

# Residential Services Application

Program applying for:  Maxwell House  Supportive Living  Permanent Supportive Housing  
Are you an:  Intravenous Drug User  At risk of losing custody of children due to drug use

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#: \_\_\_\_\_

Gender Identity: \_\_\_\_\_ Sexual Orientation: \_\_\_\_\_

## 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):

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**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>
<hr/>	<hr/>	<hr/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<hr/>	<hr/>	<hr/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<hr/>	<hr/>	<hr/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<hr/>	<hr/>	<hr/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<hr/>	<hr/>	<hr/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<hr/>	<hr/>	<hr/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Mental Health Counseling History** (Include inpatient and outpatient):

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

Other information you would like us to know: \_\_\_\_\_

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## **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:

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