Application for Atwater's Residential Programs

Please select which level of care to which the applicant is applying. Complete referral packages* should be faxed to **585-815-1815**.

- **Atwater Community Residence (Men)**

- **Supportive Living (Genesee County)**

- **Supportive Living (Orleans County)**

***Complete referral packages MUST include a psycho-social assessment, history and physical, bloodwork, PPD test, and medical urinalysis. Client will not be admitted without these requirements.**

1. Is the client homeless?
   If yes, explain:

2. Is the client pregnant?
   If yes, explain:

3. Is the client an IV user?
   If yes, explain:

4. Does the client have children that are in foster care or are at risk of being placed in foster care?
   If yes, explain:

Please complete this section carefully. Accurate and adequate information/documentation is important for a prompt intake decision.

Client Name:_____

Referral Source: _____

Residence prior to treatment:_____
(Number) (Street)

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

County of Origin: _____

Phone Number: _____

DOB: _____ Gender:_____

Social Security Number: _____

Reason for not returning to the previous address at this time_____

_____

Insurance Provider:_____

Policy #:_____

Is the client currently receiving benefits through Social Services? Y N

Is the client receiving SSI or SSD benefits? Y N

If yes, complete the following:

Case #: _____ From what county? _____

Case Worker: _____ Amount of Benefit: _____

Has the client ever been refused/sanctioned for Social Services or Social Security benefits? Y N

If yes, explain:_____

_____

Any questions/concerns please call Lauren Swimline at 585-815-1838.

Highest grade level completed: 1 2 3 4 5 6 7 8 9 10 11 12 _____GED
_____Some College _____Associates _____Bachelors _____Masters _____Doctorate

Please indicate diplomas, degrees, trade school certificates, etc. _____

_____

Do you have any medical conditions? Y N

If yes, explain: _____

_____

_____

Current medication(s), including dosages:_____

_____

_____

_____

Primary Care Physician's Name: _____

Phone #:_____ Location: _____

Date and results of last TB test: _____

History of seizures? Y N

If yes, explain: _____

History of an eating disorder? Y N

If yes, explain: _____

Does the client use tobacco products? Y N

If yes, how much daily? _____

Substance Use History

SUBSTANCE	FREQUENCY	ROUTE	DATE OF LAST USE

Has a Substance Abuse and/or Alcohol Dependence Diagnosis been assigned to the client? Y N

If yes, by whom? _____ When? _____

Diagnosis: _____

What is the client's primary substance? _____

Substance Abuse Treatment

FACILITY NAME	MONTH/YEAR	INDICATE COMPLETION

Mental Health Treatment

EVENTS LEADING TO TX	PROGRAM	LENGTH OF STAY/DATES

Has a Mental Health Diagnosis been assigned to the client? Y N

If yes, by whom? _____ When? _____

Diagnosis: _____

Legal

Is the client on probation or parole? Y N

If yes, please provide probation/parole officer's name, county, and contact info:

_____

_____

Is the client attending treatment court? Y N Where? _____

Is the client mandated for treatment? Y N By who? _____

Has the client ever been arrested? Y N

If yes, when and what were the charges? _____

_____

_____

_____

Current pending court appearances: _____

_____

Does the client have any outstanding warrants? Y N

If yes, explain: _____

Has the client ever been arrested for assault? Y N

If yes, explain: _____

_____

Has the client ever been arrested for arson or sexual assault? Y N

If yes, explain: _____

_____

Is the client a registered sex offender? Y N

_____ _____

Client Signature Date

_____ _____

Staff Signature and Title Date

_____

Staff's Phone Number

Any questions/concerns please call Lauren Swimline at 585-815-1838.