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|  | An Angel’s Wing Inc |

# 1567 Lisbon Street,

# Lewiston, Maine 04240

# ­­­­­­­­­­­­­­­­­­­­­­­­­­­­207-241-0624

# TYPE OF SERVICES REQUESTED (name, address & telephone if applicable)

ORGANIZATION WHO REFERRED YOU: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount: Needed $\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you employed?\_\_\_\_\_\_\_\_\_\_ Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Detox:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Inpatient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recovery home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ORGANIZATION WHO REFERRED YOU: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been through the detox, rehabilitation, sober living before?\_\_\_\_\_\_\_\_\_\_\_ if yes, when and where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you or have you been homeless?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have access to basic needs? Food \_\_\_\_\_\_\_\_ shelter \_\_\_\_\_\_\_\_\_\_ Medication (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your history of drug alcohol use? Drug/Drugs of choice?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much and how often?

Have you experienced DT’s (severe alcohol withdrawal) or any severe withdrawals in the past?

Are you pregnant?\_\_\_\_\_\_\_\_\_\_\_\_

Are there currently or have you experienced past suicidal thoughts or actions, aggressive behavior, violent thoughts or

harmful thoughts to yourself or others? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any mental health diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PTSD:\_\_\_\_\_\_\_\_ Anxiety disorders:\_\_\_\_\_\_\_\_\_ eating disorder:\_\_\_\_\_\_\_\_\_\_\_\_\_ Mood disorder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any Covid related symptoms within the last 7 days:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently seeing a health care physician Date::\_\_\_\_\_\_\_\_\_\_Psychiatrist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eye doctor:

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# Substance Use Disorder referral service

## Applicant Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | Date: |  |
|  | Last | First | M.I. |  |  |

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | Street Address | Apartment/Unit # |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | City | State | ZIP Code |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Serviced in the Military? \_\_\_\_\_\_\_\_\_\_\_ |  |  | Do we have permission to speak with the facilities your requesting help for?  Yes\_\_\_\_ No\_\_\_\_\_ |
|  |  |  | Sign: |

## Barriers

Please list any disabilities, health problems or barriers you may have:

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## Emergency Contact

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Next of Kin: Name/relation: |  | Tele#: |  |  |

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to assistance, I understand that false or misleading information in my application or interview may result in my release.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date: |  |

Types of future services that may be needed:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_