

Wait House Transitional Living Program

Application for Residency

Please complete this application honestly and as completely as possible. Once complete, you can fax the application to Lisa/Kate at 798-7953 or mail it to 10-12 Wait Street Glens Falls, NY 12801. Also, 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. Thank you.

Applicant Information

Date of Application: _____

Name: _____

Age: _____

Date of Birth: ____/____/____

Marital Status: _____

Gender: (please circle one) **Male Female**

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; Name/Title/Agency: _____

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

Does the father plan on signing the birth certificate? Yes No

Does the father plan on being involved with the child? Yes No

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?

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 any employment goals?** _____

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:

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/last time used and how often:

For staff use only please

Comments: _____

Personal Medical Information

Have you had sexual intercourse in the past? Yes No

Date of last intercourse: _____

Have you ever been pregnant/fathered a child? 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

Males only

Have you had a yearly physical exam? Yes No

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Comments: _____

Financial & Employment

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

Please check all that apply:

Public Assistance

Social Security Income (SSI)

Survivor Benefits

Child Support

Wages

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? _____

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Comments: _____

Domestic Violence Screening

- Does your partner call you names, yell, put you down, or criticize you? Yes No
- Does your partner behave in an overprotective or jealous way? Yes No
- Does your partner make it difficult for you to see your friends or family? Yes No
- Does your partner embarrass or humiliate you in front of other people? Yes No
- Does your partner hit, slap, punch, kick, choke or bite you? Yes No
- Do you ever feel obligated or coerced into having sex with your partner? Yes No
- Does your partner make you afraid by using looks, actions or gestures? Yes No
- Does your partner threaten to harm or kidnap your children? Yes No

Please explain any you answered yes to: _____

Comments

Is there anything else that you would like to share? *(Please attach an additional sheet if needed.)*

Attached are three reference forms, two professional and one personal. Please have the two professional references filled out by a teacher, counselor, mental health provider, physician, case worker, probation officer, or another professional referral source. The personal form can be completed by a family member or friend. If you need help in acquiring a referral, ask Wait House TLP staff for assistance. Once these are completed, please return them to the office.

Signature of Applicant: _____ Date: _____

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:

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: _____

TRANSITIONAL LIVING PROGRAM
Professional Referral Questionnaire

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Signature of Referral: _____ Date: _____

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?

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