Hope on Haven Hill Intake Application

Date of Application: ________

Intake done with: __________

DEMOGRAPHICS:

Name: ________________________ Age: _____ DOB: ________ Last 4 digits of SSN: _______

Phone: __________________________ Can we leave a message at this number? ________

Current Living Situation:

Community _____ Homeless ______ Shelter _______ Incarcerated _____ Treatment Center _______

Current Street Address: ____

City: ____________________ State: NH Zip code: _________

Length of time at current address: ____

If incarcerated, when are you eligible for release or parole? _________________________

Do you have a NH picture ID? _____YES _____NO

Current relationship status: _____ Single in a relationship _____ Single not in a relationship

_____ Married _____Divorced _____Widowed ______ Other ______________________

Are you pregnant? _____YES _____NO Anticipated Due Date: ____________________

Are you currently receiving prenatal care? ______ If YES, where? _____________________________

Do you have children? _______YES _____NO How Many? _____

What is the custody arrangement? ____

Health Insurance Carrier: ___________________________ Insurance number: ________________________

Are you the primary carrier of this insurance? _____ If not, who is the primary carrier? ___________________

If English your first language? ____

How would you describe your race/ ethnicity? ________________________________

Religious Affiliation? ____

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EMERGENCY CONTACT INFORMATION:

Name: ______________________________

Relationship to you: ______________________

Does she/he live close by? Far away? How available are they to you? ____________________

____

Can we contact this person in the event of admission to this program? ____________________

Do you currently smoke cigarettes? _____YES _____NO If YES, how many per day? _____

Do you currently drink caffeinated beverages? _____YES _____NO If YES, how many per day? _____

SUBSTANCE USE:

Are you currently using substances? _____YES _____NO

If no, current length of sobriety: ________________________

Have you ever been treated for alcohol/drug use? _____YES _____NO (include inpatient, outpatient, intensive outpatient, Medication Assistance Program, programs during incarceration, and detoxification services)

Location/type: ____________________________ DATE(S): __________ Completed? ________

Location/type: ____________________________ DATE(S): __________ Completed? ________

Location/type: ____________________________ DATE(S): __________ Completed? ________

Location/type: ____________________________ DATES(S): __________ Completed? ________

Are you on Methadone maintenance or Suboxone/Subutex? _____YES _____NO

IF YES, Current dose: _____

Provider Information: ____________________________ Phone __________

How long have you been in this program? ____________________________________

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DRUG OF CHOICE: (include alcohol, amphetamines, methamphetamines, cocaine/crack, heroin, cannabis, hallucinogens, methadone, buprenorphine, inhalants, benzodiazepines, other)

#1: __________ Date of last use: __________ How much did you use? __________

How often did you use this drug? __________ Age of first use? __________

How did you use it? (circle) smoke snort/inhale inject oral other __________

#2: __________ Date of last use: __________ How much did you use? __________

How often did you use this drug? __________ Age of first use? __________

How did you use it? (circle) smoke snort/inhale inject oral other __________

#3: __________ Date of last use: __________ How much did you use? __________

How often did you use this drug? __________ Age of first use? __________

How did you use it? (circle) smoke snort/inhale inject oral other __________

Have you ever overdosed? How many times? Approximate dates: ____________________

____

Have you ever been sober? When? ____________________

What is your longest period of sobriety? ____________________

How did you achieve that sobriety? (meetings, residential, MAT etc) ____________________

____

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MEDICAL:

Please list any medical conditions (Asthma, Diabetes, Hepatitis, HPV)

____

____

Please list all allergies (food, seasonal, and medical related) ______________________________

If you have any allergies or other medical conditions, do you carry the following with you? (circle)

EPI Pen Inhaler Other medication (insulin) __________________________

Who is you doctor? _______________________________ Phone number ___________

Address: ____

Date of last visit: __________ Reason: _________ Date of last physical: ________

Do you have any <u>vision</u> problem? _____YES _____NO Glasses/ contacts: __________

Do you have <u>dental</u> concerns? _____YES _____NO <u>Hearing</u> problems? _____YES _____NO

Have you even experienced a concussion or traumatic brain injury? _____YES _____NO

(Please include combat or accidents that resulted in head injury.)___________________________

Have you even lost consciousness? _____YES _____NO IF **YES**, for 30 minutes or more?_______

What were the circumstances? ____

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Medications/ vitamins: List all of the over the counter and prescription medications you are currently taking.

Medication	Dose	Reason for taking	Prescribing doctor

MENTAL HEALTH:

Have you ever received mental health treatment? (Circle) current past never

Agency name/Counselor name: ____

____

Have you even been given a mental health diagnosis(es)? _____YES _____NO

IF YES please list: ____

Have you ever been hospitalized for mental health issues/ concerns? _____YES _____NO

Have you ever attempted suicide? _____YES _____NO IF YES, when? ___________

Please explain: ____

____

Are you currently experiencing suicidal or homicidal thoughts? ______________________

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LEGAL:

Have you ever been arrested? _____YES _____NO

If YES please explain the charges and provide the dates of the offence(s):

OFFENSE/CHARGE DATE

____

____

Have you ever been convicted or arson? _____Violent crime? _____Sexual Assault? _____

Have you ever been arrested, charged, or convicted of a sexual offence? ____________________

Are you a registered sex offender? ____________________

Have you ever been incarcerated? _____YES _____NO When? ____________________

Are you currently on probation/ parole? ______YES _____NO

IF YES, Name of Officer: ____________ District Office: ____________ Phone: ____________

Are there any current restraining orders against you OR placed by you? _____YES _____NO

IF YES, Please explain: ____________________

Have you ever been charged with abuse/neglect of a child? ____________________

Do you have any outstanding warrants against you in any state? ____________________

Do you owe any court fines? ____________________

Have you ever experienced interpersonal violence in a relationship? _____YES _____NO

If yes, when? Have there been any recent incidences? Are you still in contact with the perpetrator? ____________

____

____

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EDUCATION/ EMPLOYMENT:

Highest level of education completed: ______________________________

Have you even been diagnosed with a learning/reading/developmental disability?

____

____

Are you currently enrolled in an educational program? _____YES _____NO

IF YES, Where? What are you studying? ______________________________

Are you employed? _____YES _____NO

Who is your employer? ______________________________

How long have you been at this job? ______________________________

Are you a veteran? _____YES _____NO IF YES, Years of active military service? ________

FINANCIAL:

If currently employed: Hourly wages: ______________ Hours per week: __________

Do you currently receive WIC? _____YES _____NO

Do you receive child care assistance from the State? _____YES _____NO

Do you receive Public Assistance? _____YES _____NO

IF YES, what benefits do you currently receive?

TANF _____	Date Started: ______________	Monthly amount: ______________
Food Stamps _____	Date Started: ______________	Monthly amount: ______________
SSI _____	Date Started: ______________	Monthly amount: ______________
Unemployment _____	Date Started: ______________	Monthly amount: ______________
City/town welfare _____	Date Started: ______________	Monthly amount: ______________
Other: _____	Date Started: ______________	Monthly amount: ______________

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CHILDREN CURRENTLY LIVING WITH YOU:

1. Name: ______________________________ male/female DOB: _______ Age: _____

Child SS#: ________________________ Current school/ daycare____________________________

Child's pediatrician: _____________________________________

Address: _________________ _____________________ Phone: ___________________________

Name of child's other parent: ______________________ Level of involvement: ______________

DCYF Involvement? _____YES _____NO If yes, name of CPSW: ________________________

District Office: ______________________ CPSW worker phone: ___________________________

How long has DCYF been involved in this case? ____

Do you receive child support for this child? _____YES _____NO _____Pending

IF YES, amount: ___________

2. Name: ______________________________ male/female DOB: _______ Age: _____

Child SS#: ________________________ Current school/ daycare____________________________

Child's pediatrician: _____________________________________

Address: _________________ _____________________ Phone: ___________________________

Name of child's other parent: ______________________ Level of involvement: ______________

DCYF Involvement? _____YES _____NO If yes, name of CPSW: ________________________

District Office: ______________________ CPSW worker phone: ___________________________

How long has DCYF been involved in this case? ____

Do you receive child support for this child? _____YES _____NO _____Pending

IF YES, amount: ___________

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CHILDREN NOT CURRENTLY LIVING WITH YOU:

1. Name: ______________________________ male/female DOB: _______ Age: _____

Address: ________________ ____________________ ____________________________

Child's guardian: _____________________ Relationship to child: ______________________

DCYF Involvement? _____YES _____NO If yes, name of CPSW: _________________________

District Office: _____________________ CPSW worker phone: __________________________

What is your level of involvement/contact with the child? _______________________________

Are you in the process of Redeeming Guardianship? ___________________________________

2. Name: ______________________________ male/female DOB: _______ Age: _____

Address: ________________ ____________________ ____________________________

Child's guardian: _____________________ Relationship to child: ______________________

DCYF Involvement? _____YES _____NO If yes, name of CPSW: _________________________

District Office: _____________________ CPSW worker phone: __________________________

What is your level of involvement/contact with the child? _______________________________

Are you in the process of Redeeming Guardianship? ___________________________________

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Please tell us what you are looking for from our program? How do you feel about living in a environment like ours, living with seven other women in recovery, following program guidelines, and participating in all aspects of the program? What goals would you like to achieve? Is there anything else we should know about you?
(use the back of this page if you need more space)

My signature certifies that, to the best of my knowledge, all of the above information is accurate. I understand that releases may be requested for the purposes of contacting any of the above mentioned providers or other individuals.

______________________________ ______________

Signature Date

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Prior to admission into Hope on Haven Hill Recovery Program you must have:

- NH photo ID or other proof of NH residence
- Physical Exam results (done within past 90 days) including Medication list (if any), approval for OTC medication and letter stating "Medical Clearance" to participate in a non-medical behavioral health substance misuse treatment facility.
- If currently pregnant; "Medical Clearance "note from OBGYN and awareness of client's history of substance misuse.
- **A written medical order** for each prescription to include vitamins and/or over the counter medication. A medical order is a list of prescribed or over the counter medication and the instructions for use. (i.e. Ibuprofen, 200mg, BID), this must be **signed by a medical doctor and or physicians assistant**
- **A 30 day supply,** and you must have the ability to refill all medication for you and your child if applicable
- Insurance card/Information if applicable (for both client and child)
- Copy of Birth Certificates for children
- Up to date record of immunizations for children
- Social security cards or numbers
- If applicable, prior mental health evaluations to be forwarded prior to admission
- Legal documents to include custody information of children

To Do:

1.

2.

3.

4.