Charles County Human Services Partnership
APPLICATION FOR RESIDENTIAL REHABILITATION SERVICES

(I) Today's Date:___________________
Applicant's Name: ____ (Last)
(First) (M.I.)
Address: ____
(Last known address in community)
Date of Birth:_______________ Social Security#:________________________
___________Gender:______ Race:________ Marital Status: ______________________
Current Entitlements and Income (Fill in amounts and/or insurance numbers)
SSI_______________SSDI:__________________Other Income:________________________________Medicaid (MA) _
________________________Medicare:____________________________________Other Insurance Name &
Number: ____

(II) Referral Source Name:__________________________________ Agency ______________________
___________Telephone # ______________________________________

Psychiatrist Name ______________________________Telephone #__________________________Other Providers (Mobile Treatment, PRP, Case Management, Outpatient)-(please circle)
___________Name of   Program contact Person   Telephone#
____
____
____

Primary Contact (applicant, therapist, family, member, friend, other)-(please circle)
___________Name of Contact   Telephone No.   Relationship to Applicant
_________________________________ ______________________ __________________________

(III) ______Current Psychiatric Diagnosis: DSM-IV Code:
Axis I: ____
____
____
____
Axis II: ____
Axis III: ____
Axis IV: ____
Axis V: (GAF)____
Number of psychiatric hospitalizations:_____________
Date, Location & Length of Stay:____
____

Applicant's Name__________________ DOB ________

(IV) Name of Primary Medical Provider (PMP) ____ Address:_ ____Telephone #:_________________________ ____

____________Significant Somatic Issues ____

____

(V) All Current Medications: (Psychiatric and Somatic) Current

Type Dosage-Frequency

____

____

____

____

____

____

__________Current ability to take medicine:

__________Independently ______ With reminders ______With daily supervision _________ Refuses medication _____________ Meds not prescribed ____________

__________Comments: ____

____

(VI)_______Legal History/Forensic Involvement

Has the applicant ever been arrested? Y____ N_____

On Probation or Parole? Y_____ N______

__________List any reported convictions ____Parole or probation officer & Phone #:____

Has applicant been found NCR? Y______N______

Is on (or will be) conditional release? Y____ N______

(VII) Substance Use/Abuse History

Drug Used (including alcohol)	Period of Use	Frequency/Cost	How Used

Drug Last Used	Date	Amount	How Used

Substance Abuse Treatment History (date and location)

A.A._______________________________ N.A. ____

Detox ____

Inpatient Services ____ Outpatient Services ____

Applicant's Name ________________________ DOB____________

(VII) Risk Assessment (Never, past week-month, past month-year, past 2+ years)
Suicide Attempts:____
Suicidal Ideation:____ Aggressive Behavior/Violence:____Fire Setting:____

(IX) ______Activities of Daily Living
_______Independent; ________ Needs moderate support; _______Needs significant support

(X) Previous RRP involvement? Yes___ No ____ If yes, reason for discontinuation of RRP
Consumer preference of provider____
Cultural preference of consumer ____

(XI) Rationale for Service:
(Please include major areas of need and applicant's goals for RRP)
____
____
____
____
____
____
____
__________ Recommended Level of Residential Placement:
__________General Level __________Intensive Level

(XII) Is the applicant in agreement with the above referral?_____Y _____N
If "No", explain :____
____

____
Date____ Referral Source Signature
____

Applicant's Name:______________________________Date: __________

CONSENT TO RELEASE INFORMATION
FOR RESIDENTIAL PLACEMENT

I give my consent to____(CSA)to release this application and other clinical and psycho-social history to a Residential Rehabilitation Program in order to assess my eligibility for residential services in the community.

I understand that this information will not be released to any other party without my express written consent.

I further understand that my consent does not commit me to accept a placement, and it does not commit the Core Service Agency to provide a placement for me.

I understand that I may revoke this consent at any time by a written statement. This consent is valid for 12 months from the date of my signature.

Signature: ____________________________ Social Security #:______________________

Date: _________________Date of Birth: _________________Witness:_________________

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