

Financial Information: (Residential /Supported Living Programs)

Source of Income: _____

Monthly Income Received From All Sources: _____

Monthly Expenses for Personal Needs: _____

Monthly Expenses for All Other Needs: _____

Part III – Psychiatric History

Registered with Community Counseling Services: Yes No

Community Mental Health Worker: _____

Phone: _____

Diagnosis: _____

Medication(s): _____

Past Treatment / Intervention: _____

History of Problem Areas: (Pertinent Information **MUST** be Included)

Emotional / Behavior _____

Self Harm _____

Drug / Alcohol / Chemical / Gambling Abuse _____

Physical Aggression _____

Criminal Activity _____

Psychiatric Problems _____

Suicidal Behavior _____

Psychiatric Institutionalization (Include Date of Last Admission / Discharge)

Self Medicating _____

Other – Specify _____

Part IV – Areas of Assistance Requested

- | | |
|---|--|
| <input type="checkbox"/> Stabilization | <input type="checkbox"/> Personal / Mental Wellness Education |
| <input type="checkbox"/> Medication Management | <input type="checkbox"/> Interpersonal / Social Skills Development |
| <input type="checkbox"/> Assessment / Observation | <input type="checkbox"/> Career Planning |
| <input type="checkbox"/> Goal Setting / Strategy Planning | <input type="checkbox"/> Job Search Supports |
| <input type="checkbox"/> Financial Management / Budgeting | <input type="checkbox"/> Other ~ Specify Below |
| <input type="checkbox"/> Nutritional / Meal Preparation | _____ |
| <input type="checkbox"/> Daily Living Skills | _____ |
| <input type="checkbox"/> Socialization / Integration | _____ |

Part V – Applicant’s Objectives (MUST BE COMPLETED BY APPLICANT)

Short Term Goals: _____

Long Term Goals: _____

How will this Program assist you in achieving your Goals?

What commitments are you willing to make to ensure the Program is successful for you?

Part VI - Discharge Plan (Mandatory for Residential Program)

**** Voluntary and Involuntary Sections MUST be Completed by Applicant ****

❖ **Voluntary** (Self ~ Discharge OR Completion of Program)

Proposed Plan for Applicant upon Discharge:

❖ **Involuntary** (Non ~ Compliant to Program)

A) Contact Name: _____ Relationship: _____

Address: _____ Phone: _____

Contact's Signature: _____
PRINT NAME SIGNATURE

B) Contact Name: _____ Relationship: _____

Address: _____ Phone: _____

Contact's Signature: _____
PRINT NAME SIGNATURE

Section VII

Applicant Name: _____
PRINT NAME SIGNATURE

Referral Source: _____
PRINT NAME SIGNATURE

Date: _____
DAY / MONTH / YEAR

For Office Use Only:

Referral Date: _____ **Intake Date:** _____

Admission Date: _____ **Discharge Date:** _____