

**eliminating racism
empowering women
ywca**

To:

- YWCA of Fort Dodge

FROM:

- YWCA of Fort Dodge

REFERRAL/APPLICATION FOR SERVICES

Return (mail or FAX) completed application or referral to
Katlin Sandlin, BA CADC
YWCA of Fort Dodge, IA
826 1st Avenue North ❖ Fort Dodge, IA 50501
Phone: 515-573-3931 ext. 212 ❖ Email: katlink@ywcafd.org
Fax: 515-573-3950

Application/Referral for:

- Shelter Residential Treatment
 Extended Outpatient Services Intensive Outpatient Services
Title XIX Eligible: Yes No

Signature: _____ Date: _____

Client information is protected by Federal regulations (42CFR, Part 2, 45 CFR HIPPA) which prohibits anyone with knowledge of client information from making any disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules prohibit any use of client information to criminally investigate or prosecute any alcohol or drug abuse patient.

Full Name: _____ Date of Birth: _____ Marital Status: _____
Home Address: _____
County of Legal Residence: _____ Social Security #: _____ Title XIX #: _____
MCO: _____ Phone Number: _____

Number of Children and ages: _____
In mother's custody? (If no, explain) _____

History of DHS Involvement Yes No

Current DHS involvement? Yes No

Are you currently receiving FIP or financial assistance from anyone? Yes No Payment Source: _____

History of domestic violence/sexual abuse? Yes No

History of Substance Use: Have you been through or successfully completed a drug/alcohol treatment program? Yes No

Last date of alcohol usage: _____ Last date of drug usage: _____

DOC	Age 1 st Used	Method of Use	Duration	Date of last use

Treatment History	Location	Dates	Type of Discharge

Physical Health

Please mark as many boxes as apply to you:

- | | | | | | |
|---|--------------------------|------------------|--------------------------|-----------------|--------------------------|
| History of seizures | <input type="checkbox"/> | Pregnant | <input type="checkbox"/> | HIV/AIDS | <input type="checkbox"/> |
| Bulimia | <input type="checkbox"/> | Suicide thoughts | <input type="checkbox"/> | Suicide attempt | <input type="checkbox"/> |
| Anorexia | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Suicide Plans | <input type="checkbox"/> |
| Hepatitis A, B, or C/any other Communicable Disease | <input type="checkbox"/> | | | | |

Mental Health

Mental health diagnosis:

Medications:

Employment History: Are you currently employed? Yes No Usual Occupation? _____

Educational History: Some High School Diploma GED Some college College Degree Grad School

Are there any warrants out for your arrest? Yes No Are you on probation? Yes No Parole? Yes No
Do you have any pending criminal charges? Yes No

Has the court suggested you be here*? Yes No

Criminal History:

Date	Conviction	Date	Conviction

Are you related to anyone that works or resides at the YWCA? IF so who? _____

To be completed by the referring agency

The information in this form is totally confidential and will not be disclosed without the applicant's express permission.

Referring Agency Name _____

Name of Individual Making Referral: _____

Level of Treatment Completed at your agency: _____

Client Needs:

- Mental Health Services
Explain: _____
- Daily Living Skills
Explain: _____
- Parenting Skills
Explain: _____
- Assistance with Employment Readiness
Explain: _____
- Other
Explain: _____

The Applicant

Housing situation: Owns Home With Parents Rented
Temporary Homeless Other

Brief details of known medical conditions/diagnosis?

1. Referred patient has had the following performed within the last 90 days:
 Physical Exam
 TB Test

2. Other medical information:

Please fax TB results, Health and physical information and ASAM (If applicable)

Next of Kin/Person available to contact in an emergency:

Name: _____ Address: _____ Phone #: _____

I agree to release this information to the YWCA of Fort Dodge IA for to determine if I am eligible for admission into the YWCA programs. Use of this information for any purpose other than program eligibility is strictly prohibited.

Client Signature: _____ Date: _____

For Referring Agency: _____ Date: _____

For YWCA Purposes:

Date of first contact:	Admission Approved? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Why?
	Wait List? <input type="checkbox"/> Yes <input type="checkbox"/> No
Admission Scheduled: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date: _____ Time: _____	Assigned Counselor: _____