The Lighthouse Women's Residence
244 Hempstead Avenue, Buffalo, New York 142151
(716) 831-7877 | f (716) 831-8666 | BestSelfWNY.org

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BEHAVIORAL HEALTH

Caring for individuals, families and the community.

Program Application

All information must be completed by the referring party before being considered for admission.
Not to be completed by the client.

Application Date: _____

REFERRAL INFORMATION

Person Completing this form: _____

Referral Agency & Address: _____

_____

Phone: _____ Fax: _____

CLIENT INFORMATION

Client Name: _____
(first) (last) (MI)

Client Phone: _____ Client Cell: _____

Street Address: _____ Permanent Address? ◉ Yes ○ No

City: _____ State: _____ ZIP: _____

SS#: _____ Sex: _____ Marital Status: _____

Date of Birth: _____

NAMES & AGES OF CHILDREN IN CUSTODY:

(Name) (Age)

(Name) (Age)

(Name) (Age)

(Name) (Age)

(Name) (Age)

CHILDREN PROJECTED TO LIVE WITH CLIENT AT LIGHTHOUSE:

(Name) (Age)

(Name) (Age)

(Name) (Age)

(Name) (Age)

(Name) (Age)

NAMES & AGES OF CHILDREN NOT IN CUSTODY:

(Name) (Age)

(Name) (Age)

(Name) (Age)

(Name) (Age)

(Name) (Age)

CARETAKER OF NON-CUSTODIAL CHILDREN AND/OR CHILDREN NOT PROJECTED TO LIVE WITH CLIENT AT LIGHTHOUSE:

(Name) (Relationship) (Phone Number)

DIAGNOSIS

Current DSM-TR Diagnostic Impression (please include all diagnoses current or by history):

_____

_____

_____

_____

If currently inpatient, pending discharge date: _____

TREATMENT HISTORY

PRIOR PSYCHIATRIC TREATMENT? ○ **YES** ◉ **NO**

ALL INPATIENT:

Place: _____ Date: _____

Place: _____ Date: _____

Place: _____ Date: _____

Place: _____ Date: _____

ALL OUTPATIENT

Place: _____ Date: _____

Place: _____ Date: _____

Place: _____ Date: _____

Place: _____ Date: _____

PRIOR CHEMICAL DEPENDENCY TREATMENT? ◉ **YES** ○ **NO**

ALL INPATIENT:

Place: _____ Date: _____

Place: _____ Date: _____

Place: _____ Date: _____

Place: _____ Date: _____

ALL OUTPATIENT

Place: _____ Date: _____

Place: _____ Date: _____

Place: _____ Date: _____

Place: _____ Date: _____

Please note status of discharge: _____

Prior halfway house participation: _____

_____

Does client take methadone? ◉ Yes ○ No Location _____

MEDICAL

Is client pregnant? ○ Yes ◉ No Estimated due date: _____

Current medications: _____

_____

Prescribed by: _____

Primary care physician: _____ Phone: _____

Current Physical/Medical problems: _____

_____

History of Special Education: _____

Learning Disability: _____

Current Use of Alcohol/Other Drugs, including date of last use/amount/frequency: _____

_____

_____

_____ Use began when? _____

LETHALITY

To Self: ○ Past ○ Current ○ None

Describe: _____

_____

_____

To Others: ○ Past ○ Current ○ None

Describe: _____

_____

_____

LEGAL

Current Legal problem or involvement: ◉ Yes ○ No

Nature of Problem: _____

_____

Current Legal supervision: ◉ Parole ○ Probation ○ Court ○ None

_____ _____

(Name) (Phone)

_____

(Address)

History of Arson: _____

History of Assault: _____

History of Sexual Abuse: _____

CPS/Social Services/Family Court:

Current or past child neglect problem? ○ Yes ◉ No

Describe: _____

_____

Current CPS/DSS/Family Court Oversight? Include Name/phone/address): _____

_____

Current or past child abuse problem? ○ Yes ◉ No

Describe: _____

_____

UPCOMING COURT DATES

Scheduled Court Dates: _____

Nature of Court: _____

Emergency Contact:

_____ _____ _____

(Name) (Relationship) (Phone Number)

INCOME

○ Public Assistance, county: _____

Medicaid #: _____ Seq: _____

○ Supplemental Security Income (SSI) Name of payee, if applicable: _____

○ Social Security Disability (SSD), monthly income: _____

○ Wages, estimated monthly income _____

○ No income (needs to apply for social services)

Does the client have history of welfare fraud? ○ Yes ◉ No

Explain: _____

_____

_____

THE FOLLOWING IS A REQUIREMENT FOR ADMISSION TO THE LIGHTHOUSE:

- Most recent psychosocial/comprehensive assessment
- History and Physical exam (within 30 days)
- Medical labs & blood work
- Recent tuberculosis test (within 30 days) with medical verification
- Up-to-date immunization records for all children projected to be residing with
- Client at the Lighthouse
- Identified provider of emergency child care

FOR CLIENTS WITH:

- A psychiatric diagnosis – a recent psychiatric evaluation
- An eating disorder diagnosis – blood work within two weeks of admission
- Current pregnancy – OB/GYN paperwork, recent sonogram report (if available)