



St. Cloud, Florida 34769

Ph: (407)892-5700 Ext. 104 Fax: (321) 805-3284 Email: Residential@thetransitionhouse.org

Application for Admission

In order for your application to be reviewed, it must be completely filled out.

Date: ___/___/___

Applicant's Name: _____

First

Middle

Last

SSN: _____/_____/_____ DOC#: _____

Date of Birth: _____ Age: _____

Sex you identify with: M___F___T___

Referring Agency: _____

Referring Agency Address: _____

Referring Peron: _____

Referring Person's phone: _____ Fax: _____

Drug History

Have you been a client with TTHI before? Yes_____ No_____

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: _____



St. Cloud, Florida 34769

Ph: (407)892-5700 Ext. 104 Fax: (321) 805-3284 Email: Residential@thetransitionhouse.org

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

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:

Are you able to get on a top bunk? Yes No

Are you able to walk up and down stairs? Yes No

Psychiatric History

Do you have a past or present psychiatric diagnosis? Y _____ N _____



St. Cloud, Florida 34769

Ph: (407)892-5700 Ext. 104 Fax: (321) 805-3284 Email: Residential@thetransitionhouse.org

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_____

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



St. Cloud, Florida 34769

Ph: (407)892-5700 Ext. 104 Fax: (321) 805-3284 Email: Residential@thetransitionhouse.org

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

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 _____



St. Cloud, Florida 34769

Ph: (407)892-5700 Ext. 104 Fax: (321) 805-3284 Email: Residential@thetransitionhouse.org

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?



St. Cloud, Florida 34769

Ph: (407)892-5700 Ext. 104 **Fax:** (321) 805-3284 **Email:** Residential@thetransitionhouse.org
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?

Please fax Application and Records to 321-805-3284 or email to residential@thetransitionhouse.org. ITEMS TO BE INCLUDED WITH YOUR APPLICATION:

History & Physical

Medication List

***TB test –must be within 1 month of admission to TTHI.**

Biopsychosocial

Psych Eval

Labs