equinox
People • Programs • Purpose

TRANSITIONAL LIVING PROGRAM
INTAKE/SCREENING

Name: _____ Date: _____

Have you applied for TLP before? YES ☐ NO ☐ If yes, when? _____

Are you working with any other Equinox programs or staff? YES ☐ NO ☐

If yes who? _____

Current Address: _____

_____

Phone: _____ Social Security #: _____

Cell/alternate #: _____ Email: _____

Birth Date: _____ Age: _____

Who referred you to TLP? Name: _____ Relationship: _____

In case of emergency:

Name: _____ Relationship: _____

Address: _____

_____

Phone: _____ Cell/alternate #: _____

PLEASE LIST IMMEDIATE FAMILY MEMBERS BELOW:

NAME	RELATIONSHIP	AGE	ADDRESS

1. Are you homeless or about to be homeless? _____

2. Reasons for not living at home? _____

3. How much contact do you have with your family ? _____

4. Do you have a supportive relationship? _____

   If yes, with whom? _____

5. Do you have a child that lives with you? _____ Age: _____

EDUCATION:

1. Present grade level _____ If you left school, when and why? _____

   _____

2. High School Diploma ☐ GED ☐ NONE ☐

3. Attending school? YES ☐ NO ☐

   If yes, where? _____

4. Are you currently attending a training or educational program? YES ☐ NO ☐

EMPLOYMENT

1. Are you currently employed? YES ☐ NO ☐ if yes, where? _____

   For how long? _____ What is your weekly income? _____

   If you are not working, why? _____

2. Have you ever worked before? YES ☐ NO ☐

MEDICAL

1. Have you ever had any serious medical problems, illnesses, hospitalizations, or physical impairments (i.e. asthma, diabetes, epilepsy, high blood pressure, etc.)? _____
   If so, please list:

   _____

   _____

2. Please list any prior medication that you have taken:

   _____

   _____

3. Do you have any allergies (i.e.: bee stings, penicillin, peanuts, etc.)? _____

   _____

4. Name of doctor: _____ Month/Year of last visit: _____

5. Name of dentist: _____ Month/Year of last visit _____

6. For females only: do you suspect you may be pregnant? _____ if pregnant, how far

along? _____

MENTAL HEALTH

1. Have you ever been diagnosed as having a mental illness? _____

   If so, please describe: _____

2. Are you on any medications for mental health problems? _____

   If so, please describe: _____

3. Are you currently seeing a psychiatrist, psychologist or a counselor? _____

   If so, who? _____

4. Have you seen a psychiatrist, psychologist or a counselor in the past? _____

   If so, who/when/what for? _____

5. Have you ever experienced hallucinations? (seeing or hearing things)? _____

   If so, please describe _____

6. How do you cope with stressors?

   _____

SUICIDE EVALUATION

1. Have you ever felt like hurting or killing yourself? _____

   If so: please explain _____

2. Have you ever attempted to hurt or kill yourself? _____

   If so: When? _____

   Where? _____

   How? _____

3. Have you ever been hospitalized in a psychiatric facility? _____

   If so, please explain _____

4. Do you feel like hurting or killing yourself now? _____

CHEMICAL DEPENDENCY

1. Is there a history of substance use (drugs/alcohol) in your family?

   _____

2. What drugs, including alcohol, have you ever tried? _____

   _____

   (if you answer none, skip to the next section)

3. What has your drug and alcohol use been like for the past year? _____

   Often?_____ Occasionally? _____

   Please explain: _____

4. When you use alcohol and other drugs, what usually prompts you to use?_____

   _____

5. Do you think you have a problem with substance abuse?_____

   _____

6. Have you ever had a substance e abuse evaluation or been in substance abuse treatment?

   _____ where? _____ when? _____

LEGAL INVOLVEMENT

1. Have you ever been on AOT, PINS or JD status? _____ if so, for what reason?

   _____

2. Have you ever been arrested? _____
   If so, please explain charges (Pending, dropped, case closed)

   _____

3. Are you currently attending court for any reason? If so why? _____

   _____

HISTORY OF VIOLENCE

1. Do you have any history of past trauma?

   _____

2. Have you ever been violent towards anyone or threatened violence during the past year?

   _____ if so, why? _____

   If so, please describe what you did? _____

3. Have you destroyed property during the past year or threatened to do so? _____

   If so, why? _____

4. Do you ever feel like hurting or killing someone? _____

   If so, please describe: _____

5. Have you ever set a fire? _____

6. Describe how you react when you are really angry: _____

   _____

HEALTH INSURANCE

1. Do you have health insurance? _____

2. If so, what kind (i.e. Medicaid, Blue Cross)? _____ # _____

3. If yes, who is the insurance holder? _____

FINANCIAL INFORMATION

1. Do you have a source of income? _____

2. If so, please list. Be specific (i.e. SSI, job, etc.): _____

3. How much do you earn per month? _____

OTHER AGENCY INVOLVEMENT (DSS, DMH, Probation, CareerLinks, counselors, etc.)

Name of Agency	Contact Person	Phone	Address

YOUR GOALS:

1. What are the goals you would like to accomplish in the next year? _____

_____

_____

2. What are your future goals and plans? Where do you picture yourself in two years? _____

_____

_____

_____

3. How do you think the Transitional Living Program will help you? _____

_____

_____

_____

4. Why do you think you are a good candidate for the program? _____

_____

_____