Pre-Admission Application

***Completed Application does not Guarantee Eligibility or Admission**

PATHWAY TO RECOVERY
SUBSTANCE-FREE SUPPORTIVE HOUSING

Date _____ Contact Phone Info _____

Name:_____ Age: _____DOB: _____SS#:_____

Marital Status: ____Current Relationship Status: _____Does person drink/drug? _____When was Last Relationship? _____

Gender:_____Race:_____Sobriety Date:_____Longest Period of Sobriety:_____When (year?):_____

Emergency Contact: _____Relationship: _____Phone: _____Alt Phone:_____

Where or with who have you been staying? _____Address: _____

Who Else in Your Family or immediate network Uses?

____Mother ____Father ____Brother(s)
____Sister(s) ____Stepmother ____Stepfather
____Aunts/Uncles ____Cousins ____Children
____Grandparents ____Other: _____

Most Recent Relationships:

From	To	Name	Drug/Alcohol Use?

Drug/Alcohol Use

Substance Age 1st Use	1st Choice	2nd Choice	3rd Choice

Check *All* That Apply

____Alcohol ____ Heroin ____ Marijuana ____Crack
____Cocaine ____Hallucinogens ____OTC ____ Meth
____Pain pills ____ Inhalants ____ IV Drugs ____Spice

Medical/Disease Screening

	Date	Result
HIV	_____	_____
HEP	_____	_____
TB	_____	_____
STD's		

Diagnosed Mental Illness

___ Schizophrenia
___ Anxiety
___ Depression
____ Bi-Polar
___ PTSD
OTHER: _____

Substance Abuse Detox/Treatment/Sober Living Program History

Date(s)	Name of Program	Program Type	Length of Stay	(Completed or Terminated)

Mental Health Treatment History

Date(s)	Name of Agency	Inpatient, Outpatient or IOP	Length of Stay	(Completed or Terminated)

Current Mental Health Physician and or Provider: _____

Address: _____Phone: _____

Mental Health Medications: _____

When do they need to be refilled? _____ Any past suicide attempts?_____Number of attempts? _____

Date and method of last attempt? _____ Do you have current suicidal thoughts or feelings_____

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Medical History

List current medical condition(s) requiring treatment, follow up or medication: _____

_____

List any mobility issues (stairs, standing, lifting) etc: _____

List any Allergies (Food, medication, seasonal)? _____

List Current Medications not listed elsewhere: _____

Physician: _____ Provider: _____ Phone #: _____

My signature authorizes Pathway to contact ALL healthcare providers listed on this application: _____

Legal-Criminal History

Current Charges: _____ Court Room _____

County, Judge & Contact Info: _____ Court Date & Time: _____

Public Defender Name & Number & Agency: _____

Attorney Name & Number & Agency: _____

Probation Officer Name & Number & Agency: _____

_____

Amount of fees/fines owed? _____ Due Date: _____ Next Appointment: _____ End of Probation: _____

Most Recent Arrest /Convictions History

Date	Charge(s)	Outcome/ Sentence

Violent Crimes Arrest /Convictions

Date	Charge(s)	Outcome/ Sentence

Sexual Crimes Arrest /Convictions

Date	Charge(s)	Outcome/ Sentence

Employment/Education

Most Current Employment History Experience

From	To	Company	Position	Reason for Leaving

Are able to Work? Yes or No If Not, Why? _____

Do you have any current income or source of income? Yes or No Amount of Current Income per month: _____

Disability or Other income List source and amount **per month** before any deductions): _____

What is your approved disability? _____

Education: Highest grade completed: _____ Type/Names of Degrees: _____ Trades/Skills: _____

Other Information

Veteran? Yes or No Service Dates: _____to _____Branch: _____Type of Discharge: _____

Check which of the following documents you have in your possession:

Valid State ID ☐ Indiana Driver's License: ☐ Birth Certificate: ☐ Social Security Card: ☐

Will you have a vehicle? Yes or No Owner's Name: _____Insurance? Yes or No

Support Network Information

Do you have a 12-step Sponsor? _____Name:_____Phone #:_____

Who is the most important person supporting your recovery? _____Phone #:_____

SUCCESSFUL DISCHARGE IS DEFINED AS ACHIEVEMENT OF THE FOLLOWING (90 DAY MINIMUM AVERAGE 4-6 MONTHS)

1. Substance-free with strong Recovery Foundation and Support System (Negative drug and alcohol screens, participation in full program including daily groups & meetings and using a 12-step sponsor while building a support system of men in recovery)(MINIMUM OF 90-DAYS)
2. Emotionally & Mentally Stable (for participants with mental health issues such as anxiety, depression, etc) by taking medications as directed, attending appointments as scheduled and complying with mental health treatment plan on own initiative without staff assistance once stabilized.
3. Financially Self-Supporting with same job and consistent hours and wages and responsible for self-payment of rent based on income with ultimately goal of paying one month in advance with zero balance. Same for clients receiving disability benefits. Must be compliant with written documented budget plan.
4. Exiting pathway to safe, affordable, substance free, supportive pre-planned destination with notice.

What is your main reason or motivation for seeking help?_____

_____

What Issues are most important to you (in order) Homelessness, addiction, mental health, job, legal, family, other? _____

_____

What has prevented you from remaining clean and sober?_____

_____

_____

What are you willing to do or what do you need to do differently to remain clean and sober this time? _____

_____

_____

What are your concerns or questions about coming to Pathway? _____

_____

_____

Return completed application via email to **Larry Lynn Llynn@pathwaytorecovery.org** or deliver to 2135 N Alabama Street Indpls, IN 46202 or fax 317.926.2250 or call 317.926.8557 with questions.

I have read and understand the successful discharge criteria and request consideration for admission. I authorize Pathway to contact agencies and individuals to verify my information.

Applicant Signature: _____

Printed Name: _____ Date: _____

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