LIBERTY RESOURCES
Improving Lives, Building Futures

Residential Services Application

Program applying for: ☐ Maxwell House ☐ Supportive Living ☐ Permanent Supportive Housing
Are you an: ☐ Intravenous Drug User ☐ At risk of losing custody of children due to drug use

Name: ____

Mailing Address: ____
Street Apt. #

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City/Town State Zip Code County

Current location (if different than referral source):___________________________

Home Phone: ______________Cell Phone: ______________Work Phone: ______________

Age: ______________ DOB: ______________ SS#: ______________

REFERRAL SOURCE
Contact Person: ______________________ Phone: ______________________

Agency: ____

Address: ____

ENTITLEMENTS
Public Assistance
Open Public Assistance Case: Yes ☐ No ☐ If yes, County: ______________

Caseworker: ______________________ Phone #: ______________________

If no, have you applied: Yes ☐ No ☐ Date of Application: ______________

Managed Care/Medicaid
Medicaid: Yes ☐ No ☐ If yes, Medicaid #: ______________________

Managed Care: Yes ☐ No ☐ If yes, provider: ______________________

DIAGNOSIS

Chemical Dependency Diagnosis: ____

Mental Health Diagnosis: ____

Medical Conditions: ____

Current Medications (Name and Dosage):

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TREATMENT HISTORY

Alcohol/Drug Treatment History (please include outpatient, detox, inpatient, crisis centers and halfway houses):

Dates	Agency/Counselor	Type of Treatment	Completed
______	__________________________	_____________________	Yes ☐ No ☐
______	__________________________	_____________________	Yes ☐ No ☐
______	__________________________	_____________________	Yes ☐ No ☐
______	__________________________	_____________________	Yes ☐ No ☐
______	__________________________	_____________________	Yes ☐ No ☐
______	__________________________	_____________________	Yes ☐ No ☐

Mental Health Counseling History (Include inpatient and outpatient):

______	__________________________	_____________________	Yes ☐ No ☐
______	__________________________	_____________________	Yes ☐ No ☐
______	__________________________	_____________________	Yes ☐ No ☐
______	__________________________	_____________________	Yes ☐ No ☐
______	__________________________	_____________________	Yes ☐ No ☐
______	__________________________	_____________________	Yes ☐ No ☐

Other information you would like us to know: ____

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PROBLEM AREAS TO BE ADDRESSED

Activities of Daily Living (check all that apply):

- ☐ Personal hygiene
- ☐ Nutrition
- ☐ Making/keeping appointments
- ☐ Managing medications
- ☐ Handling personal finances
- ☐ Accessing community services
- ☐ Other (specify): ____________________

Social/Interpersonal Behavior (check all that apply):

- ☐ Problems with authority
- ☐ Insensitivity to rights/feelings of others
- ☐ Self-esteem
- ☐ Following rules
- ☐ Aggressive behavior
- ☐ Assertiveness skills
- ☐ Disregard for safety of self or others
- ☐ Do or say things without thinking about the consequences of your actions
- ☐ Manipulative behavior
- ☐ Responsibility
- ☐ Anger management
- ☐ Developing and maintaining healthy sober friendships
- ☐ Engaging in leisure activities conducive to recovery
- ☐ Domestic violence
- ☐ Communicating clearly and asking for help when needed
- ☐ Engaging in family activities/responsibilities
- ☐ Handling conflict
- ☐ Relationship skills
- ☐ Other (specify): ____________________

Vocational/Educational Skills (check all that apply):

- ☐ Lack of adequate work experience
- ☐ Lack of education/vocational training
- ☐ Lack of marketable job skills
- ☐ Problems with reading/writing
- ☐ Problems with attendance and/or punctuality
- ☐ Problems with following directions and/or understanding job expectations
- ☐ Other (specify): ____________________

Additional Comments:

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