

# Residential Programs

## Application

Thank you for your interest in Foundation's residential program options. We look forward to reviewing the applicant's information and considering them for admission. The details provided below will help us gain a clearer understanding of the applicant's situation and explore the most appropriate services to support their needs. Please note that this information is strictly confidential, intended solely for our use, and will not be shared with anyone without the applicant's written consent.

### Program seeking Admission to:

☐ Adult Mental Health Residential ☐ Residential Substance Use ☐ Recovery Housing ☐ Sober Living

### Applicant Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sex: ☐ Female ☐ Male ☐ Transgender ☐ Other \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

In an emergency, who do we call? Contact Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Is applicant employed? ☐ Yes ☐ No

Employer: \_\_\_\_\_ Length of Employment: \_\_\_\_\_ Position: \_\_\_\_\_

Highest Level of Education Completed: \_\_\_\_\_

### Family and Significant Relationship Information:

Next of Kin/Legal Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Is family involved with applicant? ☐ Yes ☐ No

### Financial Information:

Name of Insurance Company: \_\_\_\_\_ Insurance Co. Phone # (Mental Health): \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Policy Owner's Date of Birth: \_\_\_\_\_

Policy Owner's SS#: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_ Policy or Group#: \_\_\_\_\_

Policy Owner's Address (only if different than above): \_\_\_\_\_

Is the applicant eligible for SSI/SSDI benefits? ☐ Yes ☐ No

Is he/she currently receiving these benefits? ☐ Yes ☐ No

### Social / Family Information:

Which best describes the applicant's relationship status? Choose all that apply:

☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Engaged ☐ Living Together

Does the applicant have children? If so, please provide names and ages: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If the applicant has children, with whom do they live? \_\_\_\_\_

**Housing Information:**

Which best describes the applicant's current housing situation?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Homeless shelter     | <input type="checkbox"/> Domestic violence shelter         | <input type="checkbox"/> Rental housing               |
| <input type="checkbox"/> On the street        | <input type="checkbox"/> Other transitional living program | <input type="checkbox"/> Parent/Legal Guardian's home |
| <input type="checkbox"/> Relatives home       | <input type="checkbox"/> Friend's home                     | <input type="checkbox"/> Other adult's home           |
| <input type="checkbox"/> Assisted Living Home | <input type="checkbox"/> Substance Abuse Treatment Center  | <input type="checkbox"/> Psychiatric Hospital         |
| <input type="checkbox"/> Military             | <input type="checkbox"/> Educational Institution           | <input type="checkbox"/> Correction/Detention Center  |
| <input type="checkbox"/> Other: _____         |  |   |

Has the applicant ever been homeless? ☐ No ☐ Yes; If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the applicant have any pets? If so, what type? \_\_\_\_\_

**Medical and Mental Health History / Information:**

Is the applicant currently being treated by a physician for any medical conditions? If so, please describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the applicant currently taking prescription, over-the-counter or herbal medication? ☐ No ☐ Yes;

Medication name/dose: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the applicant currently being seen by a Psychiatrist or other mental health provider? ☐ No ☐ Yes;

If yes, who? \_\_\_\_\_

Contact information: \_\_\_\_\_

What is the focus of treatment? \_\_\_\_\_

Current mental health diagnoses? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the applicant have any Intellectual or Developmental Disabilities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History:**

Is there any family history of mental illness or substance abuse? If so, please list relationship & diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Please list family, friends, support groups and community groups:

\_\_\_\_\_  
\_\_\_\_\_

List any history of emotional, physical, and/or sexual abuse:

\_\_\_\_\_  
\_\_\_\_\_

Has a family member or close friend ever committed suicide? ☐ No ☐ Yes, (who) \_\_\_\_\_

Has applicant been having any thoughts of harming self or others?

☐ Yes ☐ No ☐ Self ☐ Other(s)

Has the applicant ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation, parole)? If so, please state and under what circumstances:

\_\_\_\_\_  
\_\_\_\_\_

**Alcohol / Substance Use:**

How often does the applicant have a drink containing alcohol?

☐ Never ☐ 1/month or less ☐ 2-4/month ☐ 2-4/week ☐ more than 4/week

How many drinks containing alcohol does the applicant consume on a typical day that they are drinking?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

Does the applicant use marijuana or other "street drugs"?

☐ No ☐ Yes; what type/quantity/frequency of use: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the applicant have a history of Alcohol/Substance Use? | Yes ☐ No    IV Drug Use? | Yes | No

*If yes, list substance(s), date of last use, treatment history.*

Substance	Date of Last Use	Treatment History

**Program Information:**

Why is the applicant currently seeking admission to this program?

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What challenges have prevented the applicant for accessing permanent housing or living independently in the past? \_\_\_\_\_

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What are some of the applicant's strengths?

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What are some of the life skills/activities of daily living that applicant currently requires assistance with?

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Please list the goal(s) that the applicant hopes to address and achieve in the program.

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

**Referral Information:**

Name: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax/Email: \_\_\_\_\_

**Please email completed application to [connect@foundationsalaska.org](mailto:connect@foundationsalaska.org)**