



SOUTHWIND FIELDS CITY LOCALS PROGRAM APPLICATION

"CITY LOCAL" PERSONAL INFORMATION

FULL NAME: _____

OTHER NAMES YOU HAVE BEEN KNOWN BY: _____

CELL PHONE: (____) _____ - _____ E-MAIL: _____

EMERGENCY CONTACT NAME & NUMBER: _____

RESIDENTIAL OVERVIEW & HISTORY

PLEASE INDICATE YOUR INTEREST IN THE UPCOMING SOUTHWIND FIELDS TINY HOUSE COMMUNITY (PLEASE CIRCLE ONE):

I INTEND TO APPLY FOR THE ALL INCLUSIVE COMMUNITY / WILL RE-EVALUATE AT THE END OF AGREEMENT TERM / NOT INTERESTED

CURRENT ADDRESS: _____

TYPE OF RESIDENCE (CIRCLE ONE):

GROUP HOME ASSISTED LIVING FACILITY TRANSITIONAL PROGRAM STATE SUPPORTED LIVING FACILITY HOSPITAL SHELTER INDEPENDENT RESIDENCE

IF NOT LISTED, PLEASE LIST THE TYPE OF RESIDENCE YOU CURRENTLY LIVE IN: _____

HOW LONG HAVE YOU LIVED IN YOUR CURRENT RESIDENCE: _____ YEARS _____ MONTHS

OWNER/PROPRIETOR OF YOUR CURRENT RESIDENCE: _____

NAME OF CURRENT SERVICE PROVIDER, IF ANY: _____

APPROXIMATE LENGTH OF TIME YOU HAVE RECEIVED SERVICES FROM THIS PROVIDER
(IF NOT APPLICABLE, WRITE "N/A"): _____ YEARS _____ MONTHS

PREVIOUS PLACE OF RESIDENCE (CIRCLE ONE): HOME WITH PARENTS OR GUARDIAN / PREVIOUS PROVIDER

PLEASE LIST ANY AND SUPPORTIVE PROVIDERS FROM WHICH YOU HAVE RECEIVED SERVICES AFTER THE AGE OF 18:

NAME: _____ CITY & STATE SERVICES PROVIDED IN: _____
START DATE OF SERVICES: ____/____/____ END DATE OF SERVICES: ____/____/____
WHY WERE SERVICES TERMINATED? _____

NAME: _____ CITY & STATE SERVICES PROVIDED IN: _____
START DATE OF SERVICES: ____/____/____ END DATE OF SERVICES: ____/____/____
WHY WERE SERVICES TERMINATED? _____

NAME: _____ CITY & STATE SERVICES PROVIDED IN: _____
START DATE OF SERVICES: ____/____/____ END DATE OF SERVICES: ____/____/____
WHY WERE SERVICES TERMINATED? _____

NAME: _____ CITY & STATE SERVICES PROVIDED IN: _____
START DATE OF SERVICES: ____/____/____ END DATE OF SERVICES: ____/____/____
WHY WERE SERVICES TERMINATED? _____

I AM ON A WAITING LIST FOR: TEXAS HOME LIVING / ICF / HCS AND AM NUMBER: _____

INCOME & FINANCIAL INFORMATION

CURRENT EMPLOYER (IF YOU ARE NOT WORKING, WRITE "N/A"): _____

NAME OF IMMEDIATE SUPERVISOR: _____

CONTACT NUMBER FOR IMMEDIATE SUPERVISOR: (_____) _____ - _____

EMPLOYER ADDRESS: _____

AMOUNT OF TIME EMPLOYED THERE: _____ YEARS _____ MONTHS

EMPLOYMENT INTENTIONS: I INTEND TO KEEP MY CURRENT EMPLOYMENT / I NEED A NEW JOB / I DO NOT WANT TO WORK

INTEREST IN SOUTHWIND WORK TEAMS: I WANT TO KEEP MY CURRENT JOB / I'D BE INTERESTED IN A WORK TEAM

APPROXIMATE NUMBER OF HOURS WORKED EACH WEEK: _____

SHIFTS TYPICALLY WORKED: MORNING / AFTERNOON / EVENING / IT VARIES / PRN

HOURLY WAGE: \$_____/HOUR MONTHLY INCOME FROM EMPLOYMENT: \$_____

PAY CYCLE (PLEASE CIRCLE ONE): DAILY / WEEKLY / BI-WEEKLY / MONTHLY

AMOUNT RECEIVED FROM SSI/SSDI, IF APPLICABLE: \$_____/MONTH
 IF YOU ARE IN THE PROCESS OF APPLYING FOR SSI/SSDI OR HAVE APPLIED AND BEEN DENIED, PLEASE INDICATE HERE:_____

IF YOU CURRENTLY RECEIVE SSI, SSDI, OR OTHER INCOME BASED FINANCIAL SUPPORT, PLEASE INDICATE THE NAME OF THE PERSON WHO REPORTS YOUR PAY STUBS/INCOME TO THE FUNDER:_____

IF YOU CURRENTLY RECEIVE SSI/SSDI, PLEASE INDICATE THE NAME OF YOUR REPRESENTATIVE PAYEE (IF YOU ARE YOUR OWN PAYEE, WRITE "SELF"):_____

WHAT IS THE NATURE OF YOUR RELATIONSHIP TO YOUR REP. PAYEE:_____

REP. PAYEE STATUS: I AM HAPPY WITH MY CURRENT REP. PAYEE / I WOULD LIKE A NEW REP. PAYEE / I WOULD LIKE TO BE MY OWN REP. PAYEE

IF YOU WOULD LIKE A NEW REP. PAYEE AND KNOW WHO YOU WOULD PREFER THAT PERSON TO BE, PLEASE INDICATE THEIR NAME HERE:_____

AMOUNT RECEIVED FROM ALTERNATIVE FUNDING SOURCES:\$_____/MONTH

PLEASE INDICATE ALTERNATIVE FUNDING SOURCE:_____

<u>ASSETS</u>	FINANCIAL INSTITUTION	CURRENT BALANCE
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
TRUST FUND		
OTHER FINANCIAL ASSETS		
OTHER FINANCIAL ASSETS		
OTHER FINANCIAL ASSETS		
<u>TOTAL ASSETS</u>	N/A	

<u>DEBT</u>	FUNDER	MONTHLY PAYMENT	CURRENT BALANCE
CAR LOAN			
HOME LOAN			
CREDIT CARD LOAN			
EDUCATIONAL LOAN			
OTHER DEBT			

DEBT	FUNDER	MONTHLY PAYMENT	CURRENT BALANCE
OTHER DEBT			
OTHER DEBT			
TOTAL DEBT	N/A		

FINANCIAL DECISIONS: I MAKE MY OWN FINANCIAL DECISIONS / SOMEONE ELSE HOLD FINANCIAL POWER OF ATTORNEY FOR MY AFFAIRS

IF SOMEONE ELSE HOLDS FINANCIAL POWER OF ATTORNEY, PLEASE INDICATE THEIR NAME AND YOUR RELATIONSHIP TO THEM HERE: _____

SOCIAL SUPPORTS

NAME AND RELATIONSHIP OF THE FIRST PERSON YOU CALL WHEN YOU NEED ASSISTANCE WITH SOMETHING IMPORTANT: _____

I TALK TO THIS PERSON: SEVERAL TIMES EACH DAY / DAILY / SEVERAL TIMES EACH WEEK / WEEKLY / SEVERAL TIMES EACH MONTH / RARELY

I SEE THIS PERSON: SEVERAL TIMES EACH DAY / DAILY / SEVERAL TIMES EACH WEEK / WEEKLY / SEVERAL TIMES EACH MONTH / RARELY

STATUS OF RELATIONSHIP: GREAT / DECENT / IT COULD BE BETTER / UNSTABLE / NOT GREAT, BUT THEY ARE RELIABLE / UNSTABLE

OTHER THAN THE PERSON ABOVE, I RELY ON THIS PERSON FOR ADVICE AND GUIDANCE WHEN I'M TRYING TO MAKE A DECISION: _____

I TALK TO THIS PERSON: SEVERAL TIMES EACH DAY / DAILY / SEVERAL TIMES EACH WEEK / WEEKLY / SEVERAL TIMES EACH MONTH / RARELY

I SEE THIS PERSON: SEVERAL TIMES EACH DAY / DAILY / SEVERAL TIMES EACH WEEK / WEEKLY / SEVERAL TIMES EACH MONTH / RARELY

STATUS OF RELATIONSHIP: GREAT / DECENT / IT COULD BE BETTER / UNSTABLE / NOT GREAT, BUT THEY ARE RELIABLE / UNSTABLE

SOCIAL LIFE: RELATIONSHIPS ARE DIFFICULT FOR ME / I HAVE A SMALL GROUP OF ACQUAINTANCES / I HAVE ONE OR TWO CLOSE FRIENDS / I'M VERY SOCIAL

IF GIVEN THE OPPORTUNITY, I LIKE TO: INTERACT WITH MY FRIENDS DAILY / GO OUT ONCE OR TWICE A WEEK / STAY AT HOME

WHETHER WITH FRIENDS OR ALONE, I PREFER TO: STAY BUSY / LOUNGE AROUND / SPEND QUIET TIME ALONE

WHEN I LEAVE MY HOME, I PREFER TO GET AROUND: ON FOOT / BY BUS / IN MY CAR / UBER OR LYFT / VIA TRANS

I HAVE: MY OWN CAR / VIA TRANS ACCESS / A BUS PASS / UBER OR LYFT APP

GUARDIANSHIP STATUS: OWN GUARDIAN / PARENT IS LEGAL GUARDIAN / RELATED LEGAL GUARDIAN / COURT APPOINTED LEGAL GUARDIAN

IF YOU ARE NOT YOUR OWN GUARDIAN, PLEASE INDICATE THE NAME AND RELATIONSHIP OF THE PERSON WHO HOLDS LEGAL GUARDIANSHIP: _____

MEDICAL INFORMATION

OFFICIAL DIAGNOSIS: _____

CURRENT PRIMARY CARE PHYSICIAN: _____

PHONE NUMBER FOR CURRENT PRIMARY CARE PHYSICIAN: (____) _____ - _____

I SEE THE FOLLOWING SPECIALISTS:

NAME: _____ PHONE NUMBER: (____) _____ - _____
SPECIALTY: _____

NAME: _____ PHONE NUMBER: (____) _____ - _____
SPECIALTY: _____

NAME: _____ PHONE NUMBER: (____) _____ - _____
SPECIALTY: _____

NAME: _____ PHONE NUMBER: (____) _____ - _____
SPECIALTY: _____

NAME: _____ PHONE NUMBER: (____) _____ - _____
SPECIALTY: _____

LAST EYE EXAM: ____/20____ I WEAR (CIRCLE AT LEAST ONE): GLASSES / CONTACTS / BOTH / NONE

LAST DENTAL CLEANING: ____/20____ I WEAR (CIRCLE ONE): BRACES / RETAINERS / DENTURES / NONE

IF YOU HAVE A MEDICAL DEVICE IMPLANTED IN YOUR BODY, PLEASE INDICATE THE TYPE AND LOCATION OF THE IMPLANT: _____

I TAKE THE FOLLOWING MEDICATIONS:

MEDICATION NAME: _____	DOSAGE: _____
MEDICATION NAME: _____	DOSAGE: _____
MEDICATION NAME: _____	DOSAGE: _____
MEDICATION NAME: _____	DOSAGE: _____
MEDICATION NAME: _____	DOSAGE: _____
MEDICATION NAME: _____	DOSAGE: _____
MEDICATION NAME: _____	DOSAGE: _____
MEDICATION NAME: _____	DOSAGE: _____

MEDICATION ADMINISTRATION: SELF-MED / I NEED SOME ASSISTANCE / I CANNOT ADMINISTER MY OWN MEDICATIONS

CURRENT MEDICATION STATUS: I AM CONSISTENT IN TAKING MY MEDS / I AM INCONSISTENT WITH TAKING MY MEDS

(STAFF ONLY) NURSING CONCERNS: _____

PSYCHOLOGICAL INFORMATION

MENTAL ILLNESS DIAGNOSES (IF NONE, WRITE "N/A"): _____

CURRENTLY, I AM: MENTALLY STABLE / I FEEL AS THOUGH I AM STRUGGLING PSYCHOLOGICALLY / OTHERS ARE WORRIED ABOUT MY CURRENT BEHAVIOR

NAME OF CURRENT COUNSELOR (IF NONE, WRITE "N/A": _____

PHONE NUMBER OF CURRENT COUNSELOR: (____) ____ - _____

IF YOU ARE NOT CURRENTLY SEEING A COUNSELOR, INDICATE THE NAME AND NATURE OF ANY PSYCHOLOGICAL ASSISTANCE OR SUPPORT YOU HAVE RECEIVED IN THE PAST:

IF YOU HAVE EVER BEEN HOSPITALIZED FOR MENTAL HEALTH ISSUES, PLEASE INDICATE THE NATURE, LOCATION, AND REASON BELOW (IF NEVER, LEAVE BLANK):

SELF SUFFICIENCY

THE FOLLOWING QUESTIONS SHOULD BE ANSWERED BASED ON YOUR OWN PERSPECTIVE. PLEASE UNDERSTAND THAT EACH SKILL SET/TOPIC MAY BE EVALUATED AT THE DISCRETION OF SOUTHWIND FIELDS STAFF BEFORE ADMITTANCE TO THE PROGRAM AND AGAIN, INTERMITTENTLY, THROUGHOUT YOUR PARTICIPATION IN THE CITY LOCALS PROGRAM, AT THE DISCRETION AND/OR REQUEST OF ANY MEMBER OF YOUR CARE TEAM.

PARTICIPANT EVALUATION:

UNDERSTANDING OF EXPECTATIONS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

ABILITY TO FOLLOW DIRECTIONS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

COMMITMENT TO MEET PROGRAM EXPECTATIONS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

WILLINGNESS TO PARTICIPATE IN ACTIVITIES: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

WILLINGNESS TO MEET REGULARLY WITH STAFF: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

SELF TRANSPORTATION SKILLS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

MONEY MANAGEMENT SKILLS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

TO COMMUNICATE PERSONAL NEEDS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

COOKING SKILLS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

INTERACTION WITH FAMILY: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

SOCIAL SKILLS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

PERSONAL HYGIENE SKILLS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

ABILITY TO DO LAUNDRY INDEPENDENTLY: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

ABILITY TO MAINTAIN PERSONAL LIVING SPACE: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

ABILITY TO LIVE INDEPENDENTLY: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

MOTIVATION TO MAINTAIN EMPLOYMENT: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

UNDERSTANDING OF MEDICAL NEEDS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

UNDERSTANDING OF PSYCHOLOGICAL NEEDS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

STAFF EVALUATION (TO BE COMPLETED BY SOUTHWIND FIELDS STAFF ONLY):

UNDERSTANDING OF EXPECTATIONS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

ABILITY TO FOLLOW DIRECTIONS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

COMMITMENT TO MEET PROGRAM EXPECTATIONS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

WILLINGNESS TO PARTICIPATE IN ACTIVITIES: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

WILLINGNESS TO MEET REGULARLY WITH STAFF: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

SELF TRANSPORTATION SKILLS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

MONEY MANAGEMENT SKILLS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

TO COMMUNICATE PERSONAL NEEDS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

COOKING SKILLS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

INTERACTION WITH FAMILY: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

SOCIAL SKILLS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

PERSONAL HYGIENE SKILLS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

ABILITY TO DO LAUNDRY INDEPENDENTLY: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

ABILITY TO MAINTAIN PERSONAL LIVING SPACE: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

ABILITY TO LIVE INDEPENDENTLY: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

MOTIVATION TO MAINTAIN EMPLOYMENT: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

UNDERSTANDING OF MEDICAL NEEDS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

UNDERSTANDING OF PSYCHOLOGICAL NEEDS: UNABLE / LIMITED / NEUTRAL / GOOD / STRONG

AREAS OF CONCERN:

AREAS OF STRENGTH:

COMMENTS:

COMPLETED BY: (PRINT NAME/TITLE): _____

(SIGNATURE/DATE): _____

RESPONSIBLE PARTY

A "RESPONSIBLE PARTY" INDICATES THE INDIVIDUAL(S) WHO MAY BE CONTACT IN THE EVENT OF EMERGENCY OR OTHER CONCERN AS IT PERTAINS TO YOUR PARTICIPATION IN THE SOUTHWIND FIELDS CITY LOCALS PROGRAM. THIS PERSON MAY BE A PARENT, ADULT SIBLING, INVOLVED FAMILY MEMBER, LEGAL GUARDIAN, OR OTHER NAMED, INVOLVED INDIVIDUAL. THIS PERSON MAY BE GIVEN INFORMATION REGARDING YOUR PARTICIPATION IN THE PROGRAM AS DEEMED APPROPRIATE FOR YOUR SAFETY AND INDEPENDENCE. IF YOU DO NOT WISH FOR ANYONE TO BE CONTACTED REGARDING YOUR PARTICIPATION IN THE PROGRAM, PLEASE LEAVE THIS SECTION BLANK.

- 1) NAME: _____ RELATIONSHIP: _____
PHONE NUMBER: (____)____-_____ E-MAIL: _____
ADDRESS: _____
- 2) NAME: _____ RELATIONSHIP: _____
PHONE NUMBER: (____)____-_____ E-MAIL: _____
ADDRESS: _____

LEGAL DISCLAIMERS

PLEASE READ THIS SECTION VERY CAREFULLY AND ASK QUESTIONS IF YOU DO NOT UNDERSTAND SOMETHING. WE WILL BE HAPPY TO ASSIST YOU WITH UNDERSTANDING. YOU MAY ALSO ASK ANYONE WHOM YOU TRUST TO HELP YOU UNDERSTAND WHAT YOU ARE READING AND MAY HAVE THIS DOCUMENT READ TO YOU BY A SOUTHWIND FIELDS STAFF. BY SIGNING THIS DOCUMENT, YOU ARE AGREEING THAT YOU FULLY UNDERSTAND EACH AREA OF THE APPLICATION AND HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND TO THE BEST OF YOUR KNOWLEDGE.

I, _____, CERTIFY THAT I HAVE ANSWERED ALL AREAS OF THE ABOVE APPLICATION TO THE BEST OF MY ABILITY AND KNOWLEDGE. I CERTIFY THAT I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND HAVE NOT MADE ANY EFFORT TO DECEIVE A MEMBER OF THE SOUTHWIND FIELDS STAFF OR ANY REPRESENTATIVE OF THE ORGANIZATION. I UNDERSTAND THAT ANY DISCREPANCY OR FAILURE TO COMPLETE ANY SECTION OF THIS APPLICATION MAY MY BEING DECLINED FOR ADMITTANCE TO THE SOUTHWIND FIELDS CITY LOCALS PROGRAM. I UNDERSTAND THAT I AM FULLY RESPONSIBLE TO MAINTAIN MY OWN LEASE OR CURRENT HOUSING ARRANGEMENT AND IT IS NOT THE RESPONSIBILITY OF SOUTHWIND FIELDS TO MEET MY PERSONAL LEASE AGREEMENTS FINANCIALLY OR OTHERWISE. I UNDERSTAND THAT THIS IS NOT A LEASE OR AGREEMENT FOR HOUSING AND PERTAINS ONLY TO MY ABILITY TO MEET THE REQUIRED FEES ASSOCIATED WITH SOUTHWIND FIELDS SERVICES AS WELL AS THE INDEPENDENT LIVING SKILLS NECESSARY TO PARTICIPATE IN THE SOUTHWIND FIELDS CITY LOCALS PROGRAM. I UNDERSTAND THAT FAILURE TO MAINTAIN MY CURRENT LIVING ARRANGEMENT OR INDEPENDENT LIVING SKILLS MAY RESULT IN DISMISSAL FROM THE SOUTHWIND FIELDS CITY LOCALS PROGRAM. I ALSO UNDERSTAND THAT FAILURE TO PROVIDE NECESSARY DOCUMENTATION AS OUTLINED BELOW OR PAY REQUIRED PROGRAM FEES MAY RESULT IN MY DISMISSAL FROM THE SOUTHWIND FIELDS CITY LOCALS PROGRAM.

SIGNATURE OF APPLICANT: _____ DATE: _____
PRINTED NAME OF PERSON ASSISTING APPLICANT WITH APPLICATION: _____ RELATIONSHIP: _____
SIGNATURE OF PERSON ASSISTING APPLICANT WITH APPLICATION: _____ DATE: _____

REQUIRED DOCUMENTATION

THIS SECTION TO BE COMPLETED BY SOUTHWIND FIELDS STAFF ONLY. EACH LISTED DOCUMENT MUST BE ACCOUNTED FOR BY SOUTHWIND FIELDS STAFF. FAILURE TO PROVIDE REQUIRED DOCUMENTATION MAY PROHIBIT APPROVAL OF THIS APPLICATION. SOME DOCUMENTS MAY BE WAIVED AT THE DISCRETION AND APPROVAL OF SOUTHWIND FIELDS CHIEF EXECUTIVE OFFICER, CHIEF OPERATIONS OFFICER, OR CHIEF PROGRAM OFFICER ONLY.

- VALID DRIVER'S LICENSE OR STATE ISSUED ID
 - BIRTH CERTIFICATE
 - SOCIAL SECURITY CARD
 - INSURANCE CARD (S)
 - SSI DETERMINATION LETTER (IF ANY)
 - DRIVER'S INSURANCE (IF APPROPRIATE)
 - PSYCHIATRIC EVALUATION (IF ANY)
 - TWO RECENT PAY STUBS (IF APPROPRIATE)
 - PROOF OF CURRENT RESIDENCE IF LIVING IN GROUP HOME OR OWN RESIDENCE
 - ALL OTHER SOUTHWIND FIELDS ADMISSIONS PACKET DOCUMENTATION AS PROVIDED
 - \$50 APPLICATION FEE
 - \$250 REGISTRATION FEE - DUE BEFORE START OF SERVICES/MOVE-IN DATE
-

****SOUTHWIND FIELDS STAFF ONLY****

I, _____, WITH THE TITLE OF _____, CERTIFY THAT THIS APPLICATION HAS BEEN REVIEWED THOROUGHLY AND WITHOUT BIAS. MY SIGNATURE INDICATES THAT I HAVE EXAMINED EACH AREA OF THE APPLICATION TO THE BEST OF MY ABILITY AND SKILL SET. THE DECISION LISTED BELOW IS THAT OF MAJORITY VOTE OF THE DESIGNATED REVIEW TEAM, SET FORTH BY SOUTHWIND FIELDS PRESIDENT/CEO, SOUTHWIND FIELDS VICE-PRESIDENT/COO, OR SOUTHWIND FIELDS VICE-PRESIDENT/CPO AND HAS BEEN CAREFULLY CONSIDERED THROUGH CONVERSATION AND REVIEW OF APPROPRIATE DOCUMENTATION.

SIGNATURE OF SOUTHWIND FIELDS STAFF MEMBER LISTED ABOVE: _____

DATE OF APPLICATION REVIEW: ____/____/____

DATE OF APPLICATION DECISION: ____/____/____

■ APPROVED

■ DECLINED

REASON(S) FOR DECLINATION: _____

IF DECLINED, MAY APPLICANT RE-APPLY AT A LATER DATE: YES / NO

PERSON NOTIFIED OF DECISION: _____ RELATIONSHIP TO APPLICANT: _____

DATE OF NOTIFICATION: ____/____/____

DECISION DELIVERED BY (PRINT): _____ TITLE: _____