

CLIENT APPLICATION FOR ADMISSION TO FRIENDSHIP HOUSE

Please print, complete,	and fax to (603) 869-2355.	After sending, please call	(603) 869-2210 to check
that it was received.			

Date:

Were you referred by someone (Provider, Emergency Room, Parole Officer, Attorney)?	Yes	No
If so, who?		

Personal Information

Name:		DOB:		
What gender do you identify with? Male Female Other Marital Status (single, married, widowed, separated or divorced):				
Social Security #: Phone #:				
Mailing Address:		Email:		
Residential Address:				
Are you homeless? Yes No Are you a Veteran?	Yes	No		
Do you have a guardian or representative payee? Yes If yes, name and contact information:	No			
Preferred Drug(s): Age of 1st use: Last use date and time:		IV use?	Yes	No
Have you been in treatment before? Yes No If so, where a	and when:			
Alcohol Use: Beer Wine Liquor (type):				
How often do you drink? Daily Every few days E	Every weekend	Other:		
How much do you drink? Last drink date/	'time:			
History of seizures with withdrawal from alcohol? Yes	No			
Do you have medical insurance? Yes No				
If yes: Name of insurance company				
Group number Member Number				
Do you have an income at this point? Yes No				
If yes, approximately how much to you earn?				
Name of employer, if applicable:				

Are you disabled? Yes No If yes, Medical	Psychiatric
Do you have children? Yes No Gender and ages <u>:</u>	
If you have children, is DCYF involved? Yes No N/A	L Contraction of the second
Legal Information	
Do you have any current legal charges? Yes No If y	yes, list court dates:
Do you have any warrants in any state? Yes No	
Have you been mandated to treatment? Yes No	
If yes, who referred you?	
Have you been arrested within the last 30 days? Yes No	
Have you ever been charged with a sexual or violent crime?	Yes No
Have you ever been charged with arson? Yes No	
Do any of the following apply to you?	
Probation/Parole? Yes No	
• Bail? Yes No	
• Restraining order? Yes No	
• No contact order? Yes No	
Stalking order? Yes No	
Health Information	
Do you have a PCP? Yes No Do you have a Behavioral He	ealth Provider? Yes No
If yes, provider name and address:	
Do you have any major medical or mental health concerns?	Yes No
If yes, what is your diagnosis?	
Have you ever been diagnosed with schizophrenia, schizoaffectiv	ve, or borderline personality disorder? Yes
Do you have hallucinations? Yes No Seizure disord	der: Yes No
Do you have any communicable diseases?YesPlease check all that apply:	No
MRSA Cdiff Hepatitis A Hepa	atitis B Hepatitis C STDs
HIV/AIDS	
TB Test in last year? Yes No Positi	ive Result? Yes No
If positive TB Test, did you have a chest x-ray? Yes	No

Are you pregnant? Yes No

List any allergies or dietary restrictions here:_____

How many times have you been to the emergency room in the last 6 months?

What do you hope to get out of treatment? ______

Do you have proof of New Hampshire Residency? (NH Driver's License or NH photo ID)

Yes No

Please list any current medications below (prescriptions, over-the-counter) : (Must provide a complete medication list signed by a licensed prescriber before an admission can be approved)

For Office Use Only-Please do not write below

Documents Needed	Needed?	Date Requested/Notes	Status
Proof of NH Residency	Y		
Signed Medication List including RX and OTC/Dietary Restrictions or Needs	Y		
Medical hx/medical notes			
Psychiatric hx/MH Notes			
Legal documents needed might include:			
Letter from PO-non- violent/sexual offender			
Restraining Order			
No Contact Order			
No Trespassing OrderNo Stalking Order			
Other documents needed?			
Specific Releases needed?			

Urgent or critical needs:

Need further review by clinical for admission decision? Yes No

Approved

Not Approved Reviewer Signature:

Date:

Date all pre-admission paperwork complete and decision made re: admission:

If approved, date/ time of first contact to schedule intake date:

If not approved, resources/referral to:

If no bed available, date placed on waitlist:

Date and time intake scheduled/completed:

DOCUMENT ALL CONTACTS IN CONTACT LOG WITH FURTHER DETAILS

Record all client contacts between screening and removal from waitlist. For any client that is placed on waitlist, record referrals to and coordination with regional access point and interim services or reason that such a referral was not made

Date/time	Call made by?	Who was called?	Notes- (LM/ no answer/notes on call)

Contact Log