HERO Program Application

Date _____

Level of Care Applying for: ___Short Term Residential (30 – 45 Days)
___ Halfway House (90 Days)
___ Intensive Outpatient (6 – 10 Weeks)
___ Outpatient (4 – 6 Weeks)
___ Evaluation, Only

A. Demographic Data	Date of Interview:
Name:	
Gender:	
DOB:	
Age:	
SSN:	
Race:	
Religious Preference:	
Current Telephone Number:	
Email Address:	
Immediate Prior Address Street City, State, ZIP Length of time there	
Are you currently homeless? **Y N**	What happened to cause your homelessness?
Emergency Contact: Name Relationship Street Address City, State, ZIP Telephone 1 (home) Telephone 2 (cell) Telephone 3 (work)	
Next of Kin **(if not Emergency Contact)** Name Relationship Street City, State, ZIP Telephone 1 (home) Telephone 2 (cell) Telephone 3 (work)	
Do you have a valid ID? **Y N**	Do you have a car available for your use? **Y N** Social Security card? **Y N** Driver's License? **Y N**

B. Financial		
Source	**Amount**	**Caseworker/Telephone #**
1. ADC		
2.General Assistance		
3. SSI		
4. Unemployment		
5. Disability		
6. Medicare		
7. Medicaid		
8. Social Security		
9. Pension or retirement		
10. Veterans Benefits		
11. Family Support		
12. Other sources of income a. b. c.		
13. Medical Health Insurance Coverage		(Photo copy card and attach)
14. Agencies currently providing services to me: (example: Community Alliance, Friendship Program, etc.)		
15. Social Services you may need: (examples: job services, ex-felon services, health care, dental care, legal services, education, etc.)		

16. Do you have a current Food Stamp Card?	Yes No
C. Medical History	
1. Current Medications	Dosage, Description, Prescribing Physician
a.	
b.	
c.	
d.	
e.	
f.	
2. Are you currently taking medications listed above and only as directed?	Yes No
3. Allergies? (Please list)	
4. Physical/Medical Concerns	
a.	
b.	
c.	
d.	

e.	
5. Physical Problems in last three months	
a.	
b.	
c.	
d.	
e.	
6. Family history of: Cancer: **Y N** Diabetes: **Y N** Stroke: **Y N** High Blood Pressure: **Y N** Heart attack before age 50: **Y N** Asthma: **Y N** Emphysema: **Y N**	If yes, please explain:
7. **Women Only:** Date of last female exam: Date of last mammogram: Are you pregnant? **Y N**	How many pregnancies have you had? What method of birth control are you using, if any?
8. **Men & Women**: Are you sexually active? **Y N** Do you have symptoms of or are receiving treatment for an STD? **Y N** Do you want to be tested for an STD? **Y N**	Do you need to be tested for or have you been diagnosed with HIV? **Y N** If yes, please explain:
9. Health Behaviors: # of cigarettes smoked per day: # of days per week exercise: Healthy eating habits? **Y N**	
10. Immunizations: Tetanus shot within the last 10 years? **Y N** Hepatitis B series of shots? **Y N**	TB Skin test? **Y N** Reaction? **Y N** Flu shot this year? **Y N**
11. Are you currently receiving medical treatment? a. Condition b. Physician and contact information	
12. Is there any medical condition you should be receiving treatment for or you would like to discuss with a nurse or medical practitioner? If so, please describe:	
13. Do you have any chronic conditions? ex. diabetes, epilepsy, high blood pressure, HIV infection not disclosed in #8 above?	

D. Vocational History	
1. Level of education	
2. Did you complete high school? **Y N**	If you did not complete high school, explain why.
3. Vocational training	
4. College field of study	
5. Graduate school field of study	
6. Previous jobs:	
a. Type/Name of Company Dates Reason for leaving Salary	
b. Type/Name of Company Dates Reason for leaving Salary	
c. Type/Name of Company Dates Reason for leaving Salary	
d. Type/Name of Company Dates Reason for leaving Salary	
e. Type/Name of Company Dates Reason for leaving Salary	
f. Type/Name of Company Dates Reason for leaving Salary	
7. What training would you like to receive to improve your job skills?	
E. Military History (Please provide a copy of your DD214)	
1. Branch of Service	
2. Dates of Service	
3. Type of Discharge	
4. Service connected disability – describe	
5. Eligible for military benefits –describe	

F. Legal History

1. Legal Guardian Information Name Mailing Address City, State, ZIP	**(List name, phone number and full address)**

Telephone contact	
2. Probation/Parole Officer/Case Worker Name Mailing Address City, State, ZIP Telephone contact	**(List name, phone number and full address)**
3. Attorney Name Mailing Address City, State, ZIP Telephone contact	**(List name, phone number and full address)**
4. Legal Charges – Be specific a. Current Charges b. Past Convictions	

Current Legal Status (Including conditions of release, if any)	

H. Chemical Dependency/Substance Abuse History

1. Have you had a substance abuse evaluation within the past 6 months? **Y** **N** If so, what is the name of the counselor and/or treatment center that completed the evaluation? Do you have any other compulsive behaviors such as gambling, over spending, sexual acting out? If yes, have you ever received counseling for any compulsive behavior? If so, please explain.	

2. Have you been through treatment for chemical dependency or substance abuse? **Y N** a. Treatment facility and year Did you complete treatment successfully? **Y N** If no, why not? _____ b. Treatment facility and year Did you complete treatment successfully? **Y N** If no, why not? c. Treatment facility and year Did you complete treatment successfully? **Y N** If no, why not?	
3. **What substances have you used?** ( ) Alcohol ( ) Amylnitrates (poppers, rush, locker room) ( ) Amphetamines (uppers, crystal, meth, speed, speedball, ice, crank, dexedrine, Ritalin, black beauties) ( ) Anabolic steroids (roids, juice) ( ) Chewing tobacco (snuff) ( ) Cocaine ( ) Codeine products (codeine, Percodan) ( ) Cough syrup ( ) Diet pills (prescription: preludin, tenuate, tepanil, Sanorex) ( ) Diet pills (over the counter: Dexatrim, Acutrim, Ephedrine HCL, caffeine) ( ) Downers (Xanax, Ativan, Librium, Quaaludes, seconal, valium, halcyon, dalmane, serex) ( ) Ectasy (MDMA, MDA) ( ) Heroin (smack, horse, synthetic china white, T's blues) ( ) K2/Bath Salts	( ) Inhalants (white out, paint, huff, oz) ( ) Ketamines (cat killer, honey oil, jet) ( ) LSD (acid, trip, paper) ( ) Marijuana (hashish, pot, reefer, green, bud, ditch weed, Weed, Dabs, Edibles) ( ) Methadone ( ) Suboxone ( ) Morphine ( ) No Doz ( ) Nitrous Oxide (Whippets) ( ) Nyquil ( ) Opium ( ) Pain Killers: Prescription (Darvon, Dilaudid, Demerol, Percocet, Percodan, Oxycontin, Hydrocodone) ( ) Peyote (buttons, mescaline) ( ) Phencyclidine (PCP, angel dust, peace pill, hog, tic, zoot) ( ) Psilocybin (mushrooms) ( ) Tobacco: Chewing (snuff) ( ) Tobacco: Smoking (cigarettes, pipe, cigars) ( ) Caffeine (Energy Drinks, Pre-Workout) ( ) Other: _____

I. Detailed Substance Use History (*Required for Consideration*)

Of those substances checked in "H," answer these questions:

Substance	*Age* of First Use	*Date* of Last Use	Amount Of Last Use	Amount Generally Used in 24 hr. Period	Worst Experience From Use

J. Family Situation	
1. Marital status – circle one	Married Divorce Single Widowed Separated
2. Spouse's contact information (if applicable)	

Name Address City, State, ZIP Telephone 1 Telephone 2	
3. Number of marriages	
4. Number of biological children	
5. Children a. Name b. Age c. Sex d. Biological mother/father	
a. Name b. Age c. Sex d. Biological mother/father	
a. Name b. Age c. Sex d. Biological mother/father	
a. Name b. Age c. Sex d. Biological mother/father	
a. Name b. Age c. Sex d. Biological mother/father	
a. Name b. Age c. Sex d. Biological mother/father	
6. Child Support Information (Include amount you are ordered to pay, if any, and amount you are able to pay, if any, as well as any past due amounts)	
7. What do you find difficult about parenting?	( ) Discipline ( ) Nurturing ( ) Communication ( ) Meeting basic needs ( ) What to expect ( ) Choice of Friends ( ) Other _____
8. Have any of your children been removed from your custody? **Y N**	Explain.
9. Who lived in your family when you were growing up?	

10. As a child, were you in foster care or another type of out of home placement? **Y N**	Explain.
11. Has anyone in your family had a mental illness or an addiction? **Y N**	Explain
12. Is there anything else you would like to tell us about your family?	
13. Do you have any connection with any current resident or staff member of Stephen Center HERO Program? (Include using friends, current or past relationships, relatives, co-defendants, etc.) **Y N**	Explain:

K. Abuse History	
1. Physical a. Have you ever been the victim of physical abuse? b. Have you ever been the perpetrator of physical abuse?	
2. Sexual a. Have you ever been the victim of sexual abuse? b. Have you ever been the perpetrator of sexual abuse?	
3. Emotional a. Have you ever been the victim of emotional abuse? b. Have you ever been the perpetrator of emotional abuse?	
4. Have you ever abused animals?	YES NO

L. Emotional/Mental History and Current Situation Assessment	
1. Diagnosis and year of treatment for mental or emotional problems. Please be **specific**. a. Diagnosis and year b. Diagnosis and year c. Diagnosis and year Were you treated as an outpatient or in a hospital? Have you ever been diagnosed with an eating disorder?	
2. What three things worry you the most right now?	a. b. c.

3. What events have you experienced in the last 12 months?	( ) Death of spouse ( ) Death of someone else in immediate family: Specify: _____ ( ) Death of a close relative other than these. Specify: _____ ( ) Death of a friend ( ) Marital separation ( ) Divorce ( ) Loss of close/intimate relationship ( ) Loss of contact with friends/family ( ) Birth of child ( ) Marriage ( ) Change in financial status ( ) Fired from work ( ) Quit work ( ) Change in living conditions ( ) Trouble with boss ( ) Violations of law ( ) Personal illness or injury ( ) Injury or illness to others ( ) Violence ( ) Sex Trafficking ( ) Jail Term ( ) Other
4. What do you feel now or have felt in the last three months?	( ) Nightmares ( ) Helpless ( ) Poor self-image ( ) Low self-esteem ( ) Puzzling ideas ( ) Panicky ( ) Do not care ( ) Stressed out ( ) Fearful ( ) Hopeless ( ) Suicidal thoughts ( ) Given up ( ) Irritable ( ) Depressed ( ) Angry ( ) Racing thoughts ( ) Hearing voices ( ) Cannot sit still ( ) Cannot concentrate ( ) Seeing things which are not there ( ) Nervous ( ) Withdrawn ( ) Trouble Sleeping ( ) Hurting self or others ( ) Other _____

5. What are your best qualities?	a. b. c. d.
6. If you could make any changes in your life, what would you change?	a. b. c.