The Program requires a complete admission application to assure that the consumer needs and best interests of each applicant are met. The following information is needed to begin the application process.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral:** |  | **Referring Source:** |  |
| **Appointment Requested:** | Emergent Routine  Urgent Walk-In | **Gender:**   Male  Female | **Pronouns:** He/Him  She/her They/Them Other: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client Name:** |  | **DOB:** |  | **SS#:** |  |

|  |  |  |
| --- | --- | --- |
| **Is client their own legal guardian?** | Yes  No | *If no, please give name of legal guardian:* |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Guardian Name:** | |  | | | | **Phone#:** | |  | |
| **Client/Legal Guardian Address:** | | |  | | | | | | |
| **City:** |  | | | **State:** |  | | **Zip Code:** | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Insurance No.:** |  | **Secondary Insurance No.:** |  |

|  |  |  |
| --- | --- | --- |
| **Criminal Record:** | Yes  No | *(If so please attach a brief explanation)* |

**Current Symptoms/Behavioral Observations**

|  |  |  |  |
| --- | --- | --- | --- |
| Anxiety  Attention problems  High Risk activities | Gets Angry easily  Impulsivity  Mood Swings | Substance use  Suicidal thoughts  Tantrums/Rages | Schoolwork problems  Relationship concerns  Hopelessness  Other-Depression |

**Services Requested**

|  |  |  |
| --- | --- | --- |
| Comprehensive Clinical Assessment  Outpatient Therapy  Intensive In Home | Substance Abuse Services  Community Support Team  Transitional Living | Supportive Employment  Residential Level III |

|  |  |
| --- | --- |
| **Known Diagnosis/Treatment:** |  |
| **Known Medical Problems:** |  |
| **Medications:** |  |
| **Notes:** |  |

*A determination as to the most appropriate services for each consumer will be made based on this information; therefore, it is important to know as much as possible about each applicant. We ask that you provide the above information in its entirety before we start working with the client, so that we can make an accurate assessment of services needed.*Please forward all information to:

**Arise Destiny**

1935 J.N. Pease Place, Suite 101, Charlotte, NC 28212 ● Fax: 704.672.5234