



Admissions Application

Full Name:		Date Submitted:
Referred by:	Staff Contact:	Relationship to applicant:
Address:	Phone:	Fax:
What services are you seeking?:		
CLIENT INFORMATION:		
Full Name:		SS#:
Have you ever been known by another name? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, write name(s) below and complete next box below.</i>		DOB:
		Gender:
Alternate Name Type: <input type="checkbox"/> Alias <input type="checkbox"/> Nickname <input type="checkbox"/> Married Name <input type="checkbox"/> Name at Birth <input type="checkbox"/> Prior Marriage Name <input type="checkbox"/> Other: _____		Sexual Orientation:
Primary Language: <input type="checkbox"/> Spanish <input type="checkbox"/> English <input type="checkbox"/> Other: _____	Preferred Language for Intake: <input type="checkbox"/> Spanish <input type="checkbox"/> English <input type="checkbox"/> Other: _____	
Last Known Address:		Who were you living with? _____
City:	State:	Zip:
Do we have permission to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone:
Have you participated in this program before? <input type="checkbox"/> Yes <input type="checkbox"/> No		If homeless, for how long? _____
<i>If no phone, who should we contact to follow up regarding an intake?</i>		Phone:
NAME:		Relationship:
EMERGENCY CONTACT-Name:		Phone:
Address:		Phone:
Do we have permission to leave a message at this number?		<input type="checkbox"/> Yes <input type="checkbox"/> No

HOUSING

Do you currently have Section 8 or other subsidized housing in your name? Yes No

What is current housing status (Where did you stay last night)?

- | | | |
|---|---|--|
| <input type="checkbox"/> Emergency Shelter | <input type="checkbox"/> Jail/Prison | <input type="checkbox"/> Condominium/house you own |
| <input type="checkbox"/> Room/apartment/house you rent | <input type="checkbox"/> Psychiatric hospital/facility | <input type="checkbox"/> Stay ng /living with a relative |
| <input type="checkbox"/> Substance abuse treatment facility | <input type="checkbox"/> Detox Facility | <input type="checkbox"/> Staying/living with a friend |
| <input type="checkbox"/> Non-psychiatric hospital | <input type="checkbox"/> Hotel paid for without emergency shelter voucher | <input type="checkbox"/> Place not meant for habitation (e.g. bench, street) |
| <input type="checkbox"/> Don't Know | <input type="checkbox"/> Refused | <input type="checkbox"/> Other: _____ |

If renting, monthly cost? _____ **Is your current housing situation safe:** Yes No

What are your housing needs?

MEDICAL INFORMATION:

Do you receive regular medical care? Yes No

Date of Last Visit:

If yes: Primary care provider:

Hospital/Clinic:

Phone Number:

Other health care agencies you are involved with? (CMA, VNA, etc.)

Do you use any mobility aids? (Check all that apply):

- None Crutches/Cane Walker Manual wheelchair Electric wheelchair Other: _____

Impairments:

Vision Impairment: Yes No Hearing Impairment: Yes No

Self Care/ADL Impairment: Yes No Mental Retardation: Yes No

Which of the following conditions have you been diagnosed with?

- None Diabetes Heart Disease Asthma
 Hepatitis (A, B, C) HIV Other: _____

If HIV positive:
Date of HIV Diagnosis?

Are you currently being medically treated for any of these condition(s)? Yes No

Do you have any neurological involvement related to your HIV status? Yes No

If yes, please describe:

Do you currently take any medications? (Including prescription, psychotropic, OTC, herbal, etc.)

Yes No

Medication	Rationale/ Condition	Dose/Route/ Frequency

Do you have any known allergies? Yes (*If yes, list below*) No Unsure

Food(s): _____

Medication(s): _____

Environmental: _____

FAMILY INFORMATION**What is your current marital status?**

- Legally married (*If yes, total # times: _____*) Single with common-law partner
 Divorced Separated Single, never married Widowed

Name of significant other (if applicable)?
_____**Has there been violence in this relationship?**

-
- Yes
-
- No

Restraining Order? Yes No

If yes, which court? _____

Is it still in effect? Yes No**Partner's substance abuse history, if any:****Do you have any children?** Yes No Refused Unknown*If yes: How many?* _____**Do you have legal custody?** Yes No**Do you have physical custody?** Yes No**If no, is your goal to reunify?** Yes No

Is DCF involved with any of these children?

-
- Yes
-
- No

Ages & Gender:

Ages & Gender:

Ages & Gender:

Ages & Gender:

Are you the primary caregiver for these children?

 Yes No

Do you need assistance with childcare?

 Yes No

Have you made arrangements for a caretaker while in this program?

 Yes No

Where are the children currently residing: _____

EDUCATIONAL/VOCATIONAL HISTORY:

Highest Level of Education Completed: Grade: _____ College: _____

Do you have any vocational/special training or certificates? Yes No If yes, which?Do you have any learning disabilities that you are aware of? Yes No If yes, which?**LEGAL OBLIGATIONS:**Do you have any current/pending legal cases/obligations? Yes No

Do you have any outstanding warrants?

 Yes No

If yes, what is the status of these cases/obligations (outcomes and/or sentencing)?:

Parole/Probation Officer (If applicable):

Phone :

Address:

Date of last visit with PO?

Have you ever been a gang member? Yes No

If yes, name of gang?

If yes, are you a current gang member? Yes No

If yes, name of gang?

Any other legal responsibilities that may compromise your treatment/recovery process? Yes No*If yes, what are they?*

MENTAL HEALTH/ PSYCHIATRIC HISTORY:

Are you currently receiving any type of mental health services? Yes No

If yes, how frequently?

Date of last visit?

If no, have you ever received any type of mental health/psychiatric/psychological services? Yes No

If yes currently or ever, What types of service(s)/treatment have you received? (Check all that apply):

- Residential/supportive housing Outpatient Assertive community treatment
 Day/Intensive outpatient treatment Psychiatric inpatient/hospitalization Treatment/rehab/clubhouse (non-substance use related)
 Other: _____

Type	Dates	Reason	Provider/Agency Info (Name and Phone):	Completed?
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing

Was treatment helpful? Yes No

Past/Current Diagnoses:

If known, source(s) of information: Client Treatment records Other provider

Significant other/family member Unofficial/suspected diagnosis Other: _____

Any history of eating disorders? Yes No

If yes, have you received treatment for it? Yes No

If yes, what type? Anorexia Nervosa Bulimia Nervosa Other: _____

RISK ASSESSMENT

Have you ever thought about harming yourself or someone else? Yes No

If yes, did you have a plan and when was the last time you thought about harming yourself?

Have you ever intentionally injured/harmed yourself or someone else? Yes No

If yes, did you have a plan and when was the last time you harmed yourself or someone else?

SUBSTANCE USE AND TREATMENT HISTORY:

Primary substance use (i.e. alcohol, cocaine, crack, heroin)?		Frequency:
# Years <u>Active</u> Use:	Age Began:	First Substance Used:
Age when substance use became a problem:		Date of last use:
Longest period drug free:	Dates:	How do you support your substance use?
Have you ever participated in any type of substance use treatment before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which <input type="checkbox"/> Detox, # times ____ <input type="checkbox"/> Outpatient, # times ____ <input type="checkbox"/> Inpatient/Residential, # times ____		
Why did you leave?	Have you ever attended a 12-step program? <input type="checkbox"/> AA <input type="checkbox"/> NA	
Are there other addictive behaviors you or others are concerned about (food, gambling, exercise, sex, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please describe.</i>		
Are you <u>currently</u> on medication-assisted therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>If yes, start date:</i>
<input type="checkbox"/> Suboxone	Dosage:	Provider: Phone:
<input type="checkbox"/> Methadone	Dosage:	Provider: Phone:
<input type="checkbox"/> Naltrexone	Dosage:	Provider: Phone:
<input type="checkbox"/> Other:	Dosage:	Provider: Phone:

Insurance Type (Check all that apply):

<input type="checkbox"/> Medicaid/Mass Health	<input type="checkbox"/> Medicare (over 65 or disabled)
<input type="checkbox"/> OT-State subsidy (e.g. Commonwealth Care, Health Safety Net)	<input type="checkbox"/> HMO (private insurance through employer or client pay)
<input type="checkbox"/> Uninsured	<input type="checkbox"/> Other:
<input type="checkbox"/> Application Pending	
Insurance Co.: _____	Policy Name: _____
Policy #: _____	Group #: _____
	Policy Start Date: _____

Do you have any other insurance? Yes No *If yes:*

Insurance Co.: _____	Policy Name: _____
Policy #: _____	Group #: _____
	Policy Start Date: _____

FINANCIAL INFORMATION:**Source of Income (Check all that apply):**

<input type="checkbox"/> Wages/salary	<input type="checkbox"/> Alimony	<input type="checkbox"/> Veteran's Pension	<input type="checkbox"/> Child Support
<input type="checkbox"/> Public assistance-general	<input type="checkbox"/> Public assistance-AFDC	<input type="checkbox"/> Worker's compensation	<input type="checkbox"/> Cash income
<input type="checkbox"/> Disability-SSI	<input type="checkbox"/> Disability-SSDI	<input type="checkbox"/> Disability-Veterans	<input type="checkbox"/> Disability-Private
<input type="checkbox"/> Social Security	<input type="checkbox"/> Unemployment	<input type="checkbox"/> None	<input type="checkbox"/> Other: _____

Total Client Income: _____ Income Frequency: Weekly Bi-weekly Monthly Annually

ADDITIONAL COMMENTS/NOTES:

Signature of Client:

Date:

Signature of Interviewer:

Date:

FOR OFFICE USE ONLY

Date referral received:

Date of first contact:

Record Number:

Schedule Interview?

If yes, which interview? Phone Face-to-Face

Yes No

If no, why?

Signature of Director: _____

Date: