# APPLICATION FOR ADMISSION

Person Completing Application:______________________________ Date:________________

Applicant Name:________________________________________ SSN:________________

Address:______________________________________________ DOB:________________

City:_________________________ State/Zip:________________ Gender: Circle One M F

Phone:________________________ Cell:___________________ Marital Status:__________

Email:______________________________________________________________________

***We would like to thank our referrals. How did you hear about Hopewell House?***

Name: ____________________ Phone: ____________________

Address: ______________________________________________

Referral Source: (circle one) Current/Past Resident Therapist/Counselor Hospital Other

**1. Your vision:** Your family member will of course have his/her own plans or goals for success. We are also interested in your current hopes for him/her and for his/her future. Write a brief statement that captures your desire and hope for your family member's recovery. What is your vision? What are some of the key things you expect Hopewell House to help your family member to achieve or accomplish?

______________________________________________________________________

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**2. Describe applicants current symptoms and/or diagnosis:**

**3. Is applicant currently participating in therapy/counseling?** **Yes** **No**

**4. Is applicant working or involved in day program?** **Yes** **No**

**5. Has applicant lived in other residential program/facility?** **Yes** **No**

**6. Identification and assessment of applicant's current strengths and/or problem areas.**

| Skills/Abilities | Independent | Needs Assistance | Area of Concern |
|---|---|---|---|
| Able to follow daily routine | | | |
| Able to take medication as prescribed | | | |
| Able to abstain from illegal drug use | | | |
| Able to refrain from alcohol use | | | |
| Able to articulate needs and feelings | | | |
| Able to handle anger appropriately | | | |
| Able to work cooperatively with others | | | |
| Able to work cooperatively with staff | | | |
| Able to socialize with peers | | | |
| Able to care for personal hygiene | | | |
| Able to care for private room/ personal belongings | | | |
| Able to share in domestic responsibilities | | | |
| Able to drive a car | | | |
| Able to adapt to group living situation | | | |
| Able to handle money | | | |
| Able to make home visits | | | |
| Able to maintain employment | | | |
| Able to participate in volunteer work | | | |
| Able to pursue educational goals | | | |
| ***Any special skills/interests***: | | | |

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**7. Describe history of violence, if any.**

**8. Describe legal history including number of incarcerations, if any.**

**9. Describe the applicant's history of suicidal or homicidal behavior, if any.**

| **10. Current Medications** | | | | |
|---|---|---|---|---|
| Medication Name | Dose | Times per Day | Reason Prescribed | How Long |
| | | | | |
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| **11. List any non prescription medicines, vitamins, remedies or herbs you take.** | | | | |
| Medication Name | Dose | Times per Day | Reason Prescribed | How Long |
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| **12. List any allergies applicant may have** **(include seasonal, food, medication etc).** | |
|---|---|
| Allergy | Reaction |
| | |
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| **13. List any medical conditions** **(high blood pressure, high cholesterol, thyroid disorder etc).** |
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| **14. Use space below to provide any additional information that might be helpful.** |
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Name of Primary Care Taker for Applicant:

Relationship: Occupation:

Address:

City: State: Zip:

Phone: Cell:

Name of Relative or other person assuming financial responsibility:

Is there a court appointed Legal Guardian or Power of Attorney for medical and/or financial purposes?

| | Yes | No | Same as Primary Caregiver |
|---|---|---|---|
| Legal Guardian | ☐ | ☐ | ☐ |
| Power of Attorney | ☐ | ☐ | ☐ |

Please specify scope of power of attorney:

If yes to any of the above, please fill out the information below:
Name:

Relationship to Applicant: Occupation:

Address:

City: State: Zip:

Phone: Cell: Email:

| Health Insurance Information | |
|---|---|
| Company: | Phone: |
| Address: | |
| Policy # | Group # |
| Policy Holder: | Policy Holder DOB: |
| Medicare: | Medicaid: |

***Medical Requirement: If the applicant has had a physical examination within the past 60 days, we require a copy of that record. If not, state licensing requirements dictate that we schedule an appointment for a physical within 30 days of admission.***

FOR OFFICE USE ONLY

Date Application Received: ______________________

☐ Applicant Accepted ☐ Applicant Declined

Date of Admission/Intake: ______________________