

HAVE YOU EVER ATTENDED 12-STEP MEETINGS? YES NO IF YES, PLEASE EXPLAIN EXPERIENCE:

WHAT CAN SKYWAY HOUSE OFFER YOU?

DO YOU THINK YOU ARE AN: ALCOHOLIC? ADDICT? ALCOHOLIC/ADDICT?

SUBSTANCE ABUSE: (START WITH MOST RECENT)

SUBSTANCE: _____ HOW USED: _____ FREQUENCY: _____

QUANTITY USED AT A TIME: _____ AGE OF FIRST USE: _____ DATE OF LAST USE: _____

WHAT STOPPED YOU USING? _____

OTHER SUBSTANCE USED: _____ HOW USED: _____ FREQUENCY: _____

QUANTITY USED AT A TIME: _____ AGE FIRST USE: _____ DATE LAST USE: _____

OTHER SUBSTANCE USED: _____ HOW USED: _____ FREQUENCY: _____

QUANTITY USED AT A TIME: _____ AGE FIRST USE: _____ DATE LAST USE: _____

LEGAL:

DURING THE LAST 3 YEARS HAVE YOU BEEN OR ARE YOU NOW CONVICTED OF A CRIME THAT IS ALCOHOL OR DRUG RELATED?
 YES NO

DURING THE LAST 3 YEARS HAVE YOU BEEN OR ARE YOU NOW CONVICTED OF A CRIME THAT IS NOT ALCOHOL OR DRUG RELATED?
 YES NO

DO YOU CURRENTLY HAVE CHARGES PENDING IN A COURT OF LAW? YES NO
IF YES, PLEASE LIST WHAT THE CHARGES ARE AND WHETHER THEY ARE MISDEMEANOR OR FELONY CHARGES

CRIMINAL HISTORY: (PLEASE LIST ANY AND ALL FELONY CONVICTIONS, DATE, AND CHARGES)

ATTORNEY NAME AND PHONE NUMBER: _____

PROBATION/PAROLE OFFICER: _____

ARE YOU A PARTICIPANT OF DRUG COURT? YES NO
ARE YOU A PARTICIPANT OF PROP36? YES NO

COUNSELOR'S NAME AND PHONE # _____

UPCOMING COURT APPEARANCES AND STAGE OF LEGAL PROCESS: _____

IF INCARCERATED, WHAT IS YOUR EXPECTED RELEASE DATE? _____

EMERGENCY CONTACT:

NAME: _____ PHONE: _____

ADDRESS: _____ CITY/ZIP: _____

RELATIONSHIP TO YOU: _____

MEDICAL:

DO YOU KNOW OR HAVE YOU EVER HAD A MENTAL HEALTH DIAGNOSIS? YES NO

IF YES, PLEASE GIVE DIAGNOSIS, DETAILS, AND/OR TREATMENT PLAN: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

PLEASE LIST ANY PRESCRIBED AND/OR OVER-THE-COUNTER MEDICATIONS TAKEN
PRESENTLY:

DO YOU HAVE ANY MEDICAL CONDITIONS THAT WOULD AFFECT YOUR STAY IN SKYWAY HOUSE?

HISTORY OF SUICIDAL/ HOMICIDAL BEHAVIOR: _____

SUICIDAL IDEATION: (PLEASE EXPLAIN) _____

ARE YOU CURRENTLY ON MEDICAL? ____ YES ____ NO

DO YOU HAVE HEALTH INSURANCE? ____ YES ____ NO

TB TEST COMPLETED ON: _____ RESULTS: _____

HEAD LICE CHECK COMPLETED ON: _____ RESULTS: _____

FUNDING:

REFERRING AGENCY: _____

FUNDING SOURCE/ AGENCY: _____

FUNDING CONTACT NAME: _____

ADDRESS: _____ CITY/ST/ ZIP: _____

PHONE: _____

CLIENT STATEMENTS:

HOW DO YOU FEEL ABOUT YOUR USE OF ALCOHOL AND DRUGS? _____

WHAT WAS YOUR LAST EXPERIENCE WITH ALCOHOL AND DRUGS LIKE? _____

I UNDERSTAND THAT ANY OMISSIONS, DELETIONS OR FALSE INFORMATION PROVIDED IN THIS APPLICATION MAY BE CAUSE OF DISMISSAL FROM THE SKYWAY HOUSE PROGRAM AND /OR DENIAL OF THIS APPLICATION.

APPLICANT SIGNATURE: _____ DATE: _____

STAFF USE ONLY:

IN CUSTODY? YES NO WHAT COUNTY? _____

ACCEPTED ARRIVAL DATE: _____ ARRIVAL TIME: _____

PLACED ON WAITING LIST REASON: _____

APPLICATION DENIED REASON: _____

ADDITIONAL COMMENTS: _____

STAFF MEMBER: _____ DATE: _____