



## 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: _____	Phone: _____
Do we have permission to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	If homeless, for how long? _____
Have you participated in this program before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If no phone, who should we contact to follow up regarding an intake?</i> NAME:	Phone:
EMERGENCY CONTACT-Name:	Relationship:
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"/> Staying/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      Developmental Disability:  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: \_\_\_\_\_

<b>FAMILY INFORMATION</b>			
<b>What is your current marital status?</b>			
<input type="checkbox"/> Legally married ( <i>If yes, total # times: _____</i> )		<input type="checkbox"/> Single with common-law partner	
<input type="checkbox"/> Divorced <input type="checkbox"/> Separated		<input type="checkbox"/> Single, never married <input type="checkbox"/> Widowed	
<b>Name of significant other (if applicable)?</b> _____		<b>Has there been violence in this relationship?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Restraining Order?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which court? _____		Is it still in effect? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Partner's substance abuse history, if any:</b>			
<b>Are you pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		<i>If yes:</i> Due Date: _____	
<b>Do you have any children?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Unknown		<i>If yes:</i> How many? _____	
<b>Do you have legal custody?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Do you have physical custody?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If no, is your goal to reunify?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		Is DCF involved with any of these children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ages & Gender:	Ages & Gender:	Ages & Gender:	Ages & Gender:
Are you the primary caregiver for these children?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need assistance with childcare?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you made arrangements for a caretaker while in this program?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Where are the children currently residing: _____			
<b>EDUCATIONAL/VOCATIONAL HISTORY:</b>			
Highest Level of Education Completed: Grade: _____ College: _____			
Do you have any vocational/special training or certificates? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, which?			
Do you have any learning disabilities that you are aware of?    If yes, which?			
<b>LEGAL OBLIGATIONS:</b>			
Do you have any current/pending legal cases/obligations? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have any outstanding warrants? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	
<b>Have you recently been released from a 4-month+ incarceration?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, When?</i> _____			
<b>Have you ever been gang affiliated?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, name of gang?		<i>If yes, are you currently gang affiliated?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of gang?	
<b>Do you have a history of fire-setting?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Are you a registered sex offender?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

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: \_\_\_\_\_

Number of psychiatric inpatient hospitalizations: \_\_\_\_\_ Date of most recent: \_\_\_\_\_

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 Active 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?
<b>Have you ever participated in any type of substance use treatment before?</b> <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? AA 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?

Yes  No

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

If no, why?

Signature of Director: \_\_\_\_\_

Date:

**FOR MANAGEMENT USE ONLY**

**Schedule Intake?**     Yes             No

*If no, choose reason:*     Need more information     Requires face-to-face meeting     Not appropriate  
for our level of care

**Next Steps:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature of Director:** \_\_\_\_\_ **Date:** \_\_\_\_\_