



**APPLICATION FOR ADMISSION**

Date: \_\_\_\_\_

Applicant:		Date of Birth:	
Social Security No.		Medicaid No.	
		Medicare No.	
Address:		City:	
County:		State:	
Home Phone:		E-mail:	
Parents/Legal Representative:		Phone:	
Has the Applicant ever lived in a group living situation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the Applicant compliant with his/her current medication regimen?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Referred by:	
Agency:	Phone:

Is there a Power of Attorney?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Please provide all Power of Attorney documentation and contact information.</i>
Is there a Medical Power of Attorney?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there a Financial Power of Attorney?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Felony <input type="checkbox"/>	Misdemeanor <input type="checkbox"/>	<input type="checkbox"/> N/A	<i>Explain:</i>
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**Presenting Problems:** \_\_\_\_\_

**SUBSTANCE & ALCOHOL ABUSE HISTORY:**

Drug	Amount	Frequency	Last Used	Age Started

Check all that apply. For all items checked Current or History, provide explanation in the spaces provided below.

SYMPTOMS AND BEHAVIOR	CURRENT	HISTORY	NEVER	UNKNOWN
Homicidal Ideation/Attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Ideation/ Attempts (Date of last attempt?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Violent Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arson/Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bizarre or Inappropriate Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation of Current/History:				

**DIAGNOSIS**

	<b>Diagnosis</b>	<b>GAF:</b>
<b>Axis I</b>		<b>Date:</b>
<b>Axis II</b>		
<b>Axis III</b>		
<b>Axis IV</b>		
<b>Axis V</b>		

**BEHAVIORS**

***Does the applicant have a history of any of the following?***

<input type="checkbox"/> Yes <input type="checkbox"/> No	Refusal to attend therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stealing
<input type="checkbox"/> Yes <input type="checkbox"/> No	Refusal of medications	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arson
<input type="checkbox"/> Yes <input type="checkbox"/> No	Refusal of medical treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Destruction of Property
<input type="checkbox"/> Yes <input type="checkbox"/> No	Refusal to bathe or wear clean clothes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mood swings
<input type="checkbox"/> Yes <input type="checkbox"/> No	Inappropriate sexual behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No	Verbal assaultiveness
<input type="checkbox"/> Yes <input type="checkbox"/> No	Ingestions of toxic substances	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical assaultiveness
<input type="checkbox"/> Yes <input type="checkbox"/> No	Resistance to authority	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wandering
<input type="checkbox"/> Yes <input type="checkbox"/> No	Paranoia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disruptiveness

*If **Yes** to any of the following, provide explanation:*

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**CURRENT MEDICATIONS**

Drug	Dosage	Frequency	Date Started

***Please list all non-prescription and over-the-counter medication that you take on a daily basis.***

***Please note any physical problems and list all on-going treatment (i.e., diabetes, seizures, etc.):***

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**IDENTIFICATION & ASSESSMENT OF APPLICANT'S CURRENT STRENGTHS & PROBLEM AREAS:**

<b>ABILITY...</b>	<b>Satisfactory</b>	<b>Problem Area</b>	<b>Requires Work</b>
<i>to follow an approved daily plan</i>			
<i>to accept medication as prescribed</i>			
<i>to maintain acceptable sleep patterns</i>			
<i>to abstain from illegal drug use</i>			
<i>to refrain from alcohol use except with therapist permission</i>			
<i>to limit personal difficulties to a point of not disturbing the house</i>			
<i>to articulate needs and feelings</i>			
<i>to handle anger appropriately</i>			
<i>to work cooperatively with peers</i>			
<i>to work cooperatively with staff</i>			
<i>to socialize</i>			
<i>to care for personal hygiene</i>			
<i>to care for private room</i>			
<i>to share in the work of the house</i>			
<i>to drive a car</i>			
<i>to adapt to a group living situation</i>			
<i>to handle money</i>			
<i>to make home visits</i>			
<i>to do volunteer work</i>			
<i>to handle a paying job</i>			
<i>to continue educational goals</i>			

List the primary goals Academy House should aim toward in working with the applicant during the first 8 weeks.

**1)**

**2)**

**3)**

Any special interests or skills? (i.e., photography, music, cooking, etc.)
1)
2)
3)

Financial Responsible Party:	Person to be notified in case of emergency:
Contact Information:	Contact Information:

**We would appreciate any suggestions that would aid in understanding and caring for applicant.**

Please attach all appropriate discharge material to the application. The completed Application form and discharge material(s) can be scanned and sent to [ben@theacademyhouse.com](mailto:ben@theacademyhouse.com) or via fax to 845.625.1512. This is a confidential fax line and all transmission will be directly sent to the Administrator, Ben Howard.