardian of your children? Yes \_\_\_\_\_ No \_\_\_\_\_

Is he/she/they the only person you have been seeing? Yes \_\_\_\_\_ No \_\_\_\_\_

Additional comments:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any legal involvement? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you or your family members ever been in counseling/therapy? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you or your family members ever been hospitalized for psychiatric reasons?

No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been sexually assaulted or molested? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, when? \_\_\_\_\_ By whom? \_\_\_\_\_  
Have you ever addressed this with a counselor? Yes \_\_\_\_\_ No \_\_\_\_\_ When? \_\_\_\_\_

Note the type(s) of abuse: Physical \_\_\_\_\_  
Emotional \_\_\_\_\_  
Sexual \_\_\_\_\_  
How often? \_\_\_\_\_ Were drugs or alcohol involved? \_\_\_\_\_

Have your children ever been abused? Yes \_\_\_\_\_ No \_\_\_\_\_  
Physically \_\_\_\_\_ Emotionally \_\_\_\_\_ Sexually \_\_\_\_\_  
How often? \_\_\_\_\_ Were drugs or alcohol involved? \_\_\_\_\_

Has your abuser ever threatened to kidnap the children? \_\_\_\_\_  
Has your abuser ever threatened to kill you? \_\_\_\_\_  
Has your abuser ever stalked you? \_\_\_\_\_  
Does your abuser own weapons? \_\_\_\_\_  
Do you own any pets? Yes \_\_\_\_\_ No \_\_\_\_\_  
Has your partner ever abused them? \_\_\_\_\_ How? \_\_\_\_\_  
Have the police ever been called? \_\_\_\_\_  
Have you ever had a restraining order? Yes \_\_\_\_\_ No \_\_\_\_\_ Current? \_\_\_\_\_  
Have charges ever been pressed? Yes \_\_\_\_\_ No \_\_\_\_\_ Against whom? \_\_\_\_\_  
Is your abuser currently threatening you? \_\_\_\_\_

Were your parents married? \_\_\_\_\_ If yes, for how long? \_\_\_\_\_  
Was there abuse in their home? \_\_\_\_\_

Please list your siblings:  
Age Sex Marital Status Describe your relationship with them Substance Abuse?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had any serious injury or illness? Yes \_\_\_\_\_ No \_\_\_\_\_  
Please describe: \_\_\_\_\_

Do you have any other medical problems? Yes \_\_\_\_\_ No \_\_\_\_\_  
Please describe: \_\_\_\_\_

Please list all medications you are currently taking (include name, dosage and what they are prescribed for and by whom):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you or have you used alcohol while taking this or any medications? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever seen a new doctor because an old doctor would not refill a prescription?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain:

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Do you use alcohol at all? Yes \_\_\_\_\_ No \_\_\_\_\_ How often? \_\_\_\_\_

What kind of alcohol do you like to drink? \_\_\_\_\_

Do you ever drink to get drunk? Yes \_\_\_\_\_ No \_\_\_\_\_ How often? \_\_\_\_\_

Do you ever drink alone? Yes \_\_\_\_\_ No \_\_\_\_\_ How often? \_\_\_\_\_

Do you ever have trouble remembering things when you drink? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you think drugs or alcohol are a problem for you? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you aware of any other addictions (food, gambling, etc.)? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you currently in a recovery program? Yes \_\_\_\_\_ No \_\_\_\_\_ Which one? \_\_\_\_\_

**Please circle all areas of concern to you:**

Physical Abuse

Emotional Abuse

Sexual Abuse

Sexuality

Sexual Assault

Incest

Self-Esteem

Relationships

Separation/Divorce

Parenting

Behavior of Children

Finances

Legal issues

Gambling

Anxiety

Depression

Self-Harm

Anger

Pregnancy/Abortion

Suicidal Thoughts

Homicidal Thoughts

Grief/Loss

Physical Abuse of Children

Emotional Abuse of Children

Sexual Abuse of Children





## CHILDREN'S HISTORY

### Complete a Separate Form for Each Child

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Do you have custody of your child? No \_\_\_\_\_ Yes \_\_\_\_\_

If no, in who's care is he/she/they and why:

\_\_\_\_\_  
\_\_\_\_\_

Biological father's name: \_\_\_\_\_

Is he living? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, where? \_\_\_\_\_

If deceased, cause of death: \_\_\_\_\_

Does father have contact with children? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how often? \_\_\_\_\_

Does he have visitation rights? Yes \_\_\_\_\_ No \_\_\_\_\_ How often? \_\_\_\_\_

Does he provide child support? Yes \_\_\_\_\_ No \_\_\_\_\_ How much? \_\_\_\_\_

Child's physician's name & address: \_\_\_\_\_

Is child taking any medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what? \_\_\_\_\_

For what reason: \_\_\_\_\_

Does child have allergies? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, to what: \_\_\_\_\_

Has child received all childhood immunizations?

DTP \_\_\_\_\_ MMR \_\_\_\_\_ TB \_\_\_\_\_ Other \_\_\_\_\_ Booster \_\_\_\_\_ HepB \_\_\_\_\_

Has child ever been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, for what and when?

\_\_\_\_\_

Has child ever had any surgery? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, for what and when?

\_\_\_\_\_

Has child ever had any broken bones? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, which ones & when?

\_\_\_\_\_

Was this caused by domestic violence? Yes \_\_\_\_\_ No \_\_\_\_\_ By whom? \_\_\_\_\_

Is your child in day care? Yes \_\_\_\_\_ No \_\_\_\_\_ Is your child in school? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, where? \_\_\_\_\_

How is child's performance in school/daycare? \_\_\_\_\_

Have you noticed any changes in the child? \_\_\_\_\_

\_\_\_\_\_

Was your child ever abused physically or emotionally? Yes \_\_\_\_\_ No \_\_\_\_\_

By whom: \_\_\_\_\_

Do you have or have you ever had an open DYFS case? Yes \_\_\_\_\_ No \_\_\_\_\_

Case # \_\_\_\_\_ Worker: \_\_\_\_\_

Has child ever witnessed DV in your home? Yes \_\_\_\_\_ No \_\_\_\_\_ Reaction: \_\_\_\_\_

Has your child ever expressed concern or asked questions? Yes \_\_\_\_\_ No \_\_\_\_\_

## FAMILY DATA:

Parent/Guardian Names:	D.O.B./Still Living?	Residence:

Are they your biological parents? Yes \_\_\_\_\_ No \_\_\_\_\_

Have either of your parents experienced any significant medical problems, drug/alcohol abuse, or mental illness? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

Describe each of your parents/guardians:

Mother: Biological? Yes \_\_\_\_\_ No \_\_\_\_\_

Father: Biological? Yes \_\_\_\_\_ No \_\_\_\_\_

Describe their relationship:

Are there any other family members who are important to you (i.e. step or extended family)?

Has your family ever been involved with a social service agency? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Describe your current relationship with your siblings:

\_\_\_\_\_  
\_\_\_\_\_

Problems of significance within your family of origin:

A. Substance Abuse:

B. Mental Illness/Psychiatric History:

C. Criminal History:

What was it like growing up in your household?

## EDUCATION

School Attended	Name of School	Years Attended	Type of Training/ Degree
High School			
Vocational Training			
College			

## HOUSING HISTORY

Begin with your most recent address.

a) Lived with:  
Address:  
Rent per month:  
Move in Date:  
Move out Date:  
Reason for leaving:

b) Lived with:  
Address:  
Rent per month:  
Move in Date:  
Move out Date:  
Reason for leaving:

c) Lived with:  
Address:  
Rent per month:  
Move in Date:  
Move out Date:  
Reason for leaving:

d) Lived with:  
Address:  
Rent per month:  
Move in Date:  
Move out Date:  
Reason for leaving:

## **MEDICAL HISTORY**

1. Physician's name and address:
2. When was the last time you saw your doctor?
3. Other than childbirth, have you ever been hospitalized, had major surgeries or have ongoing health problems? Please explain:
4. Have you ever been in therapy for any reason? Please specify:
5. Have you ever been hospitalized for psychiatric reasons? Please specify:
6. Have you ever been in treatment for a drug or alcohol problem? Please specify:

## **LEGAL ISSUES**

1. Do you now or have you ever had any charges pressed against you? Please specify:
2. Have you ever been incarcerated? If so, please specify reason and length of time.
3. Have you ever or are you currently on probation or parole? Please explain and include, where applicable, the probation officer's name, agency and telephone number.
4. Please describe any conditions of your probation or parole (including fines, charges, expiration, and community service).
5. Are you currently involved in or expect to be involved in any court or legal matter? If yes, please explain, including any outstanding charges, warrants, or bonds.
6. What are your approximate debts?  
Bankruptcy:  
Credit Cards:  
Student Loans:  
Utilities:  
Lawsuits/Fines/Judgments:  
Other:

## **EMPLOYMENT:**

Are you currently employed?

If yes, employer information:

What is your approximate annual income?

How many hours per week do you work?

Do you have benefits?

Employment history (begin with the most recent):

Employer:

Dates of Employment:

Job description:

Reason for leaving:

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Employer:

Dates of employment:

Job description:

Reason for leaving:

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Employer:

Dates of employment:

Job description:

Reason for leaving:



## Release of Information

I, \_\_\_\_\_, hereby grant Dottie's House representatives authorization to request and/or release of information relative to medical, social, psychological, addiction history, legal or other information or records to the following agencies for the purpose of planning and implementing services for myself and my children.

**Agencies:**

County Board of Social Services	Municipal Housing Authorities
NJ Address Confidentiality Program	Legal Services of New Jersey
Family Court System	Division of Child Protection & Permanency (DCPP)
Social Security Administrators	Preferred Behavioral Health
Children's Home Society	Referring Agency _____

**Other Agencies involved in treatment:** \_\_\_\_\_

School(s) \_\_\_\_\_

Doctor(s) \_\_\_\_\_

Psychiatrist(s) \_\_\_\_\_

Counselor/Therapist(s) \_\_\_\_\_

Employer(s) \_\_\_\_\_

Other(s) \_\_\_\_\_

I understand I may revoke this consent at any time via written communication to Dottie's House, except to the extent that action has already been taken. This Release of Information is valid for 24 months from the date of signature or completion of Dottie's House services.

I have read or had this form explained to me, and fully understand the nature of this authorization.

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Client \_\_\_\_\_ Date \_\_\_\_\_

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Staff Signature \_\_\_\_\_ Date \_\_\_\_\_