



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) ~ 732-262-2058 (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.
- Able to work full-time.
- Considered low-income, on TANF and/or be unable to provide adequate housing and support for herself and her children.
- 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
732- 262-2058 (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 ___

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 husbands: _____

Husband or 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 have a criminal record? Yes _____ No _____
Describe: _____

Is he the father of your children? Yes _____ No _____

Is he 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 brothers and sisters:
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:

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 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's Names:	D.O.B./Still Living?	Residence:

Are they your biological parents?

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:

Mother:

Father:

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:

Employer:

Dates of employment:

Job description:

Reason for leaving:

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.

Client Date

Staff Signature Date

Dottie's House Program & Facility



Program Information

- Participants enroll in a two-year program aimed at helping domestic violence survivors escape abuse and become emotionally and financially independent
- Program services offered:
 - Opportunity to reside in a private apartment within a secure building at a confidential location
 - Weekly case management with a clinical social worker
 - Program services include domestic violence groups, individual and group counseling for the women and children, sand play therapy, therapeutic art classes and play groups, tutoring, life skills classes and visits with a therapy dog.
 - Weekly therapy sessions for women and children provided by a licensed therapist
 - Assistance with referrals for social services, childcare, schooling, and legal issues
 - Community Partnership Program with Big Brothers and Big Sisters of Ocean County for children ages 5 and up
- As a participant of the program, families are often able to take advantage of charitable donations made possible by the community. Examples vary, but may include help with holiday shopping and/or holiday gifts, birthday presents, holiday meals, and sometimes free services such as yoga classes, life coach sessions, and beauty salon visits
- Upon Graduation from the program all household items and furniture from the apartment belong to the participant so that they can more easily begin a violence-free life outside of the facility

Facility Information

- 17 Apartments, two-stories, fully furnished and carpeted
 - 10 two-bedroom apartments (\$509/mo. Program fee)
 - 6 three-bedroom apartments (\$610/mo. Program fee)
 - 1 one-bedroom apartment (\$400/mo. Program fee)
 - Security Deposit is required upon acceptance
 - \$400 (1 bedroom)
 - \$500 (2 bedroom)
 - \$600 (3 bedroom)
 - Each apartment is equipped with a living room, eat-in kitchen, bathrooms, washer/dryer and one to three bedrooms
 - Facility is equipped with:
 - 24 Hour Security Monitoring/Alarmed Building
 - Three Private Counseling Rooms
 - Computer Room/Therapy Room
 - Art Room

- Community Room (features similar to a typical living room and kitchen with dining area often used to host children's groups, women's group counseling, crafts, workshops and various communal activities)
- Enclosed Playground
- Communal Courtyard with picnic tables and grills used to host activities in the spring and summer
- Garden

Program Policies:

- Participants must be female, at least 18 years of age, who have survived domestic violence.
- Participants must be employed full time (minimum of 35 hours/week) for a minimum of 2 months consistently or, if attending school part time (minimum of 9 credits), must be employed part time (minimum of 25 hours/week). *Proof of employment and school will be required.*
- Participants must have a clear desire to improve their lives and the lives of their children
- Participants must be willing to sign the Program Manual and abide by the policies for the program duration (24 months). The Program Manual and Agreement becomes a binding contract between the participant and Dottie's House. It is NOT a landlord-tenant relationship. Violations of the Program Manual policies or procedures will result in written warnings and possible termination from the program.
- Participants and their children must agree to participate in ALL services offered at Dottie's House including, but not limited to, individual and group therapy, therapeutic art classes, tutoring and life skills groups.
- No drugs or alcohol. *Random screenings may be performed without notice.*
- No pets allowed.
- Participants should not have contact with their abuser. *Restraining Orders are encouraged.*
- Participants must not give the address of the facility to anyone outside of the program for any reason.
- Participants must adhere to strictly enforced curfews: 10pm weeknights, 12am weekends and most holidays
- Participants may have up to two female adult visitors (all visitor must submit to a criminal background screening). No adult male visitors are permitted on-site at any time.
- Participants are encouraged to not engage in romantic relationships during the program so that they may focus on healing and breaking the cycle of violence
- Individual apartment inspections are conducted randomly.



Acknowledgement and Authorization Regarding Background Investigation



I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION, A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT, AND RIGHT TO OBTAIN MORE INFORMATION REGARDING INVESTIGATIVE CONSUMER REPORTS. I certify that I have read and understand those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by _____ ("the Company")

(NAME OF BUSINESS)

at any time during the hiring process and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, insurance company or other party to furnish any and all background information requested by True Hire, LLC, 11730 Cleveland Ave., N.W., Uniontown, OH 44685, 800.262.7301, info@true-hire.com (the Agency") and/or the Company.

State of Washington applicants and employees only: If the Company requests an investigative consumer report from a consumer reporting agency, you have the right to receive a complete and accurate disclosure of the nature and scope of the investigation requested by Company. You also have the right to request from the Agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Massachusetts and New Jersey applicants and employees only: You have the right to inspect and promptly receive a copy of any investigative consumer report requested by the Company by contacting the Agency identified above directly.

New York applicants and employees only: You have the right, upon request, to be informed of whether or not a consumer report was requested from a consumer reporting agency by contacting the Agency. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report. You may also inspect and receive a copy of the report by contacting the Agency with the contact information above. By signing below, you also acknowledge receipt of Article 23-A of the NY Correction Law.

Minnesota applicants and employees only: You have the right, upon written request to the Agency, to receive a complete and accurate disclosure of the nature and scope of any consumer report. The Agency must make this disclosure within five days of receipt of your request or of Company's request for the report, whichever is later. Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

Oklahoma applicants and employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

California applicants and employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law.

Sign Here

Signature: _____

Date: _____

Print Name: _____



(NAME OF BUSINESS)

Personal Information Needed for Background Investigation

The following information will be used to conduct a background investigation. Please ensure the information below is accurate to the best of your knowledge. Please note that your personal information is confidential and will only be used for background investigation purposes.

Confidential Information Used for Background Checking Purposes Only

PRINT FIRST NAME	MIDDLE INITIAL	LAST	SOCIAL SECURITY NUMBER	DATE OF BIRTH
DRIVER'S LICENSE NUMBER	STATE OF ISSUANCE	PHONE	EMAIL	
PRESENT ADDRESS		CITY, STATE, ZIP	COUNTY	

Please list any previous addresses you have had in the past 7 years:

STREET ADDRESS, CITY, STATE, ZIP	COUNTY	DATES (FROM / TO)
STREET ADDRESS, CITY, STATE, ZIP	COUNTY	DATES (FROM / TO)
STREET ADDRESS, CITY, STATE, ZIP	COUNTY	DATES (FROM / TO)

Please list any former names (i.e. maiden or otherwise) you have used in the past 7 years (including years used):

[1] FORMER NAME	DATES (FROM / TO)
[2] FORMER NAME	DATES (FROM / TO)
[3] FORMER NAME	DATES (FROM / TO)
[4] FORMER NAME	DATES (FROM / TO)

Sign Here **Signature:** _____ **Date:** _____