Date Received at ADAMHAS BOARD:

ALCOHOL, DRUG ADDICTION, MENTAL HEALTH SERVICES BOARD
COORDINATED ADULT RESIDENTIAL REFERRAL (CARR) APPLICATION

BASIC DATA:

Client Name: _____ (Last) _____ (First) _____ (MI)

Current Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Previous Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Date of Birth: __/__/_____ SS#: _____ Phone #: _____

Client (GOSH)ID#: _____

Gender: ◯M ◯F

Ethnicity:
◯Caucasian ◯African American
◯Hispanic ◯Native American
◯Asian American ◯Other

Marital Status:
◯Married ◯Never Married
◯Widowed ◯Separated
◯Divorced

DEMOGRAPHIC DATA:

Monthly Income: _____
Income Source: _____
Medicaid/Medicare#: _____
Of Persons in Household:
Veteran: ◯Y ◯N
Education Level: _____
Education Type: _____

Current Location: _____
◯State Hospital ◯Private Hospital
◯Residential Facility ◯V.A. Hospital
◯Other _____

Previous Living Arrangement: _____
_____

Previous Residential Services: ◯Y ◯N If yes, describe: _____

VOCATIONAL/EMPLOYMENT HISORY: _____

DIAGNOSIS—DSM-V

Axis I _____/_____ Code(s):_____/_____

Axis II _____/_____ Code(s):_____/_____

Axis III _____

Axis IV (GAF) _____

ASAM LEVEL OF CARE (LOC), if applicable: _____

PSYCHIATRIC HOSPITALIZATION DATA:

Currently Hospitalized: ◯ Yes ◯ No
Most Recent Hospitalization Date: _____
Name of Hospital: _____
Date of most recent Psychiatric Assessment: _____
Anticipated Discharge Date: _____
# of Hospitalizations in the past 12 months: _____
# of days hospitalized in the past 12 months: _____

Identify Suicidal Ideations, Attempts, or self-harming behaviors: _____
_____
_____

CURRENT MEDICATIONS:

Name of Medication	Dose/Frequency	Prescribed By:
	/	
	/	
	/	
	/	
	/	

***Attach the list of medications if additional space is needed.**

Medication Compliance _____
Medication Allergies: ◯ Yes ◯ No
If Yes List: _____

SUBSTANCE USE DISORDER (SUD) HISTORY: ◯ Yes ◯ No

Describe past and current use: _____
_____
Substance(s) of Choice: _____
Patterns of Use: _____
Current Use: _____
Periods of Sobriety: _____
Previous Substance Use Disorder Treatment: _____
Willingness to enter SUD Treatment: _____

DEVELOPMENTAL DISABILITY (DD) SERVICES:

◯ Yes ◯ No
Describe any DD services the client has received or is currently receiving: _____
_____
Support Administrator _____Phone # (preferably cell) _____

PHYSICAL CONDITIONS: Please check all that apply:

Ambulatory Problems	☐	Asthma/COPD/ Respiratory	☐	Eating Disorder	☐	Gastrointestinal Problems	☐
Diabetes	☐	Hypertension	☐	Dental Problems	☐	Other	☐
Visual Impairment	☐	Epilepsy	☐	Incontinence	☐		
Hearing Impairment	☐	Allergies	☐	Sleep Disorder	☐		
High Cholesterol	☐	Cardio Vascular	☐	Tobacco User	☐		

Please Explain √ Conditions _____

_____

PREVIOUS/CURRENT CRIMINAL JUSTICE SYSTEM INVOLVEMENT: ○ Yes ○ No

Describe_____

_____

Court ordered/mandated to specialized residential services or 24 hr. supervision? ○ Yes ○ No

Explain: _____

Registered Sex Offender ○ Yes ○ No

Name of Parole/Probation Officer: _____Phone#: _____

HISTORY OF AND/OR POTENTIAL OF VIOLENCE: ○ Yes ○ No

If yes, please describe any interventions that have previously been effective:_____

_____

_____

INDEPENDENT LIVING SKILLS: Please Rate Skills Using Scale Below (circle):

UKN	Insufficient Information to Assess
N/A	Do Not Apply
1	Can Manage Independently
2	Needs Occasional Instruction/Supervision/Direction
3	Needs Regular-Not Constant Instruction/Supervision/Direction
4	Needs Continual-Consistent Instruction/Supervision/Direction

Skill Rating	N/A	UNK	1	2	3	4
Transportation	○	○	○	○	○	○
Keeping/Scheduling/ Appointments	○	○	○	○	○	○
Shopping	○	○	○	○	○	○
Cooking	○	○	○	○	○	○
Money Management	○	○	○	○	○	○
Laundry	○	○	○	○	○	○
Caring For Physical Conditions	○	○	○	○	○	○

Skill Rating	N/A	UNK	1	2	3	4
Cleaning	○	○	○	○	○	○
Following Daily Routine	○	○	○	○	○	○
Medication Compliance	○	○	○	○	○	○
Grooming/Hygiene	○	○	○	○	○	○
Setting Limits on Behaviors	○	○	○	○	○	○
Ability to Assess & Verbalize Needs	○	○	○	○	○	○

Skills Necessary for Transition to Less Restrictive Setting: _____

NARRATIVE SUMMARY:

Please Describe in Detail the Necessity for admission to a Class One Residential Facility (Most Restrictive Setting/Highest Level of Care):

_____

_____

_____

_____

_____

_____

SERVICE PROVIDER AGENCY INFORMATION:

Agency Name: _____ Office: _____Phone #_____

CPST Worker: _____ Phone # (Cell if Possible): _____

CPST Email: _____

CPST Supervisor: _____ Phone # (Cell if Possible): _____

CPST Supervisor Email: _____

PAYEE: ◯ Yes ◯ No

Name: _____ Phone # (Cell if Possible): _____

GUARDIAN: ◯ Yes ◯ No

Name: _____ Phone # (Cell if Possible): _____

OTHER SUPPORT PERSON(S): ◯ Yes ◯ No

Name: _____ Phone # (Cell if Possible): _____

SIGNATURES

Client Signature: _____ Date: _____

CPST Signature: _____ Date: _____

CPST Supervisor Signature: _____ Date: _____

Guardian Signature: _____ Date: _____
(If Applicable)

CARR Application MUST be emailed to housing@adamhscc.org.