

**FAMILIES TOGETHER
 APPLICATION FOR ADMISSION**

Last Name:		First Name:		Maiden Name:	
Address:				Phone Number:	
City:		State:	Zip Code:		
Date of Birth:		Place of Birth:			
Educational Background:		Language of Choice:			
Occupation:		Email Address:			
Place of Employment:		Hours per week:		Length of Employment:	
Employers Address:		Phone:		Monthly Income:	
Religious Preference:		Ethnicity:			
Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		Marital Status:			
Describe relationship with your Spouse/Partner:					
Are you being stalked? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is your spouse/partner the parent of your children? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are visitations allowed between spouse/partner and your children? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous Marriage		Marriage Date		Divorce Date	

Spouse/Partner Information					
Last Name:		First Name:		Maiden Name:	
Address:				Phone Number:	
City:		State:	Zip Code:		
Date of Birth:		Place of Birth:			
Educational Background:		Language of Choice:			
Occupation:					

Place of Employment:	Hours per week:	Length of Employment:
Employers Address:	Phone:	Monthly Income:
Religious Preference:	Ethnicity:	

Please list previous addresses

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

What led you to seeking services from Families Together?

In the last year, did you live in a residence that was listed in your name?

Yes No

Please describe your current homeless situation & how long have you been homeless?

Please describe your educational background and job training history

Please describe work history

Employer:	Phone Number:
Address:	Length of time at Job:
Employer:	Phone Number:
Address:	Length of time at Job:
Employer:	Phone Number:
Address:	Length of time at Job:

Work History:

Please describe your current insurance situation for you and your children

Please describe your current transportation situation/needs

Please list all sources of income

<input type="checkbox"/> Employment Pay	\$
<input type="checkbox"/> SSI Benefits	\$
<input type="checkbox"/> Food Stamps	\$
<input type="checkbox"/> TANF	\$
<input type="checkbox"/> Children's SSI	\$
<input type="checkbox"/> WIC Assistance	\$
<input type="checkbox"/> grants	\$
<input type="checkbox"/> loans	\$
<input type="checkbox"/> financial aid	\$
<input type="checkbox"/> Other Source of Income:	\$

Have you applied or been approved for Crime Victim's Compensation? YES NO

If "YES", please explain:

Please list and explain past evictions or barriers to housing

Date	Eviction/Barrier

Has this been paid?

Yes No

Please list any unpaid debts you have currently

Debt	Amount Owed

Have you ever been diagnosed with any mental health disorders? If yes, when, and please explain

Date	Diagnosis

Has there been any recent hospitalizations for psychological issues in the last 6-months to a year?

Any recent suicidal or self-harming behaviors over the last year?

Please list any medications you are currently taking and what it is prescribed for

Are you currently receiving medication management services by a provider for any type of mental health diagnoses?

Yes No

Are you currently receiving counseling?

Yes No

If not, are you open to receiving Counseling?

Yes No

Please describe your current health needs

Criminal History

Please list any misdemeanor or felony arrests along with dates and outcomes here:

Are you on probation or parole? Yes No
If so, please describe conditions?

Substance Abuse History

Describe your current drug or alcohol consumption:

What is the date of last use? How often do you use?

Have you ever received any substance use services? Yes No

Have you ever been diagnosed with substance use disorders? Yes No If yes, please explain:

Are you addicted to drugs or alcohol? Yes No
If yes, please specify which substance.

Please describe your relationship with your children

What are your children's thoughts on joining the Families Together program?

Please list in detail the goals you will establish in the following areas

Housing:

Employment:

Transportation:

Day-Care/School Enrollment:
Public Benefits:
Insurance:

Other agencies having contact with the family: <i>(Ex: therapists, psychiatrists, hospital, CPS, MHMR, Juvenile Dept., DHS, etc.)</i>				
Type of Service/Agency	Date started	City	Doctor/Counselor/Caseworker	Phone

Children Information							
Child's Name	Age	Sex	Birth Date	Grade	Ethnicity	Social Security #	Does child reside with you?
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

List Legal Guardian(s) for Child(ren)	
Child	Guardian

Relatives Involved					
Name	Address	Phone	Relationship	OK to contact?	
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No
				<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name	Address	Phone	Relationship

School Information for Child #1

Name of School: _____ Grade: _____

Name of Principal: _____ Name of Teacher: _____ Phone Number: _____

Is child enrolled in Special Education? Yes No
 If yes, list type of services received:

Name of School Counselor? OK to contact? Yes No

Does your child have a 504 plan? Yes No

Please list extra-curricular school activities your child is involved in or special honors received by your child:

Medical and Psychiatric History

Does your child have a current mental health diagnosis? Yes No If yes, please list:
 Date of Diagnosis: _____

Is your child currently taking regular medications? Yes No
 If yes, please list the name of the medications and what it is prescribed for?

Does your child have current shot records? Yes No

What emergency health needs does your child have? (asthma, allergies, diabetes, seizures, etc.)

What type of medical care is your child currently receiving?

What is the medical history of your child? (including immunizations, operations, and childhood illness)

Does your child have any juvenile convictions? Yes No
 If yes, please explain:

Describe your child's behavior:
 How do they interact with other children?
 Any self-harming behaviors?
 Any history of drug or alcohol use?
 Trauma History?

School Information for Child #2

Name of School:		Grade:
Name of Principal:	Name of Teacher:	Phone Number:
Is child enrolled in Special Education? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list type of services received: Name of School Counselor? <input type="checkbox"/> OK to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child have a 504 plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list extra-curricular school activities your child is involved in or special honors received by your child:		

Medical and Psychiatric History

Does your child have a current mental health diagnosis? If yes, please list: <input type="checkbox"/> Yes <input type="checkbox"/> No
Is your child currently taking regular medications? If yes, please list: <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have current shot records? <input type="checkbox"/> Yes <input type="checkbox"/> No

What emergency health needs does your child have? (asthma, allergies, diabetes, seizures, etc.)

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What type of medical care is your child currently receiving?

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What is the medical history of your child? (including immunizations, operations, and childhood illness)

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Does your child have any juvenile convictions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
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Describe your child's behavior: How do they interact with other children? Any self-harming behaviors? Any history of drug or alcohol use? Trauma History?

School Information for Child #3

Name of School:		Grade:
Name of Principal:	Name of Teacher:	Phone Number:
Is child enrolled in Special Education? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list type of services received: Name of School Counselor? <input type="checkbox"/> OK to contact? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child have a 504 plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list extra-curricular school activities your child is involved in or special honors received by your child:		

Medical and Psychiatric History

Does your child have a current mental health diagnosis? If yes, please list: Yes No

Is your child currently taking regular medications? If yes, please list: Yes No

Does your child have current shot records? Yes No

What emergency health needs does your child have? (asthma, allergies, diabetes, seizures, etc.)

What type of medical care is your child currently receiving?

What is the medical history of your child? (including immunizations, operations, and childhood illness)

Does your child have any juvenile convictions? Yes No
If yes, please explain:

Describe your child's behavior:
Describe your child's behavior:
How do they interact with other children?
Any self-harming behaviors?
Any history of drug or alcohol use?
Trauma History?

The information contained in this application is correct to the best of my knowledge. I understand that making false statements or being untruthful may result in termination of ACH Child and Family Services.

Signature

Date