Lowell House Addiction Treatment and Recovery

MEN'S RECOVERY HOME - APPLICATION

TODAY'S DATE		**REFERRAL SOURCE**	
CONTACT NAME OF REFERRAL SOURCE		**CONTACT PHONE NUMBER**	

Client FIRST NAME	**MIDDLE**	**LAST**
AGE	**DATE OF BIRTH**	**SOCIAL SECURITY NUMBER**
ADDRESS	**PHONE NUMBER**	
PRIMARY LANGUAGE	**2ND LANGUAGE**	
WHAT EMPLOYMENT SKILLS DO YOU POSSESS AND TRAININGS HAVE YOU DONE		
WHAT ARE SOME EMPLOYMENT OPPORTUNITIES YOU HAD THAT YOU ENJOYED	**EDUCATION (LAST GRADE COMPLETED) INTRESTED IN CONTINUING EDUCATION/JOB TRAINING**	
LAST EMPLOYMENT	**# OF HOURS**	**LENGTH OF EMPLOYMENT**
INCOME (SOURCE)	**FREQUENCY**	**AMOUNT**
DOES CLIENT RECEIVE ANY MASSACHUSETTS STATE SERVICES		
VETERAN (BRANCH)	**DATES**	**D.C STATUS**
MARITAL STATUS	**# OF CHILDREN**	**WHO HAS CUSTODY?**

EMERGENCY CONTACT	PHONE NUMBER
GENERAL HEALTH (SYMPTOMs/DIAGNOSIS/TREATMENT/MEDICATION	
MENTAL HEALTH (SYMPTOMS/DIAGNOSIS/TREATMENT/MEDICATION)	
DRUG REPLACEMENT THERAPY (METHADONE/SUBOXONE/VIVITROL/DOSAGE)	

LEGAL STATUS PROBATION	PAROLE	INCARCERATED
SPECIFY IF ANY ARE CHECKED (CHARGES/LENGTH OF STATUS/JURISTRICTION/ CONDITIONS)		
CASES PENDING/ OUTSTANDING WARRANTS		

HAVE YOU EVER BEEN A RESIDENT AT LOWELL HOUSE'S MEN'S RECOVERY HOME?	IF SO, WHEN AND D.C. STATUS

TREATMENT ADMISSION HISTORY			
PROGRAM NAME		**DATE**	**LENGTH OF STAY/ D.C. STATUS**
1.			
2.			
3.			
4.			
5.			
6.			

DRUG OF CHOICE:	
SUBSTANCE USE HISTORY (DRUGS USED/METHOD/ CIRCUMSTANCES SURROUNDING FIRST USE)	
PERIODS OF ABSTINENCE and KNOWN RISK FACTORS FOR RELAPSE	

FAMILY/SUPPORT SYSTEM
CLIENT'S GOALS, MOTIVATION FOR TREATMENT (WHAT DO YOU WANT TO ACHIEVE AT OUR PROGRAM?)

FAX COMPLETED APPLICATION TO: 978-459-9136 or email to Diana Newell at dnewell@lowellhouseinc.org

REQUIRED DOCUMENTATION MUST ACCOMPANY YOUR COMPLETED APPLICATION:

1. **Psychosocial Assessment from a Treatment Facility**
2. **Medication List**
3. **TB Assessment**
4. **CORI (if legal status is pending)**