**Application for Admission**

Dear Applicant,

We at the Jude House are excited about your commitment to becoming drug and alcohol free. Attached is the application for admission to help us determine how we can best assist you. **Please complete each part of the application thoroughly.** Several releases are included to help us gather supporting information required for your possible admission. Prior to admission, The Jude House recommends having the following information if it applies to your circumstance:

* Name, Address, and Telephone number of your Attorney/Public Defender.
* Name, Address, and Telephone number of your Parole and Probation Agent.
* Full disclosure regarding Psychiatric diagnosis or treatment you may have had.
* Full disclosure regarding all medications you are taking (Prescription & Over the counter).
* Name, Address, and Telephone number of any counselor or social worker you have had in the past 2 years.
* Copies of Original Financial Documentation supporting information provided on any financial status form that you may have attached to this application.
* A substance use evaluation.

If accepted, you will need to provide either proof of Maryland Medicaid or plan to pay out of pocket. Out of pocket **Admission Fee**, **$1120.00,** must be paid prior to you entering the facility. This fee covers the first two (2) weeks of treatment. After the two (2) weeks period, you must pay a fee of $560.00 per week for treatment. New admissions are accepted Monday – Friday between the hours of 9:00 am and 1:00 pm. There is a minimal stay of 30 days for self-paid patients. Two weeks payments is due up front.

**It is your responsibility to keep The Jude House informed of your continued interest in admission to our program. You may designate someone to contact us on your behalf. Please read and answer each question honestly to the best of your knowledge. Anything less that is falsified can result in denial of admission or unsuccessful discharge once admitted. Any Falsified information can result in denial. It is your responsibility to provide $10 monthly for prescription fees. If this money is not used it will be returned upon discharge.**

**Please Contact us if you need further assistance.**

***Thank You,***

***Admissions Coordinator***

**Application for Admission**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_

Current Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.C. # (If Applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presenting Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been a client at our facility at our facility? \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_Yes, If so, When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many times in your life have you been hospitalized for medical treatment? ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How long ago was your last hospitalization? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Years \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Months
3. Do you have a history of or a current diagnosis of any of the following?

|  |  |  |
| --- | --- | --- |
| Abscess: \_\_\_\_\_\_\_\_\_\_ | Emphysema: \_\_\_\_\_\_\_\_\_\_ | Pancreatitis: \_\_\_\_\_\_\_\_\_\_ |
| Cardiac Problems: \_\_\_\_\_\_\_\_\_\_ | Fainting: \_\_\_\_\_\_\_\_\_\_ | Cancer: \_\_\_\_\_\_\_\_\_\_ |
| Cirrhosis/ Liver Problems: \_\_\_\_\_\_\_\_\_\_ | Hepatitis A: \_\_\_\_\_\_\_\_\_\_ | Seizures or Epilepsy: \_\_\_\_\_\_\_\_\_\_ |
| High Blood Pressure: \_\_\_\_\_\_\_\_\_\_ | Hepatitis B: \_\_\_\_\_\_\_\_\_\_ | Hearing Problems: \_\_\_\_\_\_\_\_\_\_ |
| Diabetes: Hypertension \_\_\_\_\_\_\_\_\_\_ | Hepatitis C: \_\_\_\_\_\_\_\_\_\_ | Tuberculosis: \_\_\_\_\_\_\_\_\_\_ |
| Gastrointestinal Bleeding: \_\_\_\_\_\_\_\_\_\_ | Vision Problems: \_\_\_\_\_\_\_\_\_\_ | Arthritis: \_\_\_\_\_\_\_\_\_\_ |
|  |  |  |

1. Do you have any chronic medical problems that interfere with your life? \_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_ No
2. Are you taking any prescribed medications on a regular basis? \_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_ No

If Yes, Please list medications, including dosages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently taking any Medicated Assisted Treatment (MAT)? \_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_ No
2. How many days in the last 30 days have you experienced medical problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How many times in the last 30 days have you visited an emergency room? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Have you ever been diagnosed with TB? \_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_ No
5. What is your weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs.
6. Have you noticed a recent weight loss? \_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_ No
7. How many times, in the last six (6) months, have you been hospitalized due to problems related to drugs and/or Alcohol? \_\_\_\_\_\_
8. Are you currently able to feed, bathe, Dress, and walk on your own? \_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_ No
9. Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_ No If Yes, How many weeks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following questions require a Yes or No response for both columns**

|  |  |  |
| --- | --- | --- |
| **Have you:** | **Past 30 Days** | **Lifetime** |
| Experienced Serious depression, Sadness hopelessness, or lack of interest? |  |  |
| Experienced serious anxiety, tension, or unreasonable worry? |  |  |
| Experienced hallucinations or saw or heard things that did not exist? |  |  |
| Experienced trouble understanding, concentrating, or remembering? |  |  |
| Experienced trouble controlling violent behavior including rage or violence? |  |  |
| Experienced serious thoughts of suicide? |  |  |
| Attempted suicide? |  |  |

1. Have you been treated or admitted for any psychological or emotional problems in a hospital or treatment facility? \_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_ No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you been prescribed medication for psychological or emotional problems? \_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_ No

If Yes, specify medications and dosages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. If you are currently being treated for a mental health issue, please indicate the Psychiatrist and/or Therapist Information:

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Please indicate how you intend to continue these services if you are accepted, including how you will pay for medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Substance Use History**

(Please Indicate the substances that are currently problematic)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Substance** | **Yes** | **Route: Oral, IV, Nasal, Smoked** | **Years of Use** | **Date of last use?** | **Amount used?** |
| Alcohol |  |  |  |  |  |
| Amphetamines |  |  |  |  |  |
| Barbiturates – Secobarbital (Solfoton) |  |  |  |  |  |
| Barbiturates – Secobarbital/Amobarbital (Tuinal) |  |  |  |  |  |
| Barbiturates – Other |  |  |  |  |  |
| Cocaine – Crack |  |  |  |  |  |
| Cocaine – Other |  |  |  |  |  |
| Diphenylhydantoin/Phenytoin (Dilantin) |  |  |  |  |  |
| GHB/GBL (Gamma-Hydroxybutyrate, Gamma- Butyrolactone) |  |  |  |  |  |
| Hallucinogens - LSD |  |  |  |  |  |
| Hallucinogens – Other |  |  |  |  |  |
| Ketamine (Special K) |  |  |  |  |  |
| K-2 |  |  |  |  |  |
| Marijuana/hashish |  |  |  |  |  |
| Opiates/Synthetics – Heroin |  |  |  |  |  |
| Opiates/Synthetics–Hydrocodone, (Vicodin/Hydromorphone (Dilaudid) |  |  |  |  |  |
| Opiates/Synthetics – Meperidine (Demoral) |  |  |  |  |  |
| Opiates/Synthetics – Non-Prescription Methadone |  |  |  |  |  |
| Opiates/Synthetics – Oxycodone, Percocet, Percodan |  |  |  |  |  |
| Opiates/Synthetics – Pentazocine (Talwin) / Tramadol (Ultram) |  |  |  |  |  |
| Opiates/Synthetics – Kratom |  |  |  |  |  |
| Opiates/Synthetics - Fentanyl |  |  |  |  |  |
| PCP or PCP Combination |  |  |  |  |  |

**Withdrawal Risk Status:**

1. What is your longest period of abstinence?

In the last 30 Days: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ In the Last 6 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently experiencing any of the following symptoms?

|  |  |
| --- | --- |
| Abdominal Cramps/Diarrhea \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Leg Cramps \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Anxiety/Depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Nausea, Vomiting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Back Spasms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Psychomotor Agitation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Excessive Sweating \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Runny Nose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hallucinations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Seizures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Increased Pulse Rate/ Heart racing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Tremors \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insomnia, Sleep Disturbances \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Watery Eyes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. How many times in your life have you been treated for: Alcohol Abuse: \_\_\_\_\_\_\_\_\_\_ Drug Abuse: \_\_\_\_\_\_\_\_\_\_\_
2. How many treatment episodes were for: Alcohol detox only: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drug detox only: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How Many Days in the last 30 days have you been treated for Alcohol and/or Drugs

Inpatient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Outpatient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever experienced: Alcohol DT’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ A drug Overdose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you noticed the need to increase the amount you use to achieve the same effect or sometimes feel less effect or high, after using the usual amount? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Would you say that you often use more than you initially intended to use over a longer period of time?

Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever had blackouts while drinking or using drugs? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you spending more time than usual obtaining and or recovering from the effects of substance use? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you currently use Tobacco? Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Education**

Highest Level of school completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you graduate from High School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No

GED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No

Did you attend College: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree

Trade School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No Did you complete? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Status**

Do you have a profession, skill, or trade? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No

Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Do you have a valid driver’s license? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No
2. Do you have a motor vehicle for use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No
3. What is your longest full-time job? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Years \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Months
4. Your Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Does anyone contribute to help you in any way? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No
6. If Yes, does this constitute the majority of your support? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No
7. Usual employment pattern in the last three (3) years:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_\_\_ | Disabled (Cannot Work) | \_\_\_\_\_\_ | Other, Out of Work Force |
| \_\_\_\_\_\_ | Employed Full Time (35 or More Hours per week) | \_\_\_\_\_\_ | Retired |
| \_\_\_\_\_\_ | Employed Part Time | \_\_\_\_\_\_ | Seasonal Employment |
| \_\_\_\_\_\_ | Home Maker Full Time | \_\_\_\_\_\_ | Unemployed |
| \_\_\_\_\_\_ | In skills development, Training, or School | \_\_\_\_\_\_ | Incarcerated (Cannot Work) |

1. If currently employed, please provide your employers contact information:

Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Status**

1. Was this application prompted or suggested by the criminal justice system? \_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_ No
2. Are you on Parole or Probation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No
3. Have you been arrested, charged, and/or convicted of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| **(Please Indicate with a Yes or No)** | **Arrested** | **Charged** | **Convicted** |
| Shoplifting/Theft |  |  |  |
| Parole or Probation Violation |  |  |  |
| Vandalism |  |  |  |
| Drug Charges |  |  |  |
| Forgery |  |  |  |
| Weapons Offense |  |  |  |
| Burglary/Theft/Breaking & Entering |  |  |  |
| Assault |  |  |  |
| Arson |  |  |  |
| Sexual Offense |  |  |  |
| Homicide/Manslaughter |  |  |  |
| Prostitution |  |  |  |
| DWI/DUI |  |  |  |
| Contempt of Court |  |  |  |
| Other: |  |  |  |

1. How many times have you been arrested in the past twelve (12) months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How long was your last incarceration? \_\_\_\_\_\_\_\_\_\_ Years \_\_\_\_\_\_\_\_\_\_ Months \_\_\_\_\_\_\_\_\_\_ Days
   1. What was the charge? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are you presently awaiting trial or sentencing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No
   1. If Yes, What for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. How many days in the last 30 days have you been detained or incarcerated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Do you have an attorney? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No
   1. Attorney Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. If you have a probation or parole officer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No
   1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Have you ever been convicted of a sex offense or a crime of violence? \_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_ No
8. If Yes, please explain what and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Status**

To help us determine your ability to pay The Jude House treatment fees, please complete the following pages completely and accurately. Please attach copies of original documents supporting your answers.

**Identifying Information:**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_ \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_

Maryland Medicaid Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Section:**

Are you currently employed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No

If Yes, Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of time with this employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hourly Pay Rate: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Net income earned in the last two (2) Weeks: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Income/Earnings:**

Please complete the list below and be exact about the monthly totals. If an item does not apply to you, write “0” in that space.DO NOT LEAVE IT BLANK**.**

|  |  |
| --- | --- |
| **Monthly Source of Income** | **Amounts** |
| Monthly Earned Income | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Unemployment Insurance | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child Support | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Social Services Temporary Cash Assistance | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Aid to families with dependent Children | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Social Security/Retirement | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Social Security Supplemental SSI | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Disability Income | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **TOTAL** | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Regular Monthly Expenses** | **Amounts** |
| Mortgage/Rent Payment | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Car Payments | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Car Insurance | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Parole/Probation Fees | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Monthly Alimony | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Monthly Child Support Payments | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medical Fees/Expenses | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **TOTAL** | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Other Monthly Expenses** | **Amounts** |
|  |  |
| Monthly Attorney Fees | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Court Judgments/Restitution | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Self-Employment Taxes | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Back Taxes, Penalties, Fines | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dr. Bills/Medical Bills | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other: | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other: | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **TOTAL** | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Signature/Informed Consent:**

By attaching my signature below, I attest that the information provided in my financial status form is complete and accurate to the best of my knowledge. I understand that I will be asked to submit documents to support the information that I have provided in this form (i.e. Pay Stubs, tax returns, court judgements, bills, etc.). I understand that if it is revealed that I intentionally provided false or misleading information on this application, that I may be subject to immediate discharge from the program. At any time after admission.

Client First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Status \*NEEDS TO BE REVIEWED\***

The cost of treatment at The Jude House is **$560.00 per week.** The initial cost is $1,120.00 plus a $30.00 application fee. This will cover your first two (2) weeks of treatment. Afterwards, you, or the person responsible for payment, are expected to pay $560.00 on a weekly basis. If two (2) consecutive weeks pass without payment, you will be discharged from the program.

How do you intend to pay for treatment?

**\_\_\_\_\_\_\_ I will pay for my own treatment.**

**\_\_\_\_\_\_\_ A third party will pay for my treatment (Family/Friend/Etc.)**

**\_\_\_\_\_\_\_ I have Insurance (Must have a recent substance abuse assessment)**

**Applicant Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consent for Release of Confidential Information**

**from Your Referral Source**

I understand that my treatment records are protected under federal and state laws and regulations and that information about my treatment at any treatment facility cannot be disclosed without my written consent (Unless otherwise stated in law or regulation). I further understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it (e.g. Parole, probation, etc.) and that consent is not a condition of my treatment unless specifically agreed elsewhere. As provided by law, if not revoked before, this authorization will expire one (1) year from the date signed.

Therefore, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize The Jude House, Inc. and staff members to exchange information regarding treatment, treatment planning, progress notes, observations, impressions, assessments, screenings, performance, and other information pertinent to admission to The Jude House, Inc. on my behalf to assist in the continuity of treatment.

Referring Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The records and information released by this consent are only to be used for the specific purpose stated herein. It is a violation of Federal Law, 42 CFR part 2, for these records to be used for any other purpose or re-disclose in any manner. A general release, medical release, or other information is not sufficient. The Federal regulation, 43 CFR part 2, restricts use of this information to criminally investigate or prosecute any substance use client. In this way, your privacy is protected and cannot be used against you.

**Consent for Release of Confidential Information**

**Between Treatment Providers**

I understand that my treatment records are protected under federal and state laws and regulations and that information about my treatment at any treatment facility cannot be disclosed without my written consent (Unless otherwise stated in law or regulation). I further understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it (e.g. Parole, probation, etc.) and that consent is not a condition of my treatment unless specifically agreed elsewhere. As provided by law, if not revoked before, this authorization will expire one (1) year from the date signed.

Therefore, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize The Jude House, Inc. and staff members to exchange information regarding treatment, treatment planning, progress notes, observations, impressions, assessments, screenings, performance, and other information pertinent to admission to The Jude House, Inc. on my behalf to assist in the continuity of treatment.

Referring Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Emergency Contact Release**

I understand that my treatment records are protected under federal and state laws and regulations and that information about my treatment at any treatment facility cannot be disclosed without my written consent (Unless otherwise stated in law or regulation). I further understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it (e.g. Parole, probation, etc.) and that consent is not a condition of my treatment unless specifically agreed elsewhere. As provided by law, if not revoked before, this authorization will expire one (1) year from the date signed.

In case of emergency or other crisis, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorization The Jude House, Inc. to contact the emergency contacts provided.

**Contact #1**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact #2**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact #3**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Consent for Release of Confidential Information**

**To Attorney**

I understand that my treatment records are protected under federal and state laws and regulations and that information about my treatment at any treatment facility cannot be disclosed without my written consent (Unless otherwise stated in law or regulation). I further understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it (e.g. Parole, probation, etc.) and that consent is not a condition of my treatment unless specifically agreed elsewhere. As provided by law, if not revoked before, this authorization will expire one (1) year from the date signed.

Therefore, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize The Jude House, Inc. and staff members to exchange information regarding my legal situation, legal advice, treatment, treatment planning, progress notes, observations, impressions, assessments, screenings, performance, and other information pertinent to admission to The Jude House, Inc. on my behalf to assist in the continuity of treatment.

Attorney Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Consent for Release of Confidential Information**

**For Parole and Probation**

I understand that my treatment records are protected under federal and state laws and regulations and that information about my treatment at any treatment facility cannot be disclosed without my written consent (Unless otherwise stated in law or regulation). I further understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it (e.g. Parole, probation, etc.) and that consent is not a condition of my treatment unless specifically agreed elsewhere. As provided by law, if not revoked before, this authorization will expire one (1) year from the date signed.

Therefore, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize The Jude House, Inc. and staff members to exchange information regarding my legal situation, legal advice, treatment, treatment planning, progress notes, observations, impressions, assessments, screenings, performance, and other information pertinent to admission to The Jude House, Inc. on my behalf to assist in the continuity of treatment.

Agent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Extension: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Consent for Release of Confidential Information**

**For Medical Providers**

I understand that my treatment records are protected under federal and state laws and regulations and that information about my treatment at any treatment facility cannot be disclosed without my written consent (Unless otherwise stated in law or regulation). I further understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it (e.g. Parole, probation, etc.) and that consent is not a condition of my treatment unless specifically agreed elsewhere. As provided by law, if not revoked before, this authorization will expire one (1) year from the date signed.

Therefore, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize The Jude House, Inc. and staff members to exchange information regarding my legal situation, legal advice, treatment, treatment planning, progress notes, observations, impressions, assessments, screenings, performance, and other information pertinent to admission to The Jude House, Inc. on my behalf to assist in the continuity of treatment.

Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Consent for Release of Confidential Information**

**For Mental Health Providers**

I understand that my treatment records are protected under federal and state laws and regulations and that information about my treatment at any treatment facility cannot be disclosed without my written consent (Unless otherwise stated in law or regulation). I further understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it (e.g. Parole, probation, etc.) and that consent is not a condition of my treatment unless specifically agreed elsewhere. As provided by law, if not revoked before, this authorization will expire one (1) year from the date signed.

Therefore, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize The Jude House, Inc. and staff members to exchange information regarding my legal situation, legal advice, treatment, treatment planning, progress notes, observations, impressions, assessments, screenings, performance, and other information pertinent to admission to The Jude House, Inc. on my behalf to assist in the continuity of treatment.

Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The records and information released by this consent are only to be used for the specific purpose stated herein. It is a violation of Federal Law, 42 CFR part 2, for these records to be used for any other purpose or re-disclose in any manner. A general release, medical release, or other information is not sufficient. The Federal regulation, 43 CFR part 2, restricts use of this information to criminally investigate or prosecute any substance use client. In this way, your privacy is protected and cannot be used against you.

**Consent for Release of Confidential Information**

**For Mental Health Providers**

I understand that my treatment records are protected under federal and state laws and regulations and that information about my treatment at any treatment facility cannot be disclosed without my written consent (Unless otherwise stated in law or regulation). I further understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it (e.g. Parole, probation, etc.) and that consent is not a condition of my treatment unless specifically agreed elsewhere. As provided by law, if not revoked before, this authorization will expire one (1) year from the date signed.

Therefore, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize The Jude House, Inc., Charles County Department of Health, Substance Abuse and prevention Services, and Th Maryland Department of Health and Mental Hygiene, Behavioral Health Administration to exchange information, for the purpose of treatment fee subsidy and quality assurance monitoring, the following information:

|  |  |
| --- | --- |
| * Applicant Name | * Number of subsidized bed days accrued for the reporting period |
| * Admission Date | * Employment status at entry, during treatment, and discharge |
| * Referral Source | * Number of urinalysis and results done in reporting period and |
| * Percentage of Subsidy | * Number of breathalyzers and results done in reporting period |
| * Diagnosis (DSM IV) | * Projected and actual discharge dates |
| * County of residence | * Discharge Status |

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Items Allowed Upon Admission**

* Seasonal Clothing and work clothes. Closet Space is limited so no more than seven (7) sets of clothing is permitted
* Toiletries: Toothpaste, toothbrush, soap, shampoo, conditioner, razors, cosmetics, sanitary products, etc. Items may not contain any alcohol.
* Clothes Hangers
* Towels and washcloths
* Twin XL sheets, blanket, and Pillow. (Optional-These items are provided)
* Money to purchase items in the vending machines. Up to $50 can be carried at any time. Any amount over $50 will be deposited into an account for you and can be withdrawn during business office hours.
* Important personal Documents: ID, Social Security Card, Birth Certificate, Health Insurance Card
* Alarm Clock/Watch
* MP3 Player/Radio: Items cannot have recording devices, take photos, or be equipped to access the internet. Headphones must be used at all times.
* Cigarettes: Up to 3 packs may be carried at a time. Any additional packs will be kept by a counselor. No hand rolled cigarettes, chewing tobacco, or E-cigarettes are allowed.

**Items Not Allowed**

|  |  |  |
| --- | --- | --- |
| * Cell Phones | * Pornographic Material | * Tattoo/piercing equipment |
| * Tablets/Ipad | * Food or Snacks | * Candles or Incense |
| * DVD players | * TV’s | * Lottery, Dice, or gambling |
| * Nail Polish | * Aerosol containers | * Energy drinks or Shots |
| * Computers | * Weapons, knives, tasers | * Cigars or chewing tobacco |

