

Travelers Transitional Living

ADMISSION APPLICATION

Name: _____
First Name Middle/Maiden Name Last Name

Referred By _____ Date of Interview _____ Date Admitted _____ Placement Status _____

Former Address _____ City _____ State _____ Zip _____

Phone Number: _____ ☐ Home ☐ Cell/Mobile ☐ Other

SSN: _____ Transportation: ☐ Yes ☐ No

Valid Driver's License: ☐ Yes ☐ No Picture ID: ☐ Yes ☐ No

SOCIAL HISTORY

Age _____ Race _____ Date of Birth _____ Place of Birth _____

Mother's Name _____ Father's Name _____

Prior Admissions to Travelers Transitional Living: ☐ Yes ☐ No Date Last Discharged: _____

EMPLOYMENT HISTORY

Types and Skills _____

Occupation: _____ Last Employer: _____

Is this your current employer? ☐ Yes ☐ No

INCOME INFORMATION

Any source/type of income? ☐ Yes ☐ No Amount of Income: _____

If yes, what type of income: ☐ Pension/Retirement ☐ SSI/SSDI ☐ Unemployment ☐ VA Benefits ☐ Other

Are you in the process of filing disability? ☐ Yes ☐ No

If so, what is your status? ☐ Awaiting Hearing ☐ Denied ☐ Income Pending

Do you receive Medicaid? ☐ Yes ☐ No Medicaid ID Number: _____

Do you receive Medicare? ☐ Yes ☐ No Medicare ID Number: _____

Females Only

Are you pregnant now? ☐ Yes ☐ No # of times pregnant: _____ Last menstrual period date: _____

MEDICAL HISTORY

Are you currently on any medications? ☐ Yes ☐ No

If yes, please give the names and dosage: _____

Prescribed by: _____

*** Please have at least 30 days prescription of medications upon arrival to Travelers Transitional Living***

Do you presently have a disability that is covered under the Americans with Disabilities Act (ADA) that will require special accommodations or specific needs? ☐ Yes ☐ No

If yes, then what is that disability and what specific accommodations or specific need will need to be made?

Description: _____ Level of Functioning: _____

Specific Needs: _____

Psychological History:

Have you ever been a patient in a mental hospital? ☐ Yes ☐ No

Have you ever had a mental health assessment/evaluation? ☐ Yes ☐ No

Are you currently on psychiatric medication? ☐ Yes ☐ No

If yes, explain with dates and list of medications: _____

*** Please have at least 30 days prescription of psychiatric medications upon arrival to Travelers Transitional Living***

HISTORY OF ADDICTION/ALCOHOLISM

☐ Blackouts ☐ DT's ☐ Epilepsy ☐ Neuritis ☐ Hallucinations

Date of Last Drink/Use: _____

Previous Treatments (List where and when):

Travelers Transitional Living

DRUG HISTORY LIST

CLIENT NAME: _____

Specify Name of Drug You Use/Used	Age When First Used	Age Regular Use Began	Route of Use	Amount You Use	How Often Do You Use	Date Last Used
Alcohol						
Amphetamines						
Barbiturates						
Caffeine						
Cocaine						
Hallucinogens						
Heroin						
Inhalants						
Marijuana/Hashish						
Narcotics/Opiates						
Over the Counter						
PCP						
Tranquilizers/Sedatives						
Other						

Are you currently on Methadone medications? ☐ Yes ☐ No

Are you currently on Suboxone medications? ☐ Yes ☐ No If yes, please specify which type: ☐ Pills ☐ Injections

Primary drug _____ Secondary drug _____

Tertiary drug _____

Level of Severity ☐ Mild ☐ Moderate ☐ Severe ☐ Partial Remission ☐ Full Remission

Client Signature

Date

EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____ Relationship: _____

Complete address: _____

As a resident of Travelers Transitional Living, I understand and accept my written responsibilities. In consideration of your admitting me as a resident of Travelers Transitional Living, I, for myself, my heirs, assigns or personal representatives, do hereby release the staff from any liability for any personal injury or property damage that I may sustain at any time at Travelers Transitional Living, or on its premises or while I am a passenger in any vehicle, and further agree to hold Travelers Transitional Living free and harmless from any and all liability in connection therewith:

Client First and Last Name (Print)

Client Signature

Date

PREVIOUS EMPLOYER:

LONGEST EMPLOYER:

OCCUPATIONS:

SKILLS

HOSPITALITY: **SERVICE:** **COOK:** **OTHER:**

CONSTRUCTION SKILLS: **CONCRETE:** **ELECTRICAL:** **DRYWALL:**

PLUMBING: **WELDING:** **PAINTING:** **ROOFING:**

HVAC: **LANDSCAPING:** **SHEETROCK:** **OTHER:**

OTHERS:

OFFICE SKILLS: **TYPING WPM:** **WINDOWS:** **EXCEL:**

CALL CENTER: **OTHER:**

INDUSTRIAL: **FORKLIFT:** **MACHINING:** **STOCKING:**

OTHERS:

HIGHEST LEVEL OF EDUCATION: