APPLICATION FOR ADMISSION

Application is for what location? (Check which one) Send via fax and to the attention of the Program Director in that area.

	Location	Contact
☐	Charlottesville	Domonique Wilson, fax # 434-956-4787
☐	Chesterfield	David Lewis, fax # 804-590-1872
☐	Fairfax	Cate Powell, fax # 703-573-5613
☐	Radford	Indria Savoy, fax# 540-838-2132
☐	Tazewell	Indria Savoy, fax # 540-838-2132
☐	Williamsburg	Domonique Wilson, fax # 757-645-2710

For program questions or mailing addresses call Molly Bowles at 804-712-4133.

Date of Application:____________________ **Date of Tour:** ____________________

NAME: ____
(Last) (First) (Middle)

ADDRESS:____

CITY: __________________________ **STATE:** _________ **ZIP:**__________________

PHONE NUMBER:___________________**SOCIAL SECURITY #** __________________

GENDER (check): ❑ **Male** ❑ **Female**

MARITAL STATUS: ❑ **Single/Never Married** ❑ **Divorced**
❑ **Married** ❑ **Separated** ❑ **Widowed**

ETHNICITY (circle one):
❑ **African-American** ❑ **Caucasian (White)**
❑ **Asian** ❑ **Native American**
❑ **Hispanic** ❑ **Other**

AGE: ___________________ **BIRTHDATE:** ______________________

BIRTHPLACE: ___________________________________

Current Residency:
County ____________________
City: ____________________
State: ____________________

HOW DID YOU HEAR ABOUT GATEWAY HOMES?________________________

____

Clinical Information

1. **Current Diagnosis:**____

____

____

2. **Current Medications:**____

____

____

3. **Do you believe that you have a mental illness now and need to take medications?**

❑ **Yes** ❑ **No**

4. **Psychiatric History:**

   A. Age of onset of illness/symptoms: ______________________________

   B. Number of State or Community Psychiatric Hospitalizations: ______________

   C. Name and Date of Major Hospitalizations: ______________________________

   ____

   ____

   ____

   D. Past outpatient treatment history:_____________________________________

   ____

5. **Please check all the symptoms that you have previously experienced:**

Auditory/visual hallucinations	___ Yes	_____ No
Delusional thought processes	___ Yes	_____ No
Depressed mood	___ Yes	_____ No
Mania	___ Yes	_____ No
Anxiety	___ Yes	_____ No
Obsessions/Compulsions	___ Yes	_____ No
Eating-disordered behaviors	___ Yes	_____ No

6. Have you ever attempted suicide? ❑ **Yes** ❑ **No**

If so, when and by what means?___________________________________

____

7. Have you ever engaged in self-harm behaviors (e.g., self-cutting, burning, head banging, etc.)

❑ **Yes** ❑ **No**

8. Have you ever engaged in physical or verbal aggression towards others?

If so, please explain ___________________________________

9. List any history of substance use including the type of substance, amount and date last used:___________________________________

____

____

10. List any current medical conditions and allergies (include ALL allergies) that you have :

____

____

____

11. List any operations or surgeries that your have had including dates:

____

____

____

12. Have you experienced:

a. Seizures	❑ Yes	❑ No
b. Fainting spells	❑ Yes	❑ No
c. Head injury	❑ Yes	❑ No

Daily Living

1. What is your current living situation? (Please check one)

- ❑ **State hospital**
- ❑ **Community/Private Hospital**
- ❑ **Group Home**
- ❑ **Independent in an apartment/house**
- ❑ **With family**
- ❑ **Homeless**
- ❑ **Other**

2. How long have you been in your current living situation? (Please check one)

❑ **less than 1 month** ❑ **6 months B one year**

- [ ] **1-6 months** - [ ] **more than one year**

3. How many different places have you lived during the past year? ___________

4a. Have you ever lived independently?

- [ ] **Yes** - [ ] **No**

b. If Yes, what was the longest time you lived independently?

- [ ] **less than 1 month** - [ ] **6 months B one year**
- [ ] **1-6 months** - [ ] **more than one year**

5. Please describe difficulties that you had while living independently or what has prevented you from living independently. ______________________________

____

____

6. Please check all of the activities that you are able to complete independently and without assistance from others:

- [ ] **personal hygiene** - [ ] **meal preparation**
- [ ] **personal finance/budgeting** - [ ] **housekeeping**
- [ ] **medication administration**

Educational/Vocational/Social

1. What is the highest grade you completed? _______________________

2. Did you attend special education classes? - [ ] **Yes** - [ ] **No**

If Yes, what type? ______________________________________

3. Have you ever served in the Armed Forces? - [ ] **Yes** - [ ] **No**
If Yes, list branch and dates of services:_____________________________

____

4. List employment held and dates: ___________________________________

____

____

____

5. What are your hobbies, interests, special talents? _____________________

____

6. **Describe your strengths and perceived limitations**:______________________

____

____

Future Goals

1. **Why do you want to come to GW:** ____________________________________

____

____

2. **What do you hope for yourself for the future?**
____

____

3. **Please use this space to let the clinical team know any other information about you that you would like to share:**____________________________________

____

____

____

Legal

1. **Have you ever incurred legal charges?** ❑ **Yes** ❑ **No**

If Yes, please describe and give dates charges incurred:_______________

____

____

____

2 . **Have you ever physically assaulted someone?** ❑ **Yes** ❑ **No**

If Yes, please describe any physical altercations you have had, including the date, what started it, and the result:
____

____

____

3. **Have you ever engaged in destruction of property?**

☐ Yes ☐ No

If Yes, please describe the incident(s), including the date and the result:

____

____

4. Have you ever been accused of, charged with, or convicted of a sexual offense?
   ☐ Yes ☐ No

5. Are you subject to a lifetime sex offender registration requirement in any state? ☐ Yes ☐ No

6. Do you have an advanced directive? ☐ Yes ☐ No

7. Do you have a legal status of Not Guilty by Reason of Insanity? ☐ Yes ☐ No

   If so, what is your current level of privilege? ___________________________

   Who is your hospital liaison? ___________________________________

8. Are you on Probation or Parole? ☐ Yes ☐ No
   If so, how long are you under supervision? _____________

   Who is your direct contact for Probation or Parole?

   Name: _____________________________ Phone: _______________

Contact Information

1. DESIGNATED CONTACT NAME : ________________________________

CONTACT ADDRESS: ____

CITY: ________________________ STATE: __________ ZIP: _____________

CONTACT PHONE NUMBER: _________________

2. NEXT OF KIN - NAME: ____

CONTACT ADDRESS: ____

CITY: ________________________ STATE: __________ ZIP: _____________

CONTACT PHONE NUMBER: ________________

3. CASE MANAGER - NAME: ____________________________________

CONTACT ADDRESS: ____

CITY: ______________________ **STATE:** __________ **ZIP:** ____________

CONTACT PHONE NUMBER: ________________

FINANCIAL INFORMATION

Medicaid Number: ____________________________________

Medicare Number: ___________________________________

Sources of Income:

1. Monthly amount of income: __________________________________
2. What kind of income? (SSI, SSDI, SSA): ________________________

   Employment: __________ Military / Veterans Benefits: ______________

   Food Stamps : ______________ Any Other Income: __________

3. Who is the payee of benefits?

   Name: _____________________________ Phone: ________________

4. Who is your Gaurdian or Conservator?

   Name: ___________________________ Phone: _________________

5. Checking Account: __________________ Savings Account: ____________

Do you have any:

- ❑ Certificate of Deposit
- ❑ Money Market Accounts
- ❑ Treasury Bills
- ❑ Stocks, bonds
- ❑ Retirement or pension
- ❑ Annuities
- ❑ Personal Property held as an investment
- ❑ Other

Have you received any lump sum payments during this past year, such as inheritances, insurance settlements, etc.? ____**YES** ____**NO**

Have you disposed of any assets for less than fair market value in the last two years? ____**YES** ____**NO**

Are you the beneficiary of a Trust Fund? ____**YES** ____**NO** If so, how much income do you receive from this trust yearly? ______________

Who controls the account? Name: __________________ Phone: ____________________

If an applicant is approved for admission, we will need the following before admission:

1. Letter from the Social Security Administration determining the applicant's disability OR statement from Social Security Administration stating current benefit(s).
2. Copy of all insurance cards.
3. Copy of Social Security Card, Birth Certificate, and Picture ID.
4. Copy of Bank Statements.
5. Financial agreement or DAP arrangements made.
6. Physical and PPD test 30 days prior to admission.

***While a resident of Gateway, I agree that Gateway will serve as my representative payee for my social security benefits.**

I certify that the information provided for this application is complete and accurate.

Signature of Applicant: ______________________________ Date: ______________