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? □ Yes □ No *If yes, write name(s) below and complete next box below.*	DOB: Gender:
Alternate Name Type: □ Alias □ Nickname □ Married Name □ Name at Birth □ Prior Marriage Name □ Other: _____	Sexual Orientation:
Primary Language: ☐ Spanish ☐ English ☐ Other: _____	Preferred Language for Intake: ☐ Spanish ☐ English ☐ Other: _____
Last Known Address:	Who were you living with? _____
City: State: Zip:	Phone:
Do we have permission to leave a message at this number? □ **Yes** □ **No**	If homeless, for how long? _____
Have you participated in this program before? □ Yes □ No	
If no phone, who should we contact to follow up regarding an intake ? NAME:	Phone:
EMERGENCY CONTACT-Name:	Relationship:
Address:	Phone:
Do we have permission to leave a message at this number? □ Yes □ 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)?

□ Emergency Shelter □ Jail/Prison □ Condominium/house you own
□ Room/apartment/house you rent □ Psychiatric hospital/facility □ Staying/living with a relative
□ Substance abuse treatment facility □ Detox Facility □ Staying/living with a friend
□ Non-psychiatric hospital □ Hotel paid for without emergency shelter voucher □ Place not meant for habitation (e.g. bench, street)
□ Don't Know □ Refused □ 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?	*If HIV positive*:
□ None □ Diabetes □ Heart Disease □ Asthma	Date of HIV Diagnosis?
□ Hepatitis (A, B, C) □ HIV □ Other: _____	

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:	
Are you pregnant? □ Yes □ No □N/A	*If yes:* Due Date: _____
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? 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 recently been released from a 4-month+ incarceration? ☐Yes ☐No *If yes*, When? _____	
Have you ever been gang affiliated? □ Yes □ No If yes, name of gang?	*If yes*, are you currently gang affiliated? □ Yes □ No If yes, name of gang?
Do you have a history of fire-setting? □ Yes □ No	**Are you a registered sex offender?** □ Yes □ 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?
				□ Yes □ No □ Ongoing
				□ Yes □ No □ Ongoing
				□ Yes □ No □ Ongoing
				□ Yes □ No □ Ongoing

Was treatment helpful? □ Yes □ No

Past/Current Diagnoses:

Diagnosis Type	Diagnosis Date

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?	
Have you ever participated in any type of substance use treatment before? □ Yes □ No *If yes, which?* □ Detox, # times ____ □ Outpatient, # times ____ □ 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.)? □ Yes □ No *If yes, please describe*:			
Are you currently on medication-assisted therapy? □ Yes □ No			*If yes*, start date:
□ Suboxone	Dosage:	Provider:	Phone:
□Methadone	Dosage:	Provider:	Phone:
□Naltrexone	Dosage:	Provider:	Phone:
□Other:	Dosage:	Provider:	Phone:

Insurance Type (*Check all that apply*):

□ Medicaid/Mass Health
□ OT-State subsidy (e.g. Commonwealth Care, Health Safety Net)
□ Uninsured
□ Application Pending
□ Medicare (over 65 or disabled)
□ HMO (private insurance through employer or client pay)
□ Other:

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*):

□ Wages/salary	□ Alimony	□ Veteran's Pension	□ Child Support
□ Public assistance-general	□ Public assistance-AFDC	□ Worker's compensation	□ Cash income
□ Disability-SSI	□ Disability-SSDI	□ Disability-Veterans	□ Disability-Private
□ Social Security	□ Unemployment	□ None	□ 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:

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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:** _____