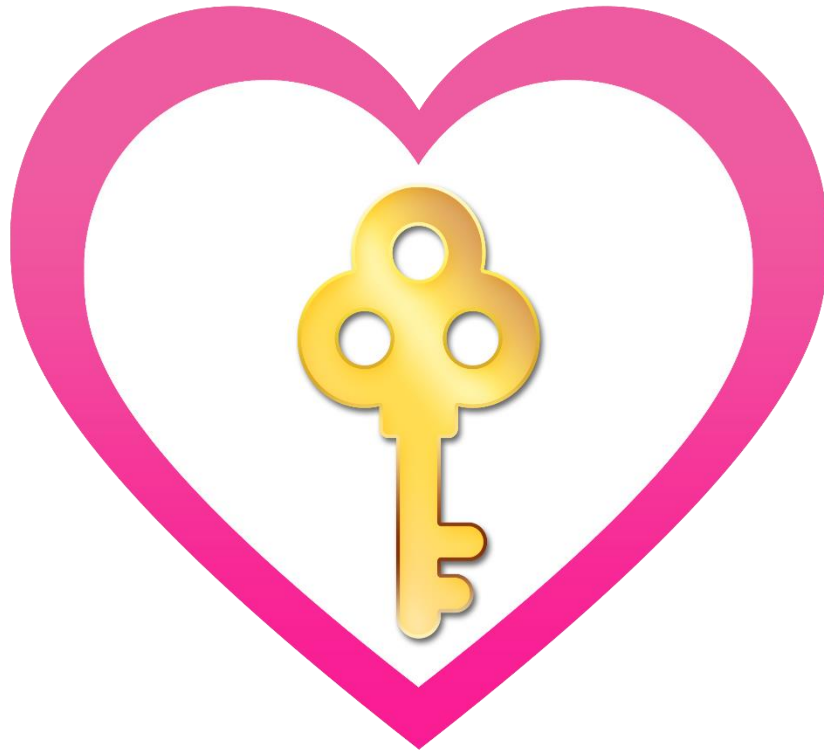

HopeHaven

Holistic Treatment Services

Referral Form

Referral Source:____*******DATE: ___________________
yyyy mmm dd

Resident Personal Information

Applicant Name____Age_______ D.O.B_______ _______ _______
MMM DD YYYY

SSN:__________________________ Ethnicity: ____________________ Tel:________________________

Length of abstinence as of today?____________________________or Clean Date:______________________

Are you an IV drug user? Yes ☐ No ☐

Are you on a methadone maintenance program? Yes ☐ No ☐ (If so, please complete MMT Questionnaire)

Address:____

A&D Counselor or Case Worker____Tel: _______________________

How did applicant hear about Hope Haven LLC ____

Do you have TB test results? Yes ☐ No ☐ Referred to Sessional Physician for testing? Yes ☐ No ☐

Marital Status: ☐ Single ☐ Common Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment Status: ☐ Unemployed ☐ Employed ☐ Looking for work ☐ Student ☐ Disabled/Retired

Homelessness Status: Are you currently homeless or at risk of homelessness? Yes ☐ No ☐

Explain your living situation for the past 30 days:

Education: ☐ High School ☐ GED ☐ College ☐ Graduate ☐ Vocational Training ☐ Other: ___________________

Substance Use History

Substance used	Route of Administration	Age first used	When was your last use?	Is it the Primary Drug of Choice?
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

Health

Diagnosed Physical Health Conditions

☐Heart Disease ☐Diabetes ☐Back Injury ☐Pain Management Issue ☐ HEP C ☐HIV+ ☐AIDS
☐ Food Allergies for
☐ Medication Allergies for ☐ Upcoming surgeries for

Is there a physical health problem you are most concerned about right now?

CURRENT MEDICATIONS				
Medication Name	**Dosage**	**How long have you been taking this medication?**	**What is the plan for the next three months?**	**Administration times per day**

I am taking these medications regularly Yes ☐ No ☐ If not, why not?
I have a prescription for the next 30 days? ☐

Diagnosed Mental Health Conditions				
Diagnosis	At what age:	Psychiatrist ☐	Family Doctor ☐	Other ☐
Diagnosis	At what age:	Psychiatrist ☐	Family Doctor ☐	Other ☐
Diagnosis	At what age:	Psychiatrist ☐	Family Doctor ☐	Other ☐

CURRENT MEDICATIONS				
Medication Name	**Dosage**	**How long have you been taking this medication?**	**What is the plan for the next three months?**	**Administration times per day**

I am taking these medications regularly Yes ☐ No ☐ If not, why not?
I have a prescription in place for the next 30 days ☐

Health – Suicide Risk

Have you ever felt suicidal? Yes ☐ No ☐ how recently?

Have you ever made an attempt? Yes ☐ No ☐ how recently? By what method?

Where you hospitalized? Yes ☐ No ☐ How long was your stay in hospital?

Were you seen by a psychiatrist while you were in hospital? Yes ☐ No ☐ Name:

	Treatment History			
Dates of Treatment	**Type: Detox, Support Recovery, Outpatient (OP), 28 day Treatment Program**		**Facility Name**	**Completed or incomplete (If incomplete, why?)**

Clean Time History (Other Periods of Abstinence)		
From	**To**	**What happened that started your substance use again?**

Sources of Income		
Type	**Amount per month**	**Comments**
Employment	**$**	**Employer:**
Unemployment Benefits	**$**	
Social Services (TCA)	**$**	
Social Services (TDAP)	**$**	
SSI:	**$**	
SSDI:	**$**	
Family/Friends:	**$**	
Self-employment:	**$**	
Savings:	**$**	
Other	**$**	

Criminal Justice Involvement History	
Do you have a criminal record? Yes ☐ No ☐	
What are your previous charges?	
Charged with:	**When**
Are you facing any current charges? Yes ☐ No ☐ What are the charges?	
Are you on probation currently? Yes ☐ No ☐ Are you on parole currently? Yes ☐ No ☐ If yes, what are the conditions of your order?	
Do you have upcoming court dates? Yes ☐ No ☐ Date:	
Probation/Parole Officer Name:	Contact Number:

Emergency Contacts		
Name:	**Address and Phone Number:**	**Relationship to You:**

Agreement and Authorization Signature

I affirm that the information given in this application is true and correct. I understand that if any of the information provided is false, misleading or incomplete, management may decline my application, or if move in has occurred; terminate my lease and evict me and my household. Do not use white-out on this form, please line through the error and initial the change. I understand that it is a crime to knowingly provide false information for the purpose of obtaining or maintaining occupancy in and/or for the purpose of securing a lower rent in a subsidized housing development. I authorize Management to make any and all inquiries to verify this information either directly or through information exchanged now or later with rental and credit screening services, previous and current landlords, law enforcement agencies or other sources of information released to appropriate Federal, State, or local agencies.

____ ____ __________

Name of Resident (Please Print) Signature of Resident mm/dd/yyyy

☐ Approved for residency at HHHTS

☐ Not Approved

☐ Staff Signature: ____

☐ Date:____

Comments: