FLACRA Application for Supportive Living Admission:

Part 1: Client Demographics

to be completed by Referral Source

Name: _____

Date of Birth: ___ /___ /___

Birth Name- if different from above:

Gender: ___ Pregnancy Status: ____ Ethnicity: _____

Social Security Number: _____-_____-_____ Primary Language: _____

Veteran Status: ____ Type of Discharge:____

County of Origin: _____ Zip Code of Origin:_____

Current Address(& type of Residence):

Phone Number:_____

_____

_____

_____

Anticipated discharge date: ___ / ____ / ____ Is this date flexible? Yes No

PART II:

to be completed by the applicant or their designee has difficulty with reading & writing, can be completed by another source-

Name:_____

Do you have a phone? Y / N
If yes, phone number (_____) _____ - _____ Text Only YES NO
Email address: _____

Have you ever been a Client of FLACRA in the past? Y / N
If so, when & in what facility? (Please indicate as many times as you remember)

_____

_____

_____

Emergency Contact Information:
Name: _____ Relationship to applicant? _____
Address: _____ Phone Number:_____

_____

_____

Education/Vocation:
Highest grade completed: _____ GED Complete? Y / N
Type of Vocational Certificate Received_____ Date received: ___ / ___ / ___
Currently Employed:_____ VAMC – IT_____ CWT_____? Hours Per week: _____
Last time employed: _____ Types of positions held: _____
_____
_____
Any problems with reading or writing in school/now?_____
Did you attend Special Ed, attend a resource room while in school?_____
Do you have a current Drivers License: Y /N What state was it issued in?_____
Will you be bringing a vehicle with you? _____ If so what is Make & Model?_____
(Please note all vehicles must be in good repair, have a current inspection, registered & insured, this information MUST be provided at admission)

Family Status:
Never married___ Married ___ Living as married___ Separated____ Legally Separated____
Widowed_____ Divorced_____

Do you have children?_____ How many?_____ Who do they live with?_____

Ages:_____ Gender:_____

How often do you see them?_____

Is CPS or Foster Care involved? Y / N Contact name?_____

County of care: _____ Contact Phone number?_____

Can your children be returned to you? _____ If yes, what is the anticipated time frame for their return? Explain:_____
_____
_____
_____

PART II CONTINUED:

Please provide all information requested. Use additional sheets of paper if necessary. Thank you.

1. Why you think you would benefit from Supportive Living and what is it that you hope to gain from being in this program?

2. What challenges can you identify at this time, including relapse triggers, at this time?

3. What Strengths can you identify that you have at this time?

4. If you are currently receiving treatment, please identify goals and problems that you are currently addressing in that service.

5. Please summarize any other addictions, including gambling, sex, food, internet, video games, work, pornography:

6. What is your work and or educational goal(s)?

7. What financial resources do you have while in supportive living? (family, expected PNA, savings?)

PART II CONTINUED:

MEDICAL NEEDS:

ALL of these questions below MUST be answered:

Who is your Primary Care Physician? Address: Phone Number: (___) ___ - _____

_____

_____

_____

Are you currently being treated for any medical problems? Yes No Explain:

Are you taking any medications?

If so, what are they & why do you take them?

Are you taking them as prescribed? YES NO

Do you have a 30 day supply?

Do you require help from staff to help you remember to take your medications?

Have you been engaging in risky behaviors? Sharing Needles, unprotected sex?

When was the last time you were at the ER?

When was the last time you were hospitalized overnight? WHY?

LEGAL INFORMATION: NO CHARGES EVER:_____

Charges pending _____ if so, when & where do you return to court? _____

Treatment Court_____ What County? _____ What Phase? _____ NONE_____

Court Coordinator's Name, Address & Phone Number:_____

_____

Probation_____ What County_____ How often do you see your probation officer? _____

Name, Address & Phone Number of Probation Officer:_____

_____

Parole_____ What County_____ How often do you see your parole officer?_____

Name, Address & Phone Number of Parole Officer:_____

_____

Does anyone have an order of protection against you? Do you have one against someone?

If yes, who & when does it expire?_____

Please share your legal history (include all arrests & charges and convictions, including time served, please use separate paper if needed).

PART II CONTINUED:

MENTAL STATUS

Do you have a co-occurring diagnosis?

Are you being treated for these issues?

If so, where do you attend?

How often?

Are you taking any medications for these issues? If yes, please list.

Have you spoken with your provider about a referral for services in this area?

Where are you being referred to?

SUPPORTS YOU WILL HAVE IN SUPPORTIVE LIVING:

What is your "Clean" or "Sober" date?

What is your longest length of sobriety /clean time?

How was this obtained?

Please identify your current support system. This should include your sober support network and all other supports you have for your recovery

_____ _____

Applicant Signature

Date