

RESIDENTIAL SERVICES APPLICATION

Program applying for: Maxwell House Supportive Living Permanent Supportive Housing

Name: _____

Mailing Address: _____

Street

Apt. #

City/Town

State

Zip Code

County

Current location (if different than referral source): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Age: _____ DOB: _____ SS#: _____

REFERRAL SOURCE

Contact Person: _____ Phone: _____

Agency: _____

Address: _____

ENTITLEMENTS

Public Assistance

Open Public Assistance Case: Yes No If yes, County: _____

Caseworker: _____ Phone #: _____

If no, have you applied: Yes No Date of Application: _____

Managed Care/Medicaid

Medicaid: Yes No If yes, Medicaid #: _____

Managed Care: Yes No If yes, provider: _____

DIAGNOSIS

Chemical Dependency Diagnosis: _____

Mental Health Diagnosis: _____

Medical Conditions: _____

Current Medications (Name and Dosage):

TREATMENT HISTORY

Alcohol/Drug Treatment History (please include outpatient, detox, inpatient, crisis centers and halfway houses):

<u>Dates</u>	<u>Agency/Counselor</u>	<u>Type of Treatment</u>	<u>Completed</u>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

Mental Health Counseling History (Include inpatient and outpatient):

_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

Other information you would like us to know: _____

PROBLEM AREAS TO BE ADDRESSED

Activities of Daily Living (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Personal hygiene | <input type="checkbox"/> Managing medications |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Handling personal finances |
| <input type="checkbox"/> Making/keeping appointments | <input type="checkbox"/> Accessing community services |
| <input type="checkbox"/> Other (specify): _____ | |

Social/Interpersonal Behavior (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Problems with authority | <input type="checkbox"/> Anger management |
| <input type="checkbox"/> Insensitivity to rights/feelings of others | <input type="checkbox"/> Developing and maintaining healthy sober friendships |
| <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Engaging in leisure activities conducive to recovery |
| <input type="checkbox"/> Following rules | <input type="checkbox"/> Domestic violence |
| <input type="checkbox"/> Aggressive behavior | <input type="checkbox"/> Communicating clearly and asking for help when needed |
| <input type="checkbox"/> Assertiveness skills | <input type="checkbox"/> Engaging in family activities/responsibilities |
| <input type="checkbox"/> Disregard for safety of self or others | <input type="checkbox"/> Handling conflict |
| <input type="checkbox"/> Do or say things without thinking about the consequences of your actions | <input type="checkbox"/> Relationship skills |
| <input type="checkbox"/> Manipulative behavior | |
| <input type="checkbox"/> Responsibility | |
| <input type="checkbox"/> Other (specify): _____ | |

Vocational/Educational Skills (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Lack of adequate work experience | <input type="checkbox"/> Problems with attendance and/or punctuality |
| <input type="checkbox"/> Lack of education/vocational training | <input type="checkbox"/> Problems with following directions and/or understanding job expectations |
| <input type="checkbox"/> Lack of marketable job skills | |
| <input type="checkbox"/> Problems with reading/writing | |
| <input type="checkbox"/> Other (specify): _____ | |

Additional Comments:
