



EXODUS HOMES  
RESIDENT APPLICATION

ADMISSION DATE: \_\_\_\_\_  
RELEASE DATE: \_\_\_\_\_  
OPUS #: \_\_\_\_\_

APPROVED \_\_\_\_\_ APPLICANT NOTIFIED \_\_\_\_\_  
DENIED \_\_\_\_\_ APPLICANT NOTIFIED \_\_\_\_\_

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HAVE YOU EVER BEEN A RESIDENT OF CATAWBA, BURKE, ALEXANDER OR CALDWELL  
COUNTIES?: \_\_\_\_yes \_\_\_\_no

TELEPHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_

AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ SEX: \_\_\_\_\_ RACE \_\_\_\_\_ RELIGION: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ MAIDEN NAME: \_\_\_\_\_  
(If married give spouse name)

OCCUPATION: \_\_\_\_\_ SSN: \_\_\_\_\_

ABLE BODIED \_\_\_\_ or DISABLED \_\_\_\_ AMOUNT OF DISABILITY \_\_\_\_\_

DO YOU HAVE MEDICAID? \_\_\_\_\_

U.S. VETERAN: \_\_\_\_yes \_\_\_\_no

IF YES, WHAT BRANCH \_\_\_\_\_

HONORABLE DISCHARGE: \_\_\_\_\_ DISHONORABLE DISCHARGE: \_\_\_\_\_

HAVE YOU EVER BEEN HOMELESS? \_\_\_\_yes \_\_\_\_no

IF SO, HOW MANY TIMES? \_\_\_\_\_

WHAT LOCATIONS:

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**CHILDREN INFORMATION:**

<b>NAME</b>	<b>AGE</b>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**CUSTODY OF CHILDREN:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IS CHILD CURRENTLY ENROLLED IN SCHOOL?  YES  NO

OTHER AGENCIES INVOLVED:  DSS  JUVENILE COURT  GAL  OTHER

**NOTIFY IN CASE OF EMERGENCY:**

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIPCODE: \_\_\_\_\_  
TELEPHONE: HOME: \_\_\_\_\_ WORK: \_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_

**REHAB PROGRAMS COMPLETED (NAME AND CITY):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NAME OF CURRENT REHAB PROGRAM: \_\_\_\_\_

NAME OF COUNSELOR: \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

RELEASE DATE: \_\_\_\_\_

SOBRIETY AND/OR CLEAN DATE: \_\_\_\_\_

REASON FOR APPLYING TO EXODUS HOUSE: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SUBSTANCE ABUSE ADMISSION ASSESSMENT**

**SYMPTOMS:**      NONE       ATTEMPTS TO CUT DOWN       INCREASED TOLERANCE  
 WITHDRAWAL       FAMILY/RELATIONSHIP PROBLEMS       JOB PROBLEMS  
 GUILTY ABOUT ACTIONS WHILE USING

SUBSTANCE	CODE	ROUTE	FREQUENCY WHEN USING	AGE	WITHDRAWAL SYMTOMS/SPECIFY

**SUBSTANCE CODES:**

- |                      |                       |                     |
|----------------------|-----------------------|---------------------|
| 00 None              | 06 Opiates/Synthetics | 12 Benzodiazepine   |
| 01 Alcohol           | 07 PCP                | 13 Tranquilizers    |
| 02 Cocaine/Crack     | 08 Hallucinogens      | 14 Barbiturates     |
| 03 Marijuana/Hashish | 09 Math Amphetamine   | 15 Sedatives        |
| 04 Heroin            | 10 Amphetamines       | 16 Inhalants        |
| 05 Methadone         | 11 Stimulants         | 17 Over-the-Counter |

**ROUTE CODES:**

- 1 ORAL      2 SMOKING      3 INHALING      4 INJECTION      5 OTHER

**FRENQUENCY CODES:**

- 00 DRUG NOT USED DURING THE PAST MONTH  
 01 DRUG USED 1-3 TIMES IN THE PAST MONTH  
 02 DRUGS USED 1-2 TIMES PER WEEK  
 03 DRUGS USED 3-6 TIMES PER WEEK  
 04 DRUGS USED DAILY

**MEDICAL HISTORY:**

DIABETES: YES NO : (IF YES, PLEASE EXPLAIN)

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HIGH BLOOD PRESSURE: YES NO : (IF YES, PLEASE EXPLAIN)

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HEART DISEASE: YES NO : (IF YES, PLEASE EXPLAIN)

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STROKE: YES NO : (IF YES, PLEASE EXPLAIN)

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SEIZURES: YES NO : (IF YES, PLEASE EXPLAIN)

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LIVER OR KIDNEY DISEASE: YES NO : (IF YES, PLEASE EXPLAIN)

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THYROID OR HORMONAL: YES NO : (IF YES, PLEASE EXPLAIN)

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CANCER: YES NO : (IF YES, PLEASE EXPLAIN)

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INFECTIOUS DISEASE: (TB, AIDS, HIV, ETC.) YES NO : (IF YES, PLEASE EXPLAIN)

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PREGNANT SURGERIES: YES NO : (IF YES, PLEASE EXPLAIN)

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LIST PRESCRIBED AND OVER-THE-COUNTER MEDICATIONS NOT LIST ABOVE:

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HAVE YOU EVER BEEN A VICTIM OF DOMESTIC VIOLENCE?  YES  NO

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IF YES, PLEASE DESCRIBE:

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**MENTAL HEALTH HISTORY:**

HAVE YOU EVER BEEN INVOLVED WITH MENTAL HEALTH?  YES  NO

IF ANSWER IS YES PLEASE ANSWER THE FOLLOWING QUESTIONS:

HOW LONG WAS YOUR INVOLVEMENT? WHAT YEAR (S)?

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WHAT WAS THE DIAGNOSIS?

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WHAT MEDICATIONS, IF ANY, WERE ADMINISTERED?

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ARE YOU CURRENTLY TAKING ANY MEDICATIONS: \_\_\_\_\_ yes \_\_\_\_\_ no

IF SO, NAME AND DOSAGE: \_\_\_\_\_

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***IF YOU ARE CURRENTLY TAKING MEDICATION THAT REQUIRES A PSYCHIATRIST FOR REFILLS AND MEDICATION REVIEWS, YOU WILL BE REQUIRED TO BECOME A CLIENT OF ALCOHOL AND DRUG SERVICES OF CATAWBA COUNTY. THEIR FEE IS \$25 FOR THE INITIAL ASSESSMENT AND \$10 PER MONTH FOR GROUP THERAPY.***

WE NEED YOU TO BRING ENOUGH MEDICATION WITH YOU WHEN YOU COME TO LAST UNTIL YOU CAN GET RE-FILLS HERE, WHICH WILL BE 3-4 WEEKS. WILL THIS BE A PROBLEM? PLEASE DESCRIBE:

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**WE CANNOT ACCEPT RESIDENTS TAKING NARCOTICS, PSYCHOTROPIC AND MEDS THAT ARE IN THE BENZODIAZAPINE FAMILY AND THE FOLLOWING MEDICATIONS:**

- ALPROZOLAM (XANAX)
- CHLORDIAZPOXIDE (LIBRIUM)
- CLONAZEPAM (KLONOPIN)
- CLORAZEPATE (TRANXENE)
- DIAZEPAM (VALIUM)
- FLURAZEPAM (DALMANE)
- LORAZEPAM (ATIVAN)
- OXAZEPAM (SERAX)
- PRAZEPAM (CENTRAX)
- TERNAZEPAM (RESTORIL)
- TRIAZOLAM (HALCION)

THESE MEDICATIONS ARE HIGHLY ADDICTIVE AND THE POTENTIAL FOR ABUSE EXISTS. THE RESIDENTS SELF-ADMINISTER THEIR OWN MEDICATION. WE FEEL THESE MEDICATIONS ACTUALLY PROLONG A PERSON'S ADDICTION.

TRAUMA, INCLUDING HEAD, PHYSICAL/SEXUAL ABUSE:  YES  NO (IF YES, PLEASE EXPLAIN)

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ALLERGIES TO ENVIRONMENT, FOOD, OR MEDICATION:  YES  NO : (IF YES, PLEASE EXPLAIN)

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**MENTAL STATUS: (CHECK AND DESCRIBE)**

**DANGER TO SELF:**

- NONE
- THREATS OF SUICIDE
- PLAN FOR SUICIDE
- PREOCCUPATION WITH DEATH
- SUICIDE ATTEMPTS
- INABILITY TO CARE FOR SELF

**DANGER TO OTHERS:**

- NONE
- THREATS TO HARM OTHERS
- PLAN TO HARM OTHERS
- ATTEMPTS TO HARM OTHERS

**ATTITUDE:**

- COOPERATIVE
- UNCOOPERATIVE
- RESERVED
- SARCASTIC
- SUSPICIOUS
- GUARDED
- HOSTILE

**EMOTIONAL STATE:**

- GOOD
- SAD/DEPRESSED
- EUPHORIC
- HOSTILE

**THOUGHT FORM:**

- NORMAL
- TANGENTIAL THINKING
- LOOSE ASSOCIATIONS
- SLOWNESS IN THOUGHT
- INCOHERENT
- CONFUSED
- FLIGHT OF IDEAS
- PRESERVATION
- OTHER

**INSIGHT:**

- GOOD
- FAIR
- POOR

**THOUGHT CONTENT**

- NORMAL
- UNABLE TO ACCESS
- IDEAS OF REFERENCE
- SUSPICIOUS
- DELUSION
- HALLUCINATIONS
- FEELING HOPELESS/HELPLESS

**DESCRIPTIONS: (To be filled out by counselor or caregiver)**

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**LEGAL:**

HAVE YOU EVER BEEN CONVICTED OF A CRIME?: \_\_\_\_\_yes \_\_\_\_\_no

IF SO, PLEASE GIVE NATURE OF CHARGE AND DATE OF  
CONVICTIONS: \_\_\_\_\_

\_\_\_\_\_

DID ANY OF THESE CONVICTIONS LEAD TO INCARCERATION?: \_\_\_\_\_yes \_\_\_\_\_no

IF SO, PLEASE LIST INSTITUTION AND YEAR OF CONFINEMENT:

\_\_\_\_\_

\_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF A SEXUAL OFFENSE? \_\_\_\_yes \_\_\_\_no

IF SO, PLEASE LIST WHERE:

\_\_\_\_\_

\_\_\_\_\_

**PAROLE OR PROBATION OFFICER:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TELEPHONE : \_\_\_\_\_

**SOCIAL WORKER:**

NAME: \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TELEPHONE \_\_\_\_\_

**MISCELLANEOUS:**

WILL YOU HAVE YOUR ADMISSION FEES? \_\_\_\_\_ Yes \_\_\_\_\_ No  
HOW MUCH WILL YOU BRING? \_\_\_\_\_

DO YOU HAVE A VALID NC DRIVERS LICENSE? \_\_\_\_\_ Yes \_\_\_\_\_ No  
IF YES, WHAT IS LICENSE NUMBER? \_\_\_\_\_

DO YOU HAVE A PICTURE ID? \_\_\_\_\_ Yes \_\_\_\_\_ No  
IF YES, WHAT IS YOUR ID NUMBER? \_\_\_\_\_

DO YOU HAVE FUTURE APPOINTMENTS (i.e. DOCTOR'S, DENTIST, SOCIAL SERVICES)  
AND/OR COURT DATES? IF YES, PLEASE EXPLAIN:

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DO YOU HAVE TRANSPORTATION TO AND FROM THESE APPOINTMENTS? \_\_\_ Yes \_\_\_ No  
OUT OF TOWN APPOINTMENTS WILL BE YOUR RESPONSIBILITY IN MOST CASES.

PLEASE CONTINUE TO CALL US EVERY FEW DAYS UNTIL YOU ARRIVE.

IF EXCEPTED INTO THIS PROGRAM YOU WILL NEED TO BRING THE FOLLOWING ITEMS:

- TWIN SHEETS
- PILLOW CASES
- BLANKETS
- CLOTHING (CASUAL AND DRESS)
- PERSONAL ARTICLES (TOOTHBRUSH, DEODERANT, ETC.)
- WASH CLOTHS, TOWELS, ETC.

ALTHOUGH SOME FOODS ARE PROVIDED, SPECIALITY ITEMS SUCH AS SODA, CAKES,  
COOKIES, ETC. WILL HAVE TO BE PURCHASED BY THE RESIDENT.

**\*\*IMPORTANT NOTICE\***

**APPLICATION IS NOT COMPLETE UNTIL WE RECEIVE A STATEMENT FROM THE  
REFERRAL SOURCE STATING THAT THE RESIDENT IS EITHER HOMELESS, OR LACKS  
THE NECESSARY RESOURCES FOR A RECOVERY LIFESTYLE. PLEASE REFER TO THE  
AREA/PARAGRAPH CHECKED AND RESPOND ON FACILITY LETTERHEAD. RESIDENTS  
WILL NOT BE ADMITTED WITHOUT THIS DOCUMENT.**

I UNDERSTAND THAT BY COMPLETING THIS APPLICATION, IT ONLY STARTS THE ADMISSIONS PROCESS. I AGREE TO CONTACT EXODUS HOMES WITHIN ONE (1) WEEK, AFTER SUBMITTING THIS APPLICATION, TO SET A DATE FOR THE ADMISSION INTERVIEW, EITHER BY PHONE OR IN PERSON.

**I \_\_\_\_\_ understand that any information that I have submitted on this application, that is false or vital information that I have omitted is grounds for my application to be denied or if I am approved for the Exodus Program, it may be grounds for my dismissal.**

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT OR TYPE NAME: \_\_\_\_\_

COMPLETED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

DIAGNOSTIC IMPRESSION: (DSM-IV)

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SIGNATURE OF QUALIFIED, LICENSED, PROFESSIONAL:

NAME: \_\_\_\_\_

POSITION: \_\_\_\_\_

DATE: \_\_\_\_\_

\*A copy of License or ID Card must be faxed with application\*



# Memorandum EXODUS HOMES

**To:** \_\_\_\_\_  
**CC:** \_\_\_\_\_  
**From:** Admissions Staff  
**Date:** \_\_\_\_\_  
**Re:** Application Requirements

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**To Whom It May Concern:**

First, allow me to thank you on behalf of Exodus Homes for your referral and interest in our program.

In order for your client's application to be complete there are several documents we will need from your agency. The process of evaluation cannot begin until these requirements have been met.

We will need a verification of homelessness in letter or paragraph form, on agency letterhead, stating that the potential client is either homeless or has no resources that would support his/her recovery.

Secondly, we will need your medical and psychological assessments of the potential client and will also need him/her to sign a release form authorizing Exodus Homes to obtain protected, confidential information (i.e. substance abuse and legal histories; psychological evaluation; medical, social, family and assessments, etc.)

Exodus Homes has a constant influx of applicants so time is of the essence. The sooner we receive this information the faster we can process the prospective resident.

Thank you for your cooperation.

# INFORMATION FOR EMPLOYMENT

## PERSONAL INFORMATION

Name \_\_\_\_\_ SSN \_\_\_\_-\_\_\_\_-\_\_\_\_

Are you prevented from lawfully becoming employed in this country because of visa or immigration status? \_\_\_\_\_

## EMPLOYMENT DESIRED

Position desired \_\_\_\_\_

Do you have experience in this field? yes\_\_\_\_ no\_\_\_\_\_ If yes how many years? \_\_\_\_\_

May we inquire from your previous employer concerning job performance? yes\_\_\_\_ no\_\_\_\_\_

## EDUCATION

	<i>Name and Location</i>	<i>No. of years attended Did you graduated?</i>	
High School	_____	_____	_____
College	_____	_____	_____
Trade, Business Or Corres. Sch.	_____	_____	_____

## FORMER EMPLOYERS

<b>DATES</b>	<b>NAME &amp; ADDRESS</b>	<b>SALARY</b>	<b>POSITION</b>	<b>REASON FOR LEAVING</b>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Which of these jobs did you like best? \_\_\_\_\_

What did you like most about this job? \_\_\_\_\_

**FORMER EMPLOYERS**

Give the names of three persons not related to you, whom you have known at least one year.

*Name*

*Address*

*Years Acquainted*

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_