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:**
Diagnosis:	**Current 3.1 / OP / IOP or Other Services at:**		**Anticipated Discharge Date:**
Sex assigned at birth:	**Pronouns:**	**Race:** **Ethnicity:**	
Marital Status: ❒ Married ❒ Divorced ❒ Separated ❒ Partnered ❒ Single ❒ Widowed	**Height:**	**Weight:**	
Insurance: ❒ Yes ❒ No **Group #:**	**Insurance Type:** **Member #:**	**Insurance Carrier (other than self):** **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)		

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)____

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LEGAL INFORMATION

Are you currently incarcerated? ❐ Yes ❐ No	Facility Type: ❐ Jail ❐ Prison ❐ Detention Center ❐ Other:	
Facility Name:	Inmate ID:	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: ____

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?: ____

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What is your motivation for treatment at this time?____

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Client Signature: ____ Date: _______________________

Authorized Referring Signature: ____ Date: _______________________

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

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For Office Use Only

Date Received: ____________________________

Program Type: _______ **Eligible for Admission on:** ______________ **Projected Admission Date:** ____________________

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

Review by: ____