



Intake Application

Applicant Information

Name: _____ Today's Date: _____

Are you homeless? Yes: _____ No: _____

Have you ever experienced domestic violence or sexual assault? Yes: _____ No: _____

If yes, a referral will promptly be made to a counselor at Elizabeth Freeman to assure your safe placement.

If Living in a Residence

Name of Facility: _____

Address: _____

How long there? _____

Residence Manager: _____

If Living at Home

Address: _____

How long there? _____

How many people living there? _____

Desired date to move in: _____ Reason for move: _____

Date of birth: _____ SSN: _____ Phone: _____

If no phone, how do we contact you? _____

Are you a veteran. Yes: _____ No: _____

Gender: M _____ F _____ Are you pregnant: Yes: _____ No: _____

Marital Status: Married: _____ Never married: _____ Separated: _____ Divorced: _____

who referred you to us? _____

Current address:

City: _____ State: _____ ZIP Code: _____

Own: _____ Rent: _____ Monthly payment or rent:- _____ How long? _____

Previous address:

City: _____ State: _____ ZIP Code: _____

Own: _____ Rent: _____ Monthly payment or rent:- _____ How long? _____

Education History:

What is the highest level of education you have completed? _____

Name and location of high school: _____

Did you graduate? Yes _____ No _____

Year of graduation: _____

Name and location of college: _____

How many years did you attend? _____

What degree(s) did you complete? _____

Recovery and Substance Use:

Do you think you have a problem with alcohol? Yes _____ No _____

Do you think you have a problem with drugs. Yes: _____ No _____

List drugs/alcohol you used addictively:

First _____ Route (smoke, IV, Oral etc.) _____

Date of last use: _____ Age of 1st use: _____

Second _____ Route (smoke, IV, Oral etc.) _____

Date of last use: _____ Age of 1st use: _____

Third _____ Route (smoke, IV, Oral etc.) _____

Date of last use: _____ Age of 1st use: _____

Others: _____

When did you attend your last AA or NA meeting? _____

How many meetings have you attended in the last 30 days? _____

Do you have a sponsor? Yes _____ No _____ If yes:

Name: _____ Phone: _____

Do you have any other recognized addictions or disorders: i.e. Eating disorder, cutting, sex addict? Yes: _____ No: _____

Please describe _____

Are you on any maintenance programs, and if so which? _____

Are you in a recovery program? Yes: _____ No: _____
How long? _____ Where? _____
Are you interested in a maintenance program, and if so which? _____
How much clean time do you currently have? _____
What is the longest you have gone substance free? _____
How many previous recovery attempts/relapses have you had? _____

Legal

Have you been arrested in the past 30 days: Yes _____ No _____
Are you currently on probation or parole: Yes _____ No _____
If yes, Name of Parole Officer: _____ Phone: _____
Are you mandated here: Yes _____ No _____
Please list any current legal problems i.e. Court dates warrants etc. Please describe:

Do you have any active restraining orders against you or someone else? Yes ___ No ___
If yes please describe: _____

Is there any court or legal action pending? Yes : _____ No: _____
Explain: _____

**Answering yes to these questions does not constitute an automatic rejection.
Date(s) of offense(s), seriousness, and nature of violation(s) and rehabilitation
will be considered.**

Family Background

Mother's full name: _____ Is she living? Yes _____ No _____
Father's full name: _____ Is he living? Yes _____ No _____
How many brothers? _____ Are they all living? Yes _____ No _____
How many sisters? _____ Are they all living? Yes _____ No: _____
Do you have contact with your family? Yes _____ No _____
Do you have children? Yes _____ No _____
How many? _____

Are they with you? Yes _____ No _____
If not with you, with whom do they live? _____
Do you have occasion to visit them? Yes _____ No _____

Health History

Primary Care Physician: _____ Tele No: _____
Health Insurance Company and Coverage: _____
Physical condition: Good _____ Fair _____ Not sure _____
Do you have any physical problems? Yes _____ No _____
If yes, please explain: _____

Mental Health: Fair _____ Good _____
Do you have any mental health problems? Yes _____ No _____
If yes, please explain: _____

Are you taking any prescription medications? Yes _____ No _____
What medications are you taking? _____

Are you taking any non-prescription medications? Yes _____ No _____
If yes, what are they? _____

Do you have any medical conditions or allergies? Yes _____ No _____
If yes, what are they? _____

Finance Information:

Do you have medical coverage? Yes _____ No _____
If so, what is the name of company and plan: _____

Are you employed? Yes _____ No _____
If yes, name/address of employer: _____

Source(s) of income: Employer _____ Food Stamps _____ Other _____
Social Security _____ Personal Income _____

Current employer:

Employer: _____ address: _____

Phone: _____

City: _____

Position: _____

Current work Schedule indicate Hours:

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

List your last 3 employers:

Company Name	Supervisor	Contact Phone #	How Long Employed

If unemployed what are your plans for getting a job: _____

Please list your vocational skills/specialized training or certifications: _____

Are you receiving welfare or other non-job related income? Yes ___ No ___

If yes, indicate source: _____

What is your monthly gross income right now: _____

Do you have a valid driver's license? Yes ___ No ___

Do you have a car: Yes ___ No ___ If yes, is it registered and insured? Yes ___ No ___

Emergency Contact:

Name of a person not residing with you: _____

Address: _____ City: _____ State: _____

Phone/Cell Phone: _____

Relationship: _____

2. Name of a person not residing with you: _____
Address: _____ City: _____ State: _____
Phone/Cell Phone: _____
Relationship: _____

3. Name of a person not residing with you:
Address: _____ City: _____ State: _____
Phone/Cell: _____
Relationship: _____

Other Information

Please list hobbies and special interests: _____

What would you say your best characteristics are: _____

Have you ever lived in a home shared with other people? Yes ___ No ___

Do you anticipate any problems with this? Yes ___ No ___

What is your main goal at this time? _____

Address: _____
Phone: _____

Anything else you want to tell us? _____

References

Please provide names and contact information for three references:

Name:	Address	Phone

Miscellaneous

Explain your special skills and talents: _____

What are your goals? _____

How did you learn about Community ReStart? _____

Please explain why you feel you are a good candidate for the program: _____

Signature of applicant:

My signature represents truthful responses to all information requested. Should any answer be found not to be true, it will be reason for immediate dismissal from the Program.

Signature: _____

Date: _____

Print Name: _____

I authorize the verification of the legal and employment information provided by me on this form

Confidentiality Statement and Release forms are attached for your review and signature.



For Office Use Only

Interviewers:

Name: _____ Date: _____

Name: _____ Date: _____

Name _____ Date: _____

Assigned to Counselor: _____ Date: _____

Date CORI Submitted: _____

Reviewed by and Date _____

Date of Committee Review #1: _____

Date of Committee Review #2: _____

Date of Manager Review: _____

Counselor's Recommendations and Date: _____

Date Accepted/Denied Admittance: _____

Applicant Contacted by Whom and Date: _____
