



Hope on Haven Hill Intake Application

Date of Application: _____

Intake done with: _____

DEMOGRAPHICS:

Name: _____ Age: _____ DOB: _____ Last 4 digits of SSN: _____

Phone: _____ Can we leave a message at this number? _____

Current Living Situation:

Community _____ Homeless _____ Shelter _____ Incarcerated _____ Treatment Center _____

Current Street Address: _____

City: _____ State: NH Zip code: _____

Length of time at current address: _____

If incarcerated, when are you eligible for release or parole? _____

Do you have a NH picture ID? _____ YES _____ NO

Current relationship status: _____ Single in a relationship _____ Single not in a relationship

_____ Married _____ Divorced _____ Widowed _____ Other _____

Are you pregnant? _____ YES _____ NO Anticipated Due Date: _____

Are you currently receiving prenatal care? _____ If YES, where? _____

Do you have children? _____ YES _____ NO How Many? _____

What is the custody arrangement? _____

Health Insurance Carrier: _____ Insurance number: _____

Are you the primary carrier of this insurance? _____ If not, who is the primary carrier? _____

If English your first language? _____

How would you describe your race/ ethnicity? _____

Religious Affiliation? _____



Hope on Haven Hill Intake Application

EMERGENCY CONTACT INFORMATION:

Name: _____

Relationship to you: _____

Does she/he live close by? Far away? How available are they to you? _____

Can we contact this person in the event of admission to this program? _____

Do you currently smoke cigarettes? ____YES ____NO If YES, how many per day? ____

Do you currently drink caffeinated beverages? ____YES ____NO If YES, how many per day? ____

SUBSTANCE USE:

Are you currently using substances? ____YES ____NO

If no, current length of sobriety: _____

Have you ever been treated for alcohol/drug use? ____YES ____NO (include inpatient, outpatient, intensive outpatient, Medication Assistance Program, programs during incarceration, and detoxification services)

Location/type: _____ DATE(S): _____ Completed? _____

Location/type: _____ DATE(S): _____ Completed? _____

Location/type: _____ DATE(S): _____ Completed? _____

Location/type: _____ DATES(S): _____ Completed? _____

Are you on Methadone maintenance or Suboxone/Subutex? ____YES ____NO

IF YES, Current dose: ____

Provider Information: _____ Phone _____

How long have you been in this program? _____



Hope on Haven Hill Intake Application

DRUG OF CHOICE: (include alcohol, amphetamines, methamphetamines, cocaine/crack, heroin, cannabis, hallucinogens, methadone, buprenorphine, inhalants, benzodiazepines, other)

#1: _____ Date of last use: _____ How much did you use? _____

How often did you use this drug? _____ Age of first use? _____

How did you use it? (circle) smoke snort/inhale inject oral other _____

#2: _____ Date of last use: _____ How much did you use? _____

How often did you use this drug? _____ Age of first use? _____

How did you use it? (circle) smoke snort/inhale inject oral other _____

#3: _____ Date of last use: _____ How much did you use? _____

How often did you use this drug? _____ Age of first use? _____

How did you use it? (circle) smoke snort/inhale inject oral other _____

Have you ever overdosed? How many times? Approximate dates: _____

Have you ever been sober? When? _____

What is your longest period of sobriety? _____

How did you achieve that sobriety? (meetings, residential, MAT etc) _____



Hope on Haven Hill Intake Application

MEDICAL:

Please list any medical conditions (Asthma, Diabetes, Hepatitis, HPV)

Please list all allergies (food, seasonal, and medical related) _____

If you have any allergies or other medical conditions, do you carry the following with you? (circle)

EPI Pen Inhaler Other medication (insulin) _____

Who is your doctor? _____ Phone number _____

Address: _____

Date of last visit: _____ Reason: _____ Date of last physical: _____

Do you have any vision problem? ____YES ____NO Glasses/ contacts: _____

Do you have dental concerns? ____YES ____NO Hearing problems? ____YES ____NO

Have you even experienced a concussion or traumatic brain injury? ____YES ____NO

(Please include combat or accidents that resulted in head injury.) _____

Have you even lost consciousness? ____YES ____NO IF **YES**, for 30 minutes or more? _____

What were the circumstances? _____



Hope on Haven Hill Intake Application

Medications/ vitamins: List all of the over the counter and prescription medications you are currently taking.

| <u>Medication</u> | <u>Dose</u> | <u>Reason for taking</u> | <u>Prescribing doctor</u> |
|-------------------|-------------|--------------------------|---------------------------|
|-------------------|-------------|--------------------------|---------------------------|

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

MENTAL HEALTH:

Have you ever received mental health treatment? (Circle) current past never

Agency name/Counselor name: _____

Have you even been given a mental health diagnosis(es)? ____ YES ____ NO

IF YES please list: _____

Have you ever been hospitalized for mental health issues/ concerns? ____ YES ____ NO

Have you ever attempted suicide? ____ YES ____ NO IF YES, when? _____

Please explain: _____

Are you currently experiencing suicidal or homicidal thoughts? _____



Hope on Haven Hill Intake Application

LEGAL:

Have you ever been arrested? ____ YES ____ NO

If YES please explain the charges and provide the dates of the offence(s):

OFFENSE/CHARGE

DATE

Have you ever been convicted of arson? ____ Violent crime? ____ Sexual Assault? ____

Have you ever been arrested, charged, or convicted of a sexual offence? _____

Are you a registered sex offender? _____

Have you ever been incarcerated? ____ YES ____ NO When? _____

Are you currently on probation/ parole? ____ YES ____ NO

IF YES, Name of Officer: _____ District Office: _____ Phone: _____

Are there any current restraining orders against you OR placed by you? ____ YES ____ NO

IF YES, Please explain: _____

Have you ever been charged with abuse/neglect of a child? _____

Do you have any outstanding warrants against you in any state? _____

Do you owe any court fines? _____

Have you ever experienced interpersonal violence in a relationship? ____ YES ____ NO

If yes, when? Have there been any recent incidences? Are you still in contact with the perpetrator? _____



Hope on Haven Hill Intake Application

EDUCATION/ EMPLOYMENT:

Highest level of education completed: _____

Have you even been diagnosed with a learning/reading/developmental disability?

Are you currently enrolled in an educational program? ____YES ____NO

IF YES, Where? What are you studying? _____

Are you employed? ____YES ____NO

Who is your employer? _____

How long have you been at this job? _____

Are you a veteran? ____YES ____NO IF YES, Years of active military service? _____

FINANCIAL:

If currently employed: Hourly wages: _____ Hours per week: _____

Do you currently receive WIC? ____YES ____NO

Do you receive child care assistance from the State? ____YES ____NO

Do you receive Public Assistance? ____YES ____NO

IF YES, what benefits do you currently receive?

TANF ____ Date Started: _____ Monthly amount: _____

Food Stamps ____ Date Started: _____ Monthly amount: _____

SSI ____ Date Started: _____ Monthly amount: _____

Unemployment ____ Date Started: _____ Monthly amount: _____

City/town welfare ____ Date Started: _____ Monthly amount: _____

Other: ____ Date Started: _____ Monthly amount: _____



Hope on Haven Hill Intake Application

CHILDREN CURRENTLY LIVING WITH YOU:

1. Name: _____ male/female DOB: _____ Age: _____

Child SS#: _____ Current school/ daycare _____

Child's pediatrician: _____

Address: _____ Phone: _____

Name of child's other parent: _____ Level of involvement: _____

DCYF Involvement? _____ YES _____ NO If yes, name of CPSW: _____

District Office: _____ CPSW worker phone: _____

How long has DCYF been involved in this case? _____

Do you receive child support for this child? _____ YES _____ NO _____ Pending

IF YES, amount: _____

2. Name: _____ male/female DOB: _____ Age: _____

Child SS#: _____ Current school/ daycare _____

Child's pediatrician: _____

Address: _____ Phone: _____

Name of child's other parent: _____ Level of involvement: _____

DCYF Involvement? _____ YES _____ NO If yes, name of CPSW: _____

District Office: _____ CPSW worker phone: _____

How long has DCYF been involved in this case? _____

Do you receive child support for this child? _____ YES _____ NO _____ Pending

IF YES, amount: _____



Hope on Haven Hill Intake Application

CHILDREN NOT CURRENTLY LIVING WITH YOU:

1. Name: _____ male/female DOB: _____ Age: _____

Address: _____

Child's guardian: _____ Relationship to child: _____

DCYF Involvement? _____ YES _____ NO If yes, name of CPSW: _____

District Office: _____ CPSW worker phone: _____

What is your level of involvement/contact with the child? _____

Are you in the process of Redeeming Guardianship? _____

2. Name: _____ male/female DOB: _____ Age: _____

Address: _____

Child's guardian: _____ Relationship to child: _____

DCYF Involvement? _____ YES _____ NO If yes, name of CPSW: _____

District Office: _____ CPSW worker phone: _____

What is your level of involvement/contact with the child? _____

Are you in the process of Redeeming Guardianship? _____



Hope on Haven Hill Intake Application

Please tell us what you are looking for from our program? How do you feel about living in a environment like ours, living with seven other women in recovery, following program guidelines, and participating in all aspects of the program? What goals would you like to achieve? Is there anything else we should know about you?
(use the back of this page if you need more space)

My signature certifies that, to the best of my knowledge, all of the above information is accurate. I understand that releases may be requested for the purposes of contacting any of the above mentioned providers or other individuals.

Signature

Date



Hope on Haven Hill Intake Application

Prior to admission into Hope on Haven Hill Recovery Program you must have:

- NH photo ID or other proof of NH residence
- Physical Exam results (done within past 90 days) including Medication list (if any), approval for OTC medication and letter stating “Medical Clearance” to participate in a non-medical behavioral health substance misuse treatment facility.
- If currently pregnant; “Medical Clearance “note from OBGYN and awareness of client’s history of substance misuse.
- **A written medical order** for each prescription to include vitamins and/or over the counter medication. A medical order is a list of prescribed or over the counter medication and the instructions for use. (i.e. Ibuprofen, 200mg, BID), this must be **signed by a medical doctor and or physicians assistant**
- **A 30 day supply**, and you must have the ability to refill all medication for you and your child if applicable
- Insurance card/Information if applicable (for both client and child)
- Copy of Birth Certificates for children
- Up to date record of immunizations for children
- Social security cards or numbers
- If applicable, prior mental health evaluations to be forwarded prior to admission
- Legal documents to include custody information of children

To Do:

- 1.
- 2.
- 3.
- 4.



Hope on Haven Hill Intake Application