



MILWAUKEE COUNTY  
HOUSING DIVISION

# Supported Apartment Application

Department of Health and Human Services • Housing Division- Special Needs • Housing Application Form  
600 W Walnut St, Suite 100 • Milwaukee, WI 53212 • 414-278-4369 • Fax: 414-223-1815

**Requirements: 30 days of case notes and copy of detailed treatment plan.**

Date: \_\_\_\_\_ Consumer Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Sex: M  F

Agency: \_\_\_\_\_ Agency Admission Date: \_\_\_\_\_

Case Manager's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Case Manager's Email Address: \_\_\_\_\_ CSP  TCM  CCS

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Income type: \_\_\_\_\_ Amount/Month: \_\_\_\_\_

Payee: \_\_\_\_\_ Payee's Phone: \_\_\_\_\_

Legal Status (✓ all that apply): Voluntary  Chapter 51  Chapter 55/880

Please explain: (Stipulation, Commitment, Exp. Dates, Guardian)

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

Parole/Probation  Sex Offender

Name of Probation/Parole Agent: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Have you ever been evicted from a residence at any time within the last five years? If yes, please explain. Yes No

Date and Reason of Eviction(s): \_\_\_\_\_

\_\_\_\_\_

Do you have any criminal charges pending or have you been convicted of a felony or misdemeanor?  
This does not include minor traffic violations. Note: A yes answer does not automatically disqualify you from tenancy since the nature of the offense, date, and type of offense will be considered.

Yes                      No

If yes, please explain the nature of the offense (s).

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**Current Residence**

Address	Dates of Stay	Landlord Name	Rent Amount	Reason for Leaving

**Previous Residence**

Please list all residences in the past three years, starting with your current landlord.

Address	Dates of Stay	Landlord Name	Rent Amount	Reason for Leaving

Medication Compliance:      Yes                      No

Medication Monitoring Plan: \_\_\_\_\_

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AODA History: \_\_\_\_\_

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ADL's: please rate (poor/fair/good)

Cooking	Cleaning	Hygiene	Laundry

Does the consumer receive FoodShare?      Yes      No      Amount: \_\_\_\_\_

Does the consumer smoke?      Yes      No

If yes, are they currently smoking indoors at their current residence? \_\_\_\_\_

\_\_\_\_\_

Are there any concerns regarding the consumer having a roommate? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In the past 6 months has the consumer had any hospitalizations and/or CRC, Crisis Respite stays?

Yes      No      If yes, please list and explain below:

Location	Dates of stay	Reason

Does the consumer have a history of suicidal ideation, homicidal ideation, history of violence and/or self-harm?      Yes      No      If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List of providers	Name	Location	Phone
Primary Dr.:			
Psychiatrist:			
Therapist:			
Other:			
Other:			
Other:			

How is the consumer transported to their appointments? \_\_\_\_\_

\_\_\_\_\_

Does the consumer need assistance in food shopping?      Yes      No

If yes, please explain who will be assisting them: \_\_\_\_\_

\_\_\_\_\_

Additional notes: \_\_\_\_\_

\_\_\_\_\_

**I certify that all information I have given in this application is true to the best of my knowledge. I understand that intentional falsification of the information provided in this application will immediately void my application for tenancy with Supported Apartments.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature (if applicable)

\_\_\_\_\_  
Date

***HOUSING DIVISION USE ONLY:***

Application Approved: \_\_\_\_\_ Application Denied: \_\_\_\_\_

Denial Reason: \_\_\_\_\_