

WESTERN NEW YORK COMMUNITY RESIDENTIAL PLACEMENT APPLICATION
TO BE COMPLETED BY REFERRING AGENCY & APPLICANT

Please complete this section carefully. Adequate diagnostic information and documentation is essential to a prompt and informed intake decision.

Client name _____

Residence prior to entering treatment (if applicable) _____

(Number) _____ (Street) _____

(City/Town) _____ (County) _____ (State) _____ (Zip code) _____

(____) _____

Telephone number _____ Date of birth _____ Social Security number _____

Reason for not returning to the previous address at this time _____

1. Are you currently receiving Social Services benefits? _____ Are you receiving SSI or SSD benefits? _____. If yes, complete the following:

Case name & number _____ Case worker _____

Amount of benefit _____ Medicaid # _____ Managed Care Provider _____

2. Have you ever been refused/sanctioned for Social Services or Social Security benefits? _____ If yes, explain _____

3. Are relationships an addiction or a problem for you? _____. How are relationships a factor in your chemical dependency and recovery _____

4. Education - circle the highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 ____ 2 years ____ 4 years ____ Grad Please indicate diplomas, degrees, trade school certificates etc. _____

5. Are you currently receiving medical treatment? _____. If yes, explain _____

Current medication(s) _____

Physician name _____ Phone # _____

Clinic name & location _____

Primary care physician/clinic & location (if different from above) _____

Date and results of last TB test _____

6. List previous alcohol and drug detox, inpatient, outpatient and/or residential treatment history.

FACILITY NAME	MONTH & YEAR	LENGTH OF STAY/INDICATE COMPLETION
---------------	--------------	------------------------------------

7. Have you used drugs other than alcohol? _____. If yes, describe.

WESTERN NEW YORK COMMUNITY RESIDENTIAL PLACEMENT APPLICATION

TYPE	FREQUENCY	ROUTE OF INGESTION	DATE OF LAST USE
-------------	------------------	---------------------------	-------------------------

8. Has an Alcohol Dependence Diagnosis been assigned to the client?_____.
 If yes, by whom?_____ Date this diagnosis was given_____.

9. Has a Substance Abuse Diagnosis been assigned to the client?_____.
 If yes, by whom?_____ Date this diagnosis was given_____.

10. Are you receiving or have you ever received mental health treatment?_____. If yes, answer the following:

EVENTS LEADING TO TREATMENT	PROGRAM	LENGTH OF STAY	DATES	STAFF CONTACT
------------------------------------	----------------	-----------------------	--------------	----------------------

11. Has a Mental Health Diagnosis been assigned?_____.
 If yes, by whom_____ When _____
 Diagnosis_____

12. Legal information:

a. Current Probation _____ Probation Officer's Name_____

Telephone Number_____

b. Current Parole_____ Parole Officer's Name_____

Telephone Number_____

c. Are you mandated to treatment?_____.

d. Current pending court appearance - explain_____

e. Do you have any outstanding warrants?_____. If yes, explain_____

f. Have you been convicted of any crimes?_____. Have you been incarcerated?_____.

If yes, list the charges with approximate dates_____

g. Has the applicant assaulted others or violently acted out?_____.
 If yes, explain_____

h. Has the applicant accidentally or intentionally set fires?_____.
 Has the applicant been charged or convicted of arson?_____.
 If yes, explain_____

i. Does the applicant possess a history of rape or sexual abuse?_____.
 If yes, explain_____

NOTE: YOU MUST RETURN THE MOST RECENT PSYCHO-SOCIAL ASSESSMENT AND A RELEASE WITH THIS APPLICATION FORM.

NOTE: AN INTERVIEW APPOINTMENT WILL NOT BE SCHEDULED UNTIL THIS APPLICATION AND THE PSYCHO-SOCIAL ASSESSMENT ARE RECEIVED BY THIS AGENCY.

 Applicant's signature Date

 Staff member's signature Date/phone number site/applic 10/8/97