

## ADDICTION RECOVERY PROGRAM ADMISSION APPLICATION

IN PERSON  TELEPHONE  MAIL  FAX  ONLINE

Date \_\_\_\_\_ Completed By \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

Age \_\_\_\_ Current Marital Status  Single (Never Married)  Married  Divorced \_\_\_\_\_

Are you currently in Fort Wayne?  Yes  No, I am in \_\_\_\_\_

**Housing Status**  Homeless: where are you staying and how did you end up there? For how long?

\_\_\_\_\_

<input type="checkbox"/> Homeless Shelter	<input type="checkbox"/> Transitional Living/Treatment Facility
<input type="checkbox"/> Eviction (with no resources for housing)	<input type="checkbox"/> Own home/rental
<input type="checkbox"/> Incarcerated (County and release date)	<input type="checkbox"/> Friends/Family

\_\_\_\_\_

**How did you hear about YWCA Northeast Indiana's Addiction Recovery Program?**

\_\_\_\_\_

Are you pregnant?  Yes  No

Do you have an open DCS case  Yes  No (If yes, provide County and FCM name and contact information)

\_\_\_\_\_

List your children by name, age, and their living situation.

\_\_\_\_\_

Family Physician \_\_\_\_\_

If you do not have a family physician, where do you go for medical care?

\_\_\_\_\_

Medical Problems \_\_\_\_\_

**Mental Health Care Providers** (ex. Psychiatrist, Counselor, Therapist)

Name \_\_\_\_\_ Location and Phone # \_\_\_\_\_

Name \_\_\_\_\_ Location and Phone # \_\_\_\_\_

Do you have a psychiatric diagnosis?  Yes  No

If yes, please list what, when, and by whom (ex. PTSD, 2006, Dr. Smith at Mental Health, Inc.).

\_\_\_\_\_

**Medications**

Name & Reason \_\_\_\_\_ Name & Reason \_\_\_\_\_

Name & Reason \_\_\_\_\_ Name & Reason \_\_\_\_\_

Name & Reason \_\_\_\_\_ Name & Reason \_\_\_\_\_

**Employment Status**

\_\_\_\_ Employed    Place of employment \_\_\_\_\_  
\_\_\_\_ Unemployed    Date and place of last employment \_\_\_\_\_ SSI \_\_\_\_ SSDI \_\_\_\_

**Please list any current or pending legal issues/charges.**

\_\_\_\_\_  
\_\_\_\_\_

**Are you currently on probation/parole?** \_\_\_\_ No \_\_\_\_ Yes

**List the name and number of your PO, CM, and/or attorney**

\_\_\_\_\_

**Are you eligible for Recovery Works?** \_\_\_\_Yes \_\_\_\_ No

**May YWCA Northeast Indiana contact this person?** \_\_\_\_ Yes \_\_\_\_ No

**Have you previously had and/or are you currently receiving treatment for either substance abuse or mental health?**

FACILITY	REASON FOR LEAVING	DATES (Approximately)
_____	_____	_____
_____	_____	_____
_____	_____	_____

**List the top three substances that you are currently (or recently) using:**

SUBSTANCE	AGE OF FIRST USE	FREQUENCY OF USE	DATE OF LAST USE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Are you an IV drug user?** \_\_\_\_Yes \_\_\_\_No

**What is your clean/sobriety date?** \_\_\_\_\_

**When and for how long was your longest period of being clean/sober?** \_\_\_\_\_

**Do you have a history of seizures, blackouts, DT's, or withdrawal?** \_\_\_\_ No \_\_\_\_ Yes

**Are you having any suicidal ideation or threats?** \_\_\_\_ Yes \_\_\_\_ No

**If yes, is there a specific plan and what?** \_\_\_\_\_

**Do you have a support network family and/or friends?** \_\_\_\_ No \_\_\_\_ Yes

**What is your reason for seeking treatment at YWCA Northeast Indiana?**

\_\_\_\_\_  
\_\_\_\_\_

**Please list a phone number where you can be contacted.** \_\_\_\_\_

**YWCA NORTHEAST INDIANA STAFF ONLY**    NO SHELTER \_\_\_\_\_    ABUSER \_\_\_\_\_    NSOPW \_\_\_\_\_

**SERVICES AND REFERRELS OFFERED:**

\_\_\_\_\_