

3800 5th Street
St. Cloud, Florida 34769
Ph: (407)892-5700 Fax: (407)593-2932

Application for Admission

**In order for your application to be reviewed, it must be completely filled out
and H&P and TB /PPD test must be attached.**

Date: ___/___/___

Applicant's Name: _____

First Middle Last

SSN: _____ / _____ / _____ DOC#: _____

Date of Birth: _____ Age: _____ Sex: M ___ F ___

Referring Agency: _____

Referring Agency Address: _____

Referring Person: _____

Referring Person's phone: _____ Fax: _____

Drug History

Have you been to other treatment facilities: Yes ___ No ___

If yes, where and when: _____

Primary Drug of Choice: _____ Age of first use: _____

Frequency of use: (daily, weekly, monthly etc.) _____ Method: _____

Secondary Drug of Choice: _____ Age of first use: _____

Frequency of use: (daily, weekly, monthly etc.) _____ Method: _____

Third Drug of Choice: _____ Age of first use: _____

Frequency of use: (daily, weekly, monthly etc.) _____ Method: _____

Medical Insurance

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Do you have medical insurance: Yes _____ No _____

If yes, what company: _____

Policy Holder Name: _____

Policy # _____ telephone # _____

Type of Coverage: PPO HMO Other If other explain: _____

Medical History

Date of last TB test? _____ if it is within 12 months of your release date please attach a copy to this application or bring with you upon admission.

Do you have any present medical conditions? Y____ No_____

If yes, please list:

_____ Any past medical conditions? Y__ N__

If yes, please list:

Psychiatric History

Do you have a past or present psychiatric diagnosis? Y____ N____

If yes, where and when were you diagnosed? _____

What was the diagnosis? _____

Medications

Are you currently taking medications: Y__ N__

If yes, please list medications:

Name of drug	Dosage (mg, how you are supposed to take it)
_____	_____
_____	_____
_____	_____

Military History

Are you a Veteran: Y__N__

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If Yes, which branch did you serve in: _____ Dates of service: _____

What type of discharge: _____

Employment History

Place of last employment: _____ Date: _____

Type of work experience that you have: _____

Income Status

Do you receive income: Y____ N____

If yes, which kind: SSI____ SSDI____ Unemployment____ Wages____ Pension____

Other: _____

Monthly income: \$_____ Do you have any financial responsibilities? _____

If yes, what are they _____

Legal History

Any present legal issues: Y____ N____

If yes, list the **charges**, **dates**, and **locations**: _____

Have you been in prison: Y____ N____ If yes, please list **when** and **where**:

Release Date(s): _____ DOC #: _____

Are you currently on probation, parole, or community service: Y____ N____ Explain:

Probation Officer's Name: _____

Address: _____

Phone # _____ Fax # _____

Education

Highest grade completed: _____ Do you have your GED: Y____ N____

If you have a college degree, what is the degree: _____ Field of study: _____

Marital Status

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Single ___ Married ___ Widowed ___ Divorced ___ Separated ___

Do you have children: Y ___ No ___ If yes, how many ___ ages: _____

Whom do your children reside with? _____

Where do they reside? _____

Do you have parental rights? Y ___ N ___

Is your family supportive of you getting help for your substance abuse disorder? Explain _____

Living Arrangements

Are you homeless: Y ___ N ___ If yes, how many times have you been homeless in the past 5 yrs? _____

During your periods of homelessness how long have they been? _____

If you are not homeless, what is your current address? (include, city, state and zip code) _____

Telephone: _____ Cell: _____

Emergency Contact Person

Name: _____ Relationship: _____

Address: _____

Telephone: _____ Cell: _____

Your Goals and Plans

What do you hope to accomplish if you are admitted into The Transition House?

What are your short term goals?

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Define your long term goals?

What is your plan to obtain employment, do you have a resume?

What are your plans to obtain long term permanent housing?

ITEMS TO BE INCLUDED WITH YOUR APPLICATION or to bring Upon admission into The Transition House Inc.

*History & Physical	Bio/Psycho/Social Assessment	30 Days of medication	*TB test –must be within 12 months of admission to TTHI.
Nursing Assessment	All lab work	MARS	

*** Must be attached with this application**

FOR OFFICE USE ONLY:

Accepted: Yes _____ No _____

Type of Funding: _____ Scheduled arrival date: _____ Time: _____