Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Location: \_\_\_\_\_\_\_\_

Each Question & Section of this application must be complete to be considered for approval.

Applicant Qualifications for the Re-Entry Programs: (Check All That Apply)

* 18 years of age or older
* Currently incarcerated in a county or state correctional facility
* Has an addiction to substance
* Willingly /able to work up to 40 hours per week in order to pay weekly program fee ($124)
* Willing to volunteer
* Client must be ambulatory and able to do activities of daily living such as: dressing, bathing, feeding)

Is this your first time applying for transitional housing at Dorothy’s House of Second Chances? Yes Or No

\* DHOSC do not accept returning applicants \*

PERSONAL INFORMATION (PROVIDE JAIL/PRISON ADDRESS)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TDOC/Inmate # \_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_ Age \_\_\_\_ Martial Status \_\_\_\_\_\_\_\_\_\_\_\_\_

Present Address (Jail/Prison) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Dorothy’s House Of Second Chances, does not discriminate based on medical history or diagnosis. DHOSC reserved the right to accept/decline application for our program. Any information provided will be protected and will not be shared with individuals without written consent by the applicant.

\* **Please mark the following yes or no questions with an X. \***

Please Provide A List of the Medications you are currently taking: (Write N/A of not Applicable)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication | Reason For Taking | Dosage | Time Per Day | Date Prescribed |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

* Staff will be responsible for administering all residents all non/prescription meds \*

Do you any allergies? Yes\_\_\_ No\_\_\_ If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any chronic medical conditions (i.e. high blood pressure, diabetes, thyroid, et.)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you ever been told you needed surgery for any medical condition? \_\_\_\_\_\_\_

If so, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was it for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*. Do you owe child support?

 Yes\_\_\_\_ No\_\_\_\_ If yes, what amount do you owe? \_\_\_\_\_\_\_\_\_

 Monthly Payments Amount: \_\_\_\_\_\_\_\_\_\_ Have your wages been garnished due to child support? Yes\_\_\_\_ No\_\_\_\_

**MENTAL HEALTH HISTORY**

Have you ever been or are currently diagnosed with mental health illness? Yes\_\_\_\_ No\_\_\_\_

If yes, what is your historical or current mental health diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attempted suicide or tried to kill someone else? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please describe when and how you though or attempted in the past. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUBSTANCE USE/ABUSE HISTORY**

 **Alcohol Use**

 What age did you start drinking? \_\_\_\_\_\_\_\_\_\_\_ How have you been drinking? \_\_\_\_\_\_\_\_\_\_\_

When was your last drink?\_\_\_\_\_\_\_\_\_\_\_

 Do you feel you are addicted to alcohol? Yes\_\_\_ No\_\_\_

Have you tried to stop using alcohol in the past? Yes\_\_\_ No\_\_\_

 Have you ever been in treatment? Yes\_\_\_\_ No\_\_\_

If yes, when, and where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were the consequences of your use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Use**

What was /is your drug (s) of choice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What age did you start using drugs? \_\_\_\_\_\_\_\_ How long did/have you used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often would you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When did you last use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you are addicted to drugs? Yes\_\_\_ No\_\_\_

Have you tried to stop before? Yes\_\_\_ No\_\_\_

Have you ever been in treatment or recovery programs? Yes\_\_\_ No\_\_\_

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were the consequences of your use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you willing to work DHOSC intensive recovery program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LEGAL ISSUES**

Are you or will you be on Parole or Probation upon release? Yes\_\_\_ No\_\_\_

Incarceration History: What are your current charges? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any pending charges or outstanding warrants in any other counties/states?

 Yes\_\_\_ No\_\_\_

Have you ever been convicted of a sex offense? Yes\_\_\_ No\_\_\_

Have you ever received a write-up(s) Yes\_\_\_ No\_\_\_ How many? \_\_\_\_\_\_\_\_ If yes, please identify the write-up (s) and explain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your most recent write-up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COLLATERAL CONTACT INFORMATION**

In order for us to facilitate your possible admittance into our program, we must have a way to obtain information regarding your release. Please provide the name and phone number of a corrections/re-entry counselors who we may contact.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position (Case Manager/counselor/Sgt./etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT BACKGROUND**

All residents must find employment and maintain at least 30-40 hours per week.

Do you feel that you are capable of working at least 30-40 hours per week? Yes\_\_\_\_ No\_\_\_\_

Last Year Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

 If I am approved for residency, I give Dorothy’s House of Second Chances permission to contact the following individual in the event of an emergency and to assist in arranging transportation DHOSC:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number (Including Area Code)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree that the information provided is true and accurate to my knowledge. I give DHOSC permission to use the information given to make a decision regarding my acceptance into the program or to help with my admission date and/or transportation. I further understand that if I am approved, I will be expected to be compliant with the program guidelines.

Sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Out of the following issues, what are your priorities upon release? Please circle 3-5.

* Housing
* Employment
* Food Education
* Health Care/Medical needs
* Life Skills
* Family/Social Relationships
* Mental
* Health

**Substance Abuse/Recovery Safety**

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you willing to commit for up to 6 month program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASES OF INFORMATION**

To facilitate your journey through the admissions process, you are required to complete the Release of Information included on the next page. This form means you are giving the facility you are located in permission to talk to DHOSC and help schedule possible admissions to the program. You must complete and return this form in order for your application to be processed.

1. Please fill in your name, date of birth, social security number at the top of the page.
2. Then fill in the name and address of the facility you are currently located in.
3. Write the date you entered incarceration in the space next to Treatment dates to release: From:
4. Next to the words Treatment dates to release: To: Please date it 6 months from the date
5. Please sign and date at the bottom of the page.

If you have outside individuals or parties (attorneys, public defenders, family member, etc.) whom we need to discuss your case with, an additional general release of information form is included on page 6. If an applicant refuses to sign a release of information for any party, DHOSC will not be able to confirm or deny information pertaining to that applicant due to Federal Laws of Confidentially.

**Authorization for Release of Information**

**(Criminal Justice Referrals)**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the release of the following specific information: (check all item that apply)

|  |  |  |
| --- | --- | --- |
| Presence In Treatment | Aftercare Plans | Progress in Treatment  |
| Medication Record | Psychiatric Evaluations | Psychosocial History |
| Admissions & Discharge Dates | Diagnosis | Discharge Summary |
| Physicians H&P | Labs & Ancillary Labs | HIV Related Information |
| Complete Client File (Excluding Psycho-therapy notes) | Discharge Certificate |  |

OTHER Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychotherapy Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 NOTE: If this item is selected, the items above cannot be selected. An authorization for a use or disclosure of psychotherapy notes cannot be combined with another authorization.

Treatment dates to release: Date Range: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_

From: Dorothy’s House Of Second Chances

 To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I understand that this information will be used to determine present and future eligibility for probation, parole, bail bond, pretrial release or other diversion or conditional release process within criminal justice system. This consent will remain in effect until, and will be revocable upon, the final disposition of my diversion or conditional release. The consent for release of information is given freely, voluntarily, and without coercion. I understand my records are protected under Federal Regulations governing Confidentially of Alcohol and Drug Abuse Patient Records, 42 CFR, (“Part 2”) and the Health Insurance Portability and Accountability Act of 1996 (“HIPPAA”), 45 CFR, Parts 160 and 164, and may be subject to re-disclosure by the recipient and no longer protected by law, except to the extent Part limits such disclosure. I understand that Dorothy’s House Of Second Chances may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. Resident/Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Release of Information**

**(General)**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_\_\_\_\_\_

I hereby authorize the release of the following specific information: (check all item that apply)

 Presence in Treatment Aftercare Plans Progress in Treatment

|  |  |  |
| --- | --- | --- |
| Presence In Treatment | Aftercare Plans | Progress in Treatment  |
| Medication Record | Psychiatric Evaluations | Psychosocial History |
| Admissions & Discharge Dates | Diagnosis | Discharge Summary |
| Physicians H&P | Labs & Ancillary Labs | HIV Related Information |
| Complete Client File (Excluding Psycho-therapy notes) | Discharge Certificate |  |

OTHER Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychotherapy Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NOTE: If this item is selected, the items above cannot be selected. An authorization for a use or disclosure of psychotherapy notes cannot be combined with another authorization. Treatment dates to release:

 Date Range: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: Dorothy’s House Of Second Chances To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand that this information will be used to determine present and future eligibility for probation, parole, bail bond, pretrial release or other diversion or conditional release process within criminal justice system. This consent will remain in effect until, and will be revocable upon, the final disposition of my diversion or conditional release. The consent for release of information is given freely, voluntarily, and without coercion. I understand my records are protected under Federal Regulations governing Confidentially of Alcohol and Drug Abuse Patient Records, 42 CFR, (“Part 2”) and the Health Insurance Portability and Accountability Act of 1996 (“HIPPAA”), 45 CFR, Parts 160 and 164, and may be subject to re-disclosure by the recipient and no longer protected by law, except to the extent Part limits such disclosure. I understand that Dorothy’s House Of Second Chances may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. Resident/Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_