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:**
County:	**Was this safe housing or conducive to recovery?** ❒ Yes ❒ No		
Telephone:	**Social Security #:**		**DOB:**
Referring Agency and Phone #:	**Referring Counselor:**		**Sobriety Date:**
Current 3.1 / OP / IOP or Other Services at:		**Anticipated Discharge Date:**	
Marital Status: ❒ Married ❒ Divorced ❒ Separated ❒ Partnered ❒ Single ❒ Widowed ❒ In A Relationship	**Height:**		**Weight:**
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:			**Military Veteran:** ❒ Yes ❒ No
Are you currently employed: ❒ Yes ❒ No **If yes, where:**	**Other forms of income:** ❒ Disability/SSI/SSDI ❒ Child Support ❒ **Other:** (please explain)		

LEGAL INFORMATION

Are you currently incarcerated? ❒ Yes ❒ No	**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 #:		

MEDICAL INFORMATION

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)		

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

Identify and describe other medical problems or physical limitations:
List any current medications:

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	Do you have a history of suicidal ideation or attempts: ❐ Yes ❐ No Date of last attempt:

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: ____

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: ❐ Detox Only ❐ Inpatient ❐ Outpatient

What is your motivation for treatment at this time?

Client Signature: ____ Date: ____

Authorized Referring Signature: ____ Date: ____

Please return this completed form, including bio-psychosocial, medication list, and any other supporting documentation to:
info@brookeshouse.org

Revised: 10/2021