

# Wait House Transitional Living Program

## Application for Residency

*Please complete this application honestly and as completely as possible. Once complete, contact Wait House TLP staff to schedule an interview to review your application. If there are any questions, please call Wait House TLP staff to assist you with the application. Wait House TLP staff can be reached at 798-4384. You can mail the application to 10-12 Wait St. Glens Falls, NY 12801 or Fax it to 798-7593. Thank you.*

### Applicant Information

**Date of Application:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Marital Status:** \_\_\_\_\_

**Current Address:** \_\_\_\_\_

**Name of individual you are staying with and relationship:** \_\_\_\_\_

**Phone Number (where you can be reached):** \_\_\_\_\_

**Whose phone is this & relationship to you:** \_\_\_\_\_

**Additional Phone Number (if applicable):** \_\_\_\_\_

**Whose phone is this & relationship to you:** \_\_\_\_\_

**Referral Source/Agency:** \_\_\_\_\_

**Contact Information:** \_\_\_\_\_

**Dependent Information**

**Are you pregnant with, or parenting, a child that will be coming to the program with you?**

\_\_\_\_\_ Yes \_\_\_\_\_ No\* \_\_\_\_\_ Not Applicable\* \*please go to page 3

**Are you pregnant?** \_\_\_\_\_ If yes, what is your due date?\_\_\_\_/\_\_\_\_/\_\_\_\_

**Do you have alternative plans after giving birth?** (i.e. adoption) \_\_\_\_\_

**Do you have any children?** \_\_\_\_\_ If yes, how many?\_\_\_\_\_ Who has custody? \_\_\_\_\_

1.) \_\_\_\_\_

Child's First and Last Name      Age      DOB      Biological Parents' First and Last Name

\_\_\_\_\_

Child's Address      Other Parent's Address

Child's Primary Doctor: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Does your child have a physical or mental health diagnosis?  Yes  No

If yes explain \_\_\_\_\_

2.) \_\_\_\_\_

Child's First and Last Name      Age      DOB      Biological Parents' First and Last Name

\_\_\_\_\_

Child's Address      Other Parent's Address

Does your child have a physical or mental health diagnosis?  Yes  No

If yes explain \_\_\_\_\_

**For staff use only please**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Parent/ Legal Guardian and Family Information**

**Your Birth Father's Name** \_\_\_\_\_

Do you have contact with him? \_\_\_\_\_

**Your Birth Mother's Name** \_\_\_\_\_

Do you have contact with her? \_\_\_\_\_

**Name of Legal Guardian** (if different than parent) \_\_\_\_\_

Do you have contact with them? \_\_\_\_\_

**Please explain why you are unable to live at home with your parents/family? Please be specific. If you have moved out, please state when you moved out.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Has anyone ever had custody of yourself other than your birth parents?**  Yes  No  Unsure

**Do you have any siblings?** \_\_\_\_\_

**Do your Parents/ family know you are applying to TTLP?**  Yes  No

If yes, how do they feel about it?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are you homeless or at risk of becoming homeless? Please explain:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Personal Information**

Do you have a criminal history? Yes or No \_\_\_\_\_

Do you have pending charges? Yes or No \_\_\_\_\_

Are you currently involved with the legal system? \_\_\_\_\_

**Please list all of your closest friends and the people you associate with:**

First and Last name

Age

_____	_____
_____	_____
_____	_____
_____	_____

What do you do when you are hanging out with your friends?

\_\_\_\_\_  
\_\_\_\_\_

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Educational Information**

- 1.) **Are you currently enrolled in school?**  Yes (skip to question 2)  No (please continue)  
Have you graduated high school?  Yes  No  
Have you received your GED?  Yes  No
- 2.) **Are you planning on receiving your GED?**  Yes (please continue)  No (skip to next question)  
Anticipated Graduation/GED date \_\_\_\_\_
- 3.) **Do you have an educational goal:** \_\_\_\_\_

**Medical/Mental Health History**

- Do you have/have you ever seen the following within the year:** *Please check all that apply*  
 doctor  dentist  counselor  psychologist
- Are you current with immunizations?**  Yes (answer question that follows)  No (skip next question)  
**Can you provide a copy of your immunization record?**  Yes  No  
**When was your last physical exam?** \_\_\_\_\_ **When was your last dental exam?** \_\_\_\_\_

- Have you ever attended/stayed at a:** *Please check all that apply*  
 Counseling or Therapy  CPEP (Crisis Center)  
 Hospital  \_\_\_\_\_  
 Psychiatric Hospital

- Have you had a history with any of the following?** *Please check all that apply*
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Suicide Attempts               | <input type="checkbox"/> Sexually Aggressive Behavior | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Suicide Threats                | <input type="checkbox"/> Verbally Aggressive/Abusive  | <input type="checkbox"/> Family Violence |
| <input type="checkbox"/> Self Injuries                  | <input type="checkbox"/> Fire Setting                 | <input type="checkbox"/> Hurting Animals |
| <input type="checkbox"/> Physically Aggressive Behavior |   | <input type="checkbox"/> Anger           |
|   |   | <input type="checkbox"/> Bed Wetting     |

Please explain:

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**Drug and Alcohol History**

- Have you ever used/tried:** *Please check all that apply*
- |                                     |   |                                  |                                |
|-------------------------------------|---|----------------------------------|--------------------------------|
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Prescription drugs for fun | <input type="checkbox"/> Cocaine | <input type="checkbox"/> LSD   |
| <input type="checkbox"/> Tobacco    | <input type="checkbox"/> Marijuana                  | <input type="checkbox"/> Heroin  | <input type="checkbox"/> Other |
| <input type="checkbox"/> Alcohol    |   | <input type="checkbox"/> Crack   |                                |

Have you ever been treated for substance use/abuse?  Yes  No  
If yes, where:

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**For staff use only please**

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Personal Medical Information**

**Have you ever been pregnant before?**  Yes  No  
How many times? \_\_\_\_\_

**\*Females only\***

**Are you currently receiving prenatal care?**  Yes  No

**Have you ever had a PAP smear in the past?**  Yes  No

**For staff use only please**

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Financial & Employment**

**1.) Do you receive any of the following as income?**

*Please check all that apply:*

- |   |   |
|---|---|
| <input type="checkbox"/> Public Assistance            | <input type="checkbox"/> Child Support                  |
| <input type="checkbox"/> Social Security Income (SSI) | <input type="checkbox"/> Wages                          |
| <input type="checkbox"/> Survivor Benefits            | <input type="checkbox"/> Other Income (other than work) |

**2.) Do you have a bank account?**  Yes  No

**3.) Work History**

Have you ever had a job?  Yes (please continue)  No (please go to next section)

Have you ever been fired from a job?  Yes  No

**4.) Do you currently have employment?**  Yes (please continue)  No (please go to next section)

Place of Employment \_\_\_\_\_

How long have you worked there \_\_\_\_\_

Pay per hour \_\_\_\_\_ How many hours do you work a week? \_\_\_\_\_

**For staff use only please**

Comments: \_\_\_\_\_  
\_\_\_\_\_





**This page to be completed by TTLP Staff**

Referred by: _____	Date of Screening: _____
Agency: _____	Date of Admission: _____
Phone No.: _____	Time of Admission: _____

Screening Committee Results: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To Do:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**TEEN TRANSITIONAL LIVING PROGRAM**  
Professional Referral Questionnaire

Name of Applicant: \_\_\_\_\_

Name of Reference: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

- Give a brief history, including the applicant's involvement with any agencies/services:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- What information can you provide about this applicant's peers? Please include names:

\_\_\_\_\_  
\_\_\_\_\_

- What important relationships does the applicant have? Please include people the applicant relies on for emotional support:

\_\_\_\_\_  
\_\_\_\_\_

- What, if any, are some goals the applicant has set, and which ones are you assisting them with?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- What are some of the applicant's strengths?

\_\_\_\_\_  
\_\_\_\_\_

- What are some things the applicant needs to work on or improve?

\_\_\_\_\_  
\_\_\_\_\_

- What support services does this applicant use or need?

\_\_\_\_\_  
\_\_\_\_\_

- What is the applicant's need for substance abuse counseling?  low  med  high  unknown  
Please provide additional information:

\_\_\_\_\_  
\_\_\_\_\_

- Will you be continuing with this applicant if he/she is accepted in to the program?  Yes  No  
If no, what are your suggestions for continuing contact with existing service providers?

\_\_\_\_\_  
\_\_\_\_\_

- Have you reviewed our program rules and guidelines?  Yes  No

Do you feel that the applicant will have any problems following any of our rules? If yes, which ones?

\_\_\_\_\_  
\_\_\_\_\_

Signature of Referral: \_\_\_\_\_ Date: \_\_\_\_\_

**TEEN TRANSITIONAL LIVING PROGRAM**  
Professional Referral Questionnaire

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Name of Reference: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

- Give a brief history, including the applicant's involvement with any agencies/services:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

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\_\_\_\_\_

- What, if any, are some goals the applicant has set, and which ones are you assisting them with?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- What are some of the applicant's strengths?

\_\_\_\_\_  
\_\_\_\_\_

- What are some things the applicant needs to work on or improve?

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\_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

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Do you feel that the applicant will have any problems following any of our rules? If yes, which ones?

\_\_\_\_\_  
\_\_\_\_\_

Signature of Referral: \_\_\_\_\_ Date: \_\_\_\_\_

**TEEN TRANSITIONAL LIVING PROGRAM**  
Personal Referral Questionnaire

Name of Applicant: \_\_\_\_\_

Name of Reference: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

- Give a brief history, including the applicant's involvement with any agencies/services:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- What information can you provide about this applicant's peers? Please include names:  
\_\_\_\_\_  
\_\_\_\_\_
- What important relationships does the applicant have? Please include people the applicant relies on for emotional support:  
\_\_\_\_\_  
\_\_\_\_\_
- What, if any, are some goals the applicant has set, and which ones are you assisting them with?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- What are some of the applicant's strengths?  
\_\_\_\_\_  
\_\_\_\_\_
- What are some things the applicant needs to work on or improve?  
\_\_\_\_\_  
\_\_\_\_\_
- What support services does this applicant use or need?  
\_\_\_\_\_  
\_\_\_\_\_
- What is the applicant's need for substance abuse counseling?  low  med  high  unknown  
Please provide additional information:  
\_\_\_\_\_  
\_\_\_\_\_
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If no, what are your suggestions for continuing contact with existing service providers?  
\_\_\_\_\_  
\_\_\_\_\_
- Have you reviewed our program rules and guidelines?  Yes  No  
Do you feel that the applicant will have any problems following any of our rules? If yes, which ones?  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Referral: \_\_\_\_\_ Date: \_\_\_\_\_