gcasa *The path to recovery begins here.*
Prevention. Treatment. Recovery. Support.

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**

◯ **Supportive Living**

***Complete referral packages MUST include a psycho-social assessment, history and physical (signed by an RN or above), bloodwork, PPD test (signed by an RN or above), and a medical urinalysis (not a drug screen). Client will not be admitted without these requirements.**

Is the client homeless? ◯ Yes ◯ No
If yes, explain:

Is the client pregnant? ◯ Yes ◯ No
If yes, explain:

Is the client an IV user? ◯ Yes ◯ No
If yes, explain:

Does the client have children that are in foster care or are at risk of being placed in foster care? ◯ Yes ◯ No
If yes, explain:

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

Client Name: _____

Referral Source: _____

Name and contact information of referring staff:

_____

(Name) (Phone Number) (E-mail)

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? ◯ Yes ◯ No

Is the client receiving SSI or SSD benefits? ◯ Yes ◯ No

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? ◯ Yes ◯ No

If yes, explain: _____

_____

EDUCATION

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. _____

_____

Any questions/concerns please email Alexis Lukovich at alukovich@gcasa.org.

MEDICAL HISTORY

Do you have any medical conditions? ◯ Yes ◯ No

If yes, explain: _____

_____

_____

Current medication(s), including dosages: _____

_____

_____

Primary Care Physician's Name: _____

Phone #: _____ Location: _____

Date & results of last TB test: _____

History of seizures? ◯ Yes ◯ No

If yes, explain: _____

History of an eating disorder? ◯ Yes ◯ No

If yes, explain: _____

Does the client use tobacco products? ◯ Yes ◯ No

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? ◯ Yes ◯ No

If yes, by whom? _____ When? _____

Diagnosis: _____

What is the client's primary substance? _____

SUBSTANCE USE 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? ◯ Yes ◯ No

If yes, by whom? _____ When? _____

Diagnosis: _____

LEGAL

Is the client on probation or parole? ◯ Yes ◯ No

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

_____

_____

Is the client attending treatment court? ◯ Yes ◯ No Where? _____

Is the client mandated for treatment? ◯ Yes ◯ No By who? _____

Has the client ever been arrested? ◯ Yes ◯ No

If yes, when and what were the charges? _____

_____

_____

_____

Current pending court appearances: _____

_____

Does the client have any outstanding warrants? ◯ Yes ◉ No

If yes, explain: _____

Has the client ever been arrested for assault? ◯ Yes ◯ No

If yes, explain: _____

Has the client ever been arrested for arson or sexual assault? ◯ Yes ◯ No

If yes, explain: _____

Is the client a registered sex offender? ◯ Yes ◯ No

_____ _____

Client Signature Date

_____ _____

Staff Signature and Title Date

_____

Staff's Phone Number