Application for Services

17670 Technology Boulevard ~ Hagerstown, MD 21740 ~ 240-267-2230 ~info@brookeshouse.org

Level of Care Applying for: ❒ **Residential Care 3.1** ❒ **Intensive Outpatient 2.1 (IOP)** ❒ **Outpatient Level 1 (OP)**

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

Full Name:		**Today's Date:**	
Address (before treatment or incarceration):	**City:**	**State:**	**Zip Code:**
Was this safe housing or conducive to recovery? ❒ **Yes** ❒ **No**	**Primary Substance Use Diagnosis:**	**Telephone:**	
Email:	**Social Security #:**	**DOB:**	
Race:	**Ethnicity:**	**Military Veteran:** ❒ **Yes** ❒ **No**	
Marital Status: ❒ **Married** ❒ **Divorced** ❒ **Separated** ❒ **Partnered** ❒ **Single** ❒ **Widowed**	**Height:**	**Weight:**	
Is this Court Appointed Treatment: ❒ **Yes** ❒ **No**	**Referring Agency:**		
Agency Phone #:	**Referring Counselor:**	**Sobriety Date:**	
Current 3.1 / OP / IOP or Other Services at:		**Anticipated Discharge Date:**	
Insurance: ❒ **Yes** ❒ **No** **Insurance Type:**		**Insurance Carrier (other than self):**	
Group #:	**Member #:**	**Contact #:**	
Current Forms of ID (please check all that apply): ❒ **Driver's License** ❒ **ID Card** ❒ **Birth Certificate** ❒ **Social Security Card** ❒ **Passport** ❒ **Other:**	**Are you currently employed:** ❒ **Yes** ❒ **No** **If yes, where:**	**Other forms of income:** ❒ **Disability/SSI/SSDI** ❒ **Child Support** ❒ **Other:** (please explain)	

Presenting Problem (check all that apply)

Primary Substances	**Mental Health**	**Medical**	**Physical Environment**	**Legal Problems**
☐ Alcohol	☐ Exposure to Violence	☐ Pregnant	☐ Homeless / Shelter needs	☐ Alcohol Crimes
☐ Cocaine	☐ Domestic Violence	☐ Physical Disability	☐ Food needs	☐ Drug Charges
☐ Fentanyl	☐ Grief	☐ Allergies	☐ Employment needs	☐ Sex Crimes
☐ Heroin	☐ Physical Abuse	☐ Other: _____	☐ Financial needs	☐ Violent Crimes
☐ Hallucinogens	☐ Sexual Abuse		☐ Sanitation	☐ Cyber Crimes
☐ Inhalants	☐ Self Harm		☐ Safety needs	☐ Crimes against Justice
☐ Marijuana	☐ Suicidal Ideation/Attempts			☐ Public Safety Violations
☐ Methamphetamines	☐ Victim of Discrimination (i.e. Sexual orientation, race, gender)			☐ Fraud/Financial Crimes
☐ Tobacco/Nicotine	☐ Eating Disorder _____			☐ Property Crimes
☐ K2/Spice	☐ Mental Health Disorder _____			☐ Attempt, Conspiracy/Aiding
☐ MDMA				☐ Homicide
☐ Other _____				☐ Other _____

Any Other Information:(explain)_____

LEGAL INFORMATION

Are you currently incarcerated? ❒ Yes ❒ No	**Facility Type:** ❒ Jail ❒ Prison ❒ Detention Center ❒ Other:	
Facility Name:	**Scheduled Release Date:**	
If applicable, enter current charge(s)		
Type of charge(s): ❒ misdemeanor ❒ felony ❒ both	**Do you have any pre-court with charges pending?** ❒ Yes ❒ No	**Where are the charges pending?** (County and State)
Do you have legal representation? ❒ Yes ❒ No	**Legal Representation Name and Phone #:**	
Are you currently on probation? ❒ Yes ❒ No	**What county are you required to report to for probation?**	**Are you a repeat offender?:** ❒ Yes ❒ No
Probation Officer Name and #:		
Previous Incarcerations/Reason/and Estimated Dates:		

MEDICAL INFORMATION

Name of Current Physician: **Office Telephone#:**			
Pregnant : ❒ Yes ❒ No	**HIV:** ❒ Yes ❒ No	**Hepatitis C:** ❒ Yes ❒ No	**IV Drug Use:** ❒ Yes ❒ No
Drug Allergies: ❒ Yes _____ ❒ No		**Food Allergies:** ❒ Yes _____ ❒ No	
Are you currently on any form of Medically Assisted Treatment (MAT): ❒ Yes ❒ No	**If yes, please list: (suboxone, sublocade, vivitrol, methadone)**		
Have you tried MAT previously? ❒ Yes ❒ No	**Was it successful?** ❒ Yes ❒ No **If not, why?:**		
Identify and describe other medical problems or physical limitations:			
Are you able to take medications by yourself?: ❒ Yes ❒ No	**Are you able to climb stairs without assistance:** ❒ Yes ❒ No	**History of Seizures:** ❒ Yes ❒ No	

Substances Used	Age of First Use	Frequency	Method: Orally, Injection, Inhaled, Smoked	Date of Last Use
1.				
2.				
3.				
4.				

MENTAL HEALTH INFORMATION

Do you have a mental health diagnosis: ❒ Yes ❒ No	**If yes, please list DSM 5 with description and dates of diagnosis:** **Primary:** _____ **Description:** _____ **Date of Diagnosis:** _____ **Secondary:** _____ **Description:** _____ **Date of Diagnosis:** _____ **Tertiary:** _____ **Description:** _____ **Date of Diagnosis:** _____

Are you taking medication for this condition: ❒ Yes What: ❒ No	**Are you currently receiving psychiatric services for this condition :** ❒ Yes By whom: _____ ❒ No

Have you ever been hospitalized for mental health? ❒ Yes ❒ No	**If yes, please list nature and dates:**

Do you have a history of suicidal ideation or attempts: ❒ Yes ❒ No **How many times:** _____ **Date of last attempt:** _____	**Do you have a history of homicidal ideation or attempts:** ❒ Yes ❒ No

HISTORY

Have you had any attempts at sobriety without treatment? ❒ Yes ❒ No **If yes, how many?** _____

Have you been in treatment within the last calendar year? ❒ Yes ❒ No

If yes, how many times for each? Detox Only: _____ **Inpatient:** _____ **Outpatient:** _____

Please list in order of most recent:

1. Where: _____ **When:** _____

Counselor/Probation Officer/Case Worker Name: _____

Contact Info: _____

2. Where: _____ **When:** _____

Counselor/Probation Officer/Case Worker Name: _____

Contact Info: _____

3. Where: _____ **When:** _____

Counselor/Probation Officer/Case Worker Name: _____

Contact Info: _____

4. Where: _____ **When:** _____

Counselor/Probation Officer/Case Worker Name: _____

Contact Info: _____

HISTORY Continued

Have you had a period of sobriety in the past year: ❒ **Yes** ❒ **No** **How long did you remain sober:** _____

What did you do to maintain your sobriety and why did you relapse?: _____

_____

_____

_____

_____

_____

_____

What is your motivation for treatment at this time?_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Client Signature: _____ **Date:** _____

Authorized Referring Signature: _____ **Date:** _____

Please return completed forms, including a bio-psychosocial and any other supporting documentation to:
info@brookeshouse.org

For Office Use Only

Date Received: _____

Program Type: _____ **Eligible for Admission on:** _____ **Projected Admission Date:** _____

❒ **Not Appropriate for Services** **Determination:** _____

Review by: _____