



SUSAN B. ANTHONY CENTER, INC

REFERRAL SCREENING FORM/APPLICATION

Please be sure to complete this form and attach a copy of all the information that is required on the enclosed checklist. For all **Yes** or **No** questions, please check the appropriate answer and fill in all explanations if applicable.

Date of Application : _____ Tentative admission date: _____

Person Served Name: _____ DOB: _____ SS#: _____

Race: _____ Ethnicity: _____ Phone#: _____

Current Address: _____

Homeless ALF/Group home Family/Friend Jail/Prison State hospital

Independent housing Residential program: _____

Referred by: _____ Title: _____ Phone: _____

Referring Agency: _____

Do you have Insurance: Yes No Policy Name: _____ ID# _____

Applicants language preference: English Spanish Creole Other: _____

Substance Abuse History

If applying for substance abuse services please fill out the following, if not, please skip this portion of the application.

Drug of choice	Frequency of use:	Date of last use:

Have you ever tried to stop using? Yes No If yes, how many times? _____

What is the longest period of time that you have remained substance free? _____

Please list any previous treatment programs Person Served has participated in and what caused her to use again? _____

Medical and Mental Health Information

Do you have any medical conditions or concerns : _____

_____ Allergies: _____

Hospitalization in past 12 months: _____

Are you able to perform basic living activities without assistance? : _____

Are you pregnant? Yes No If **yes**, when is the baby due? _____

Do you have any of the following eating disorders?

Anorexia Yes No

Bulemia Yes No

Excessive over eating (loss of control, obese) Yes No

Have you ever been to a therapist, psychologist, or psychiatrist for mental health problems? Yes No

If **yes**, please give details including diagnosis and any medication that she is on: _____

Compliance with medication in the past 3-4 months Poor Fair Good N/A

Criminal Justice History

Have you ever been arrested? Yes No # of arrests: _____

Behavior under the influence? Yes No Date(s): _____

Sales or possession? Yes No Date(s): _____

Theft? Yes No Date(s): _____

Assault of any kind? Yes No Date(s): _____

Has the Person Served ever been incarcerated? Yes No For which Charge? _____

Length of incarceration? _____

Currently on probation? Yes No Officers Name: _____

Any pending charges? Yes No Next Scheduled Court date: _____

If Yes, please describe: _____

Have you been violent in your past? Yes No If **yes** please describe: _____

Educational/Vocational Information

What is the highest grade level completed? _____ Do you have a GED? Yes No

Do you have any academic or vocational training? Yes No Describe: _____

Where were you last employed? _____ Date you were last employed: _____

Children's Information

Do you have any children? Yes No

Has Child Net or Child Protective Services ever been involved with you or your children? Yes No

If **yes** please explain: _____

Child's Name	Age	DOB	Gender	In Custody of	Child Advocate or Investigator Name & Number

Do the children have any mental health problems? Yes No
 If **yes** please give details including diagnosis and any medication that child is on: _____

Do the children have any health concerns? Yes No
 If **yes** please list them: _____

Homeless History

If applying for homeless services please fill out the following, if not please skip this portion of the application.

Definition of homeless status:

- a) Homelessness -- a person sleeping in a place not meant for human habitation or in an emergency shelter, a person in transitional or supportive housing for homeless persons referred from community agencies, hospitals, churches and the police department who originally came from the street or an emergency shelter.
- b) At risk of Homelessness -- The client's substance abuse or mental health diagnosis impedes her ability to maintain stable housing or has put her at risk of losing current housing.

How long has Person Served been homeless or at risk of homelessness? _____

What lead to homelessness or risk of homelessness? _____

The following Documents MUST be attached to this application, if applicable:

- Psychiatric Evaluations Competency Evaluations Hospital Discharge Records

The following information may be required from the referring facility prior to admission. Please confirm before sending application:

- PPD or chest X-rays Medication List (MAR) Urine Pregnancy Test
 Health Assessment U/A RPR Complete Metabolic Panel
 History & Physical Hepatitis Panel CBC
 S-TSH Profile Clearances (Medical, Psychiatric, Detox)
- HIV (if available, or if client is HIV+ has had blood work within the past 6 months)

I authorize Susan B. Anthony Center, Inc. to obtain my benefits and eligibility information from any payer whatsoever (including, but not limited to, commercial insurance coverage, ERISA-governed benefit plans, governmental health benefits plans, Medicare, Medicaid, and any other source of welfare coverage or insurance.)

Applicant's Signature

Guardian or Representative Payee

Referring Agency's Signature

Referring Agency's Name (Print)