Community Residence Program

Application for Admission

Valeo
Community Residence Program, Inc.

Date:_____

Applicant:_____

Date of Birth:_____ SS#_____

Parents/Guardian:_____

Address:_____ City:_____ State: _____ Zip:_____

Home Ph:_____ Work Ph:_____ E-mail_____

Is there a Power of Attorney? ☐Yes ☐No Cell Phone:_____

Is there medical Power of Attorney? ☐Yes ☐No E-mail:_____

Is there financial Power of Attorney? ☐Yes ☐No Please provide all Power of Attorney documentation

Referred by:_____
Phone:_____
Agency:_____ _____
_____
_____

Please note any physical problems and list on-going treatment:
_____
_____
_____

Presenting Problems (send any records)
_____
_____
_____
_____
_____

DIAGNOSIS:

Primary _____ Secondary _____

PRIOR HOSPITALIZATIONS:

Facility	Dates	Comments

HISTORY

Past suicide attempts:_____
Current risk:_____
Violence:_____
Assaultiveness:_____
Self-destructive behavior:_____
_____

SUBSTANCE & ALCOHOL ABUSE HISTORY:

Drug	Amount	Frequency	Last used	Age started

*CURRENT MEDICATIONS

Drug	Dosage	Frequency	When Started

* Please list all non-prescription drugs that you take on a daily basis

IDENTIFICATION & ASSESSMENT OF PATIENT'S CURRENT STRENGTHS & PROBLEM AREAS:

(Please complete carefully!)

Ability	Satisfactory	Problem Area	Requires Work
to follow an approved daily plan			
to accept medication as prescribed			
to maintain acceptable sleep patterns			
to abstain from illegal drug use			
to refrain from alcohol use			
to limit personal difficulties to a point of not distrubing the house			
to articulate needs and feelings			
to handle anger appropriately			
to work cooperatively with peers			
to work cooperatively with staff			
to socialize			
to care for personal hygiene			
to care for private room			
to share in the work of the house			
to drive a car			
to adapt to a group living situation			
to handle money			
to do volunteer work			
to handle a paying job			
to continue educational goals			

RESIDENT RECORD

Resident's Name:_____ Date of Admission: _____

Social Security #:_____ Date of Birth:_____

Medicaid Number: _____ Marital Status:_____

Medicare Number: _____

Private Insurance Company: _____

Address:_____

Policy Number: _____Group Number: _____

Name of Company you work for: _____

SSI number the policy is under:_____

Case Manager: _____

Name of staff person at the insurance company that has approved stay:

_____Phone:_____

Person financially responsible for this resident:_____

Relationship:_____Address:_____

Home Phone: _____Work Phone: _____

IN CASE OF EMERGENCY NOTIFY:

Name:_____Home Phone:_____

Address:_____Work Phone:_____

_____

Other Significant Persons: (Family members, social workers, counselors, payee, guardian, physician, conservator)

1. Name:_____
   Relationship:_____
   Address:_____
   _____
   _____
   Home Phone:_____
   Work Phone:_____

2. Name_____
   Relationship: _____
   Address:_____
   _____
   _____
   Home Phone:_____
   Work Phone:_____

3. Name:_____
   Relationship:_____
   Address:_____
   _____
   _____
   Home Phone:_____
   Work Phone:_____

4. Name_____
   Relationship: _____
   Address:_____
   _____
   _____
   Home Phone:_____
   Work Phone:_____