908 SW 1st Street
Fort Lauderdale, Florida 33312
954-524-8989 Office
954-284-8448 Fax
intake@houseofhope.org

Application for Admission into Treatment Program
House of Hope/ Stepping Stones

This form must be completely filled out or assessment may be delayed.
ANSWER ALL QUESTIONS

Please check one: ☐House of Hope (Men) ☐Stepping Stones (Women)

Date of Application: _____ _____

Person Served Name: _____ DOB:_____ Tele# _____

Race: _____ Ethnicity: _____ Phone #:_____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐ Separated ☐Legally Separated

Judge Name: _____ Attorney Name: _____ Phone: _____

Current Address: _____

☐Homeless ☐ALF/Group home ☐Family/friend ☐ Jail/Prison

Referred by:_____ Title: _____ Phone:_____

Referring Agency: _____

Do you have insurance: ☐Yes ☐ No Name of Insurance_____ Policy # _____

Applicant's language preference: ☐English: ☐Spanish: ☐Creole: ☐ Other:

CRIMINAL HISTORY

Charges related to **sexual offense, arson or violent crimes** are excluded. Each client is evaluated case by case. If applicable, please attach documentation to support these circumstances which are decided on a case-by-case basis.

Have you ever been in prison or jail? ☐Yes ☐No Dates:_____

What were/are your charges: _____

Any violent/weapons charges present or past? ☐Yes ☐No

Charges: _____

Did you have any Domestic Violent charges? Y / N Dates: _____

What is your DOC# If applicable? _____

Any Domestic Violence Charges: Y / N Dates: _____

EDUCATIONAL/ VOCATIONAL HISTORY

What is the highest grade completed? _____ Do you have a GED or Diploma? ☐Yes ☐ No

Where you in ESE or E/BD (Emotional/Behavioral) classes? ☐Yes ☐ No

SUBSTANCE ABUSE HISTORY

Drug of choice:	**Frequency of use:**	**Last time used:**

Have you ever had a seizure or a severe withdrawal or physical reaction (severe tremors, fever, fainting, nausea/vomiting) or requested emergency room / hospital treatment as a result of abruptly stopping your drinking or drugging usage? ☐ Yes ☐No

Have you tried to stop using drugs/alcohol? ☐Yes ☐No If yes how many times? _____

Have you been admitted into detox ? ☐Yes ☐ No If yes, how many times? _____

Have you been to treatment in the past? ☐Yes ☐No If yes, how many times? _____

Have you been arrest for dealing/trafficking? ☐Yes ☐No If yes, how many times? _____

MEDICAL & MENTAL HEALTH INFORMATION

Do you have any medical issues that needs to be addressed?_____

_____

Do you have any allergies? Yes / No If yes, please list all allergens: _____

Have you been diagnosed with a mental health disorder? _____

_____

Are you taking any medications now? List _____

_____

Are you able to perform basic living activities without assistance? ☐ Yes ☐ No

Have you been hospitalized in the past 12 months? ☐Yes ☐ No If yes, please explain: _____

_____

CHILDREN'S INFORMATION

Do you have any children: ☐ Yes ☐No If yes, how many children do you have: _____

Any DCF Involvement? ☐Yes ☐ No

Case Manager Name: _____ Telephone Number: _____

Are you pregnant? ☐Yes ☐ No If yes, how many months: _____

AUTHORIZATION FOR RELEASE AND REQUES OF MEDICAL & PSYCHOLOGICAL INFORMATION

This authorization specifically includes any and all information regarding medical record and reports, mental health and psychiatric records, evaluation and examinations, all examination, diagnosis and treatment for all substance abuse or mental health treatment, all neuropsychological testing, all prescriptions, all progress notes and all other medical and psychological health information without limit. This release may apply to all health care and treatment providers and all facilities including hospitals and rehabilitation centers. It is also intended to satisfy the requirements of HIPPA.

I understand and agree that this information be obtained, released, and used be my attorney or their designated representative, to assist me in my case, and that this information will be used on my behalf and in my best interests. I also understand and agree that this information may be released to a state prosecutor and/or judge and/or treatment program(s) in Broward County, Florida at either the House of Hope (for men) or Stepping Stones (for woman).

This release also allows representatives from House of Hope (for men) or Stepping Stones (for woman) to use this information to determine whether I may be accepted into the treatment program, and I grant those representatives permission to disseminate this information only in such manner as is required for this application and my treatment therein. I therefore release both my above-signed attorney and the representative from House of Hope / Stepping Stones from all liability for conforming with the statement herein.

I understand that this release is voluntary and may be revoked from me at any time, or within one year of this date, whichever comes first. I also agree that a copy of this form may serve as an original.

Patient's Signature _____ Date: _____

Attorney Signature _____ Date: _____

I hereby confirm that my client: Please check off each to confirm acceptance.

I hereby confirm that my client: (Please check off each to confirm acceptance.)

□ Will either be drug/alcohol free at the time of admission, or medically cleared by detox facility

□ Is medically cleared; i.e., Free from severe medical conditions and is self-ambulatory.

□ Is psychiatrically stable such that they are not danger to themselves or others under the Baker Act, and have not been Baked Acted within the last week.

□ **Will have a 14-day supply of all prescription drugs in-hand, or supplied by the jail, when admitted**

□ Has no history of violence in the last 90 days;

□ Has indicated a willingness to participate in treatment, perform household chores with supervision, to interact socially with other clients, to maintain personal hygiene, and medication compliant.

□ Is a Broward County resident.

□ Understands and agrees that they will not be permitted to smoke or otherwise use tobacco.

□ My client has knowingly signed the HIPPA release on the back of this application.

A client requires detox clearance when there is: (A) reported daily used of alcohol, opioids or benzos for more than 30 days; (B) a history of seizure, DT's, cardiac issues or is medically compromised; (C) use of benzos within the last 3 days; (D) addiction to Suboxone or Methadone

_____ _____

Attorney Signature Date

Please submit completed application to: Fax: 954-284-8448 Email: intake@houseofhope.org

Contact info: Intake Coordinator, email: inake@houseofhope.org Phone: 954-524-8989 ext.1006