Raven House
Protecting with Purpose!

Admission Application

Thank you for your interest in Raven House Inc. Our agency provides both group home and independent housing for youth. Our group homes range from transitional to long-term and provide services to both male and female consumers.

Please review the following criteria prior to completing the attached referral form. RH does not discriminate based on race, creed, color, age, ethnicity, religion, gender, sexual orientation or national origin in either the eligibility or intake process.

Once your completed referral packet is received, it will be thoroughly reviewed. You will be contacted as to its disposition within three working days. **Do not leave areas blank, if it doesn't apply, put N/A**

Once again, thank you for your interest in Raven House, Inc.

ADMISSION SOURCE: Date:_____

Contact Person: _____ Date: _____

Placement Agency:_____ Phone: ( ) _____

Email: _____ Address: _____

City: _____ State: _____ Zip: _____ Reason for placement:_____

CLIENT INFORMATION:

Client Name: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

D.O.B.: _____ Social Security #: _____-_____-_____ Sex: ( ) Male ( ) Female

Does client have any children? ( ) Yes ( ) No If yes, how many children? _____

Race/Ethnicity:
( ) American Indian or Alaskan Native
( ) Asian or Pacific Islander
( ) Black, Not of Hispanic Origin
( ) Hispanic
( ) White, Not of Hispanic Origin
( ) Other: _____

Significant Features
( ) Bruises
( ) Injuries
( ) Scars
( ) Tattoos
( ) Birthmarks

Primary Lang:
( ) English
( ) Spanish
( ) American Sign Language
( ) Other: _____

Height____ Weight_____ Eye Color____ Hair color_____

Religion_____

COMMUNITY CONTACTS:

Name: _____ Relationship: _____ Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____ Relationship: _____ Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

DIAGNOSIS (DSM IV):

Axis I: _____ DSM Code: _____

Axis I: _____ DSM Code: _____

Axis II: _____ DSM Code: _____

Axis III: _____ DSM Code: _____

Axis IV: _____ DSM Code: _____

Axis V(GAF): _____ DSM Code: _____

MEDICAL INFORMATION

Describe presenting illness. _____

_____

_____

MEDICATION HISTORY:

Medication	Dosage	Frequency	Physician	Date Prescribed	Date Stopped

HISTORY OF ILLNESS:

List previous hospitalizations.

Name of Hospital	Reason for Admission	Admission Date	Discharge Date

Has client ever been involved in outpatient/partial care treatment? ( ) Yes ( ) No If yes, explain:

Name of Facility Dates of Attendance

Is there a history of suicide attempts/gestures/ideations? ( ) Yes ( ) No If yes, explain:

Is there a history of violent/assaultive behavior? ( ) Yes ( ) No If yes, explain:

Is there a history of fire setting? ( ) Yes ( ) No If yes, explain:

SUBSTANCE USE HISTORY:

Does client have history of alcohol or drug use? ( ) Yes ( ) No If yes, explain:

Substance(s) Date of First Use Amt./Freq. of Use Date of Last Use

What was the client's longest period of abstinence? _____

Has client ever been in treatment for substance use? ( ) Yes ( ) No If yes, explain:

Type of Treatment (IP, OP, Rehab, Residential, etc.) | Admission Date | Discharge Date

Has client participated in self-help/support groups? ( ) Yes ( ) No If yes, explain:

Type of Group	Attended (Y/N)	Last Date Attended	Frequency of Attendance
Alcoholics Anon.			
Narcotics Anon.			
MICA			
Other (specify)			

HEALTH CONCERNS/CURRENT HEALTH ISSUES:

Has client ever been treated for any of the following? Check all that apply and explain below.

( ) Allergies
( ) Blood Pressure
( ) Cancer
( ) Diabetes
( ) Eating Disorders
( ) Gait/Balance Problems
( ) Gynecological Problems
( ) Hearing Problems
( ) Heart Disease
  ( ) Heart Attack
  ( ) Endocarditis
  ( ) Other: _____
( ) Hepatitis A, B, or C
( ) Hyponeutremia
( ) Kidney Disease
( ) Liver Disease
( ) Muscular/Skeletal Problems
( ) Pancreatitis
( ) Respiratory Problems
( ) Seizure Disorder
( ) Sexually Transmitted Diseases
( ) Sleep Problems
( ) Thyroid Problems
( ) Tuberculosis
( ) Ulcer
( ) Vision Problems
Other: _____

If any medical conditions are noted above, describe treatment of existing medical conditions.

Are there any restrictions on daily activity? ( ) Yes ( ) No If yes, explain:

When was the client last tested for Tuberculosis? What were the results?

When was the client last tested for Hepatitis? What were the results?

Has client undergone any surgery? ( ) Yes ( ) No If yes, explain:

Is client prone to falls or accidents? ( ) Yes ( ) No If yes, explain:

History of Abuse:

( ) Physical
( ) Sexual
( ) Emotional
( ) Domestic

If yes, explain: _____

EDUCATION:

Can client read? ( ) Yes ( ) No If yes, what language(s)? _____

Can client write? ( ) Yes ( ) No If yes, what language(s)? _____

Can client do simple math? ( ) Yes ( ) No

What is the highest grade/level completed? _____ Current School:_____

Has client attended special classes (e.g.: math, english, learning disabled)? ( ) Yes ( ) No If yes, explain:

Has client had any trade or technical training? ( ) Yes ( ) No If yes, explain:

LEGAL STATUS:

Has client ever been involved in the legal system? ( ) Yes ( ) No If yes, explain:

Describe Charge/Involvement Date of Charge/Involvement Current Status

ECONOMIC RESOURCES:

Does client have an employment history? ( ) Yes ( ) No If yes, explain:

Type of Job	Dates of Employment	Salary	Reason for Leaving

Does client receive any of the following assistance? ( ) Yes ( ) No If yes, explain:

Type of Assistance	Currently Receiving	Amount	Application Date
SSI			
SSD			
Welfare			
Food Stamps			
Other			

Does client receive Medicaid? ( ) Yes ( ) No Medicaid #: _____

Does client receive Medicare? ( ) Yes ( ) No Medicare #: _____

Does client have other insurance? ( ) Yes ( ) No

Name of insurance company: _____ Identification Number: _____

LIVING ARRANGEMENTS:

Describe client's living arrangements over the past 5 years (e.g., apartment, group/boarding home, with family).

Placement	Length of Stay	Reason for Leaving

ACTIVITIES OF DAILY LIVING (ADL) SKILLS:

Please rate client's performance in the following areas by placing a checkmark in the appropriate space.

Skill/Task	Performs Independently	Needs Reminders	Needs Hands-On Assistance	Unable to Perform	Unable to Assess
Eating					
Cooking					
Hygiene/Grooming					
Cleaning					
Laundry					
Budgeting					
Shopping					
Public Transportation					
Self-Medication					
Use of Leisure Time					
Socializing					
Accessing Resources					

Please include the following documentation with this application:

Copy of Social Security Card
Copy of Birth Certificate

Additional Information Required:

1. Photo
2. Copy of most recent health screening
3. Copy of initial (admission) psychosocial assessment and annual/(re-admission) assessments (if applicable)
4. Copy of most recent treatment plan
5. Copy of most recent physical examination
6. Copy of discharge summaries of previous admissions
7. Copy of most recent substance abuse assessment
8. Copy of case review/treatment team notes

_____ Phone: ( ) _____
Name of placement source/Transporter

Time:_____