

NEAM, THE BRIDGE HOUSE PROGRAM, ADMISSIONS FORM

New England Aftercare Ministries, Inc.,
The Bridge House Program
18 Summit St. Framingham, MA 01702
Intake Tel: 508-872-6194 ext. 105
Intake Fax: 508-302-0090

Interview _____
Accepted/Rejected: _____
Letter Sent: _____
Arrival Date: _____
Arrival From: _____

PLEASE PRINT. Application must be COMPLETE (no blank spaces)

Date of Birth: _____ First Name: _____

Middle Initial: _____ Last Name: _____

Permanent Address (If no address -- Provide the city and state where you most recently lived):
Street: _____

City: _____ State: _____ Zip _____

Check which living arrangement best describes your situation prior to entering treatment:

___ Shelter ___ Jail ___ Friends ___ Family ___ Streets ___ Hotel or room rental ___ Apt/House

- Have you ever served in the military? ___ Yes ___ No
- If yes, do you have VA benefits? ___ Yes ___ No

Substance(s) of choice: _____ Date of last use: _____

INSURANCE: Mass Health ID #: _____ Type of Plan:

<input type="checkbox"/> MBHP	<input type="checkbox"/> BMC	<input type="checkbox"/> Fallon 365
<input type="checkbox"/> Welforce	<input type="checkbox"/> CCA	<input type="checkbox"/> Other (describe below)

Other Insurance: _____

LEGAL: Do you have any outstanding warrants or legal cases? ___ Yes ___ No

CHECK ALL CURRENT ISSUES THAT APPLY:

<input type="checkbox"/> Probation	<input type="checkbox"/> Open Case	<input type="checkbox"/> Batterers Program
<input type="checkbox"/> Superior Probation	<input type="checkbox"/> Suspended License	<input type="checkbox"/> Need ID
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Violence	<input type="checkbox"/> Child support

Most recent or current open case:

CRIME	COURT	STATUS

Do you have a criminal record? _____ (Yes) _____ (No)

Total time incarcerated: _____ Longest Time Incarcerated: _____ # of Incarcerations: _____

MEDICAL/MENTAL HEALTH:

Primary Care Provider (PCP) name:	City:
If no PCP (who provides your prescriptions? Name:	City:
Medically Assisted Treatment (MAT) Provider:	City:

If on MAT provide type (Suboxone, Methadone, Vivitrol, Buprenorphine, Subutex, Other):

_____ Dosage: _____

If not on MAT (Medically Assisted Treatment) do you have interest in MAT? ___ Yes ___ No

Please describe any MEDICAL PROBLEMS. _____

CHECK OFF ALL MEDICAL CONCERNS

<input type="checkbox"/> Mobility problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Asthma
<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sleep problems
<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Other Allergies	<input type="checkbox"/> Other

PLEASE PROVIDE ANY FOOD LIMITATIONS (Special Dietary Requirements): _____

Please describe below *any medical/physical limitations (including allergies)?* _____

Please describe *any MENTAL HEALTH PROBLEMS.* _____

CHECK OFF BELOW ALL PAST or CURRENT MENTAL HEALTH CONCERNS or HISTORY:

<input type="checkbox"/> Depression	<input type="checkbox"/> Sec 35 hx	<input type="checkbox"/> Trauma/PTSD
<input type="checkbox"/> Anxiety	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Suicidology
<input type="checkbox"/> Anger/Violence	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Psych Hosp
<input type="checkbox"/> Grief	<input type="checkbox"/> Bipolar I II	<input type="checkbox"/> O/D history

Please list all medicines _____

Are you on SSI/SSDI? ___ Yes ___ No

Or applying for SSI/SSDI ___ Yes ___ No

HISTORY OF SUBSTANCE DEPENDENCY TREATMENT:

Primary Drug _____ Secondary Drug _____

Other (Gambling, Gaming, Sex, Food, Shopping) describe: _____

Number of detoxes: ___ Number of TSS/CSS: ___ Number of residential programs: ___

Please List below any halfway house (ASAM 3.1) residential programs that you have attended:

CENTER	Dates Attended	Length of stay

VOCATIONAL INFO: Can you work legally in taxable employment? Yes No

Do you have a Driver's License Yes No or Mass ID? Yes No

Do you have a Social Security Card? Yes No or Green Card? Yes No

Tell us about your most recent employment? _____

Did you graduate from high school? (Check one): Diploma GED Did not graduate

Have you had any additional education? Yes No (If yes, please list and describe below)

LIVING BACKGROUND:

What is your marital status? Single Married Separated Divorced Widowed

un-married domestic partner

Please give details on the number of children you have -- boys or girls and ages: _____

Do your children or others (such as parents or wife) depend on your income yes no:

Do your children live with you or your wife/partner? yes not (if not, explain): _____

Upon completing Bridge House -- do you anticipate living with your wife/partner: yes no

Do you anticipate living with your children: yes no

Where do you expect to live after the Bridge House? _____

FINANCIAL INFORMATION:

If you pay child-support and/or arrears, court fees/fines please give details, including if you owe and how much you pay each month): _____

Detail other financial obligations such as past credit card debt or car loans, insurance etc.):

SPIRITUAL ASSESSMENT:

Do you have spiritual faith? ___ Yes ___ No

If yes, how do you express your spirituality? _____

What are your expectations in coming to the Bridge House? _____

Have you read the Bridge House program overview? ___ Yes ___ No

In signing below – I agree that the information provided is as truthful as I my understanding allows and that I have read the Bridge House program overview and have a better idea of what to expect –including what my individual responsibility is to my own recovery while using the Bridge House program.

PRINT NAME: _____

Applicant Signature : _____ Date _____