

LAKE SHORE BEHAVIORAL HEALTH

The Lighthouse Women's Residence

244 Hempstead Avenue

Buffalo, New York 14215

Phone (716) 831-7877

FAX (716) 831-8666

APPLICATION TO PROGRAM

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

Date: _____ **Person Completing this form:** _____

Referral Agency & Address: _____

Phone & FAX #'s: _____

Client Name: _____

Street Address: _____ (first) _____ (last) _____ (MI) _____ **Perm. Address** **Yes** **No**

City: _____ **State:** _____ **ZIP** _____

SS#: _____ **Sex:** _____ **Marital Status:** _____

Date of Birth: _____

Names & ages of children in custody: _____

Children projected to live with client at Lighthouse: _____

Names & ages of children NOT in custody: _____

Name & relationship of caretaker of non-custodial children and/or children not projected to live with client at Lighthouse: _____

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: _____

Date: _____

Date: _____

All Outpatient – Place: _____

Date: _____

Date: _____

Date: _____

Date: _____

Prior Chemical Dependency Treatment? Yes No

All Inpatient: _____

Date: _____
Date: _____
Date: _____
Date: _____

All Outpatient: _____

Date: _____
Date: _____
Date: _____
Date: _____

Please note status of discharge: _____

Prior halfway house participation: _____

Does client take methadone? Yes, location _____ No

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: Yes No

To Self: Past Current

Describe: _____

To Others: Past Current

Describe: _____

Legal:

Current Legal problem or involvement: Yes No

Nature of Problem: _____

Current Legal supervision: (Parole, Probation, Court) 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 Person, 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)**