Application for Admission

Dear Applicant,

We at the Jude House are excited about your commitment to becoming drug and alcohol free. Attached is the application for admission to help us determine how we can best assist you. **Please complete each part of the application thoroughly.** Several releases are included to help us gather supporting information required for your possible admission. Prior to admission, The Jude House recommends having the following information if it applies to your circumstance:

- Name, Address, and Telephone number of your Attorney/Public Defender.
- Name, Address, and Telephone number of your Parole and Probation Agent.
- Full disclosure regarding Psychiatric diagnosis or treatment you may have had.
- Full disclosure regarding all medications you are taking (Prescription & Over the counter).
- Name, Address, and Telephone number of any counselor or social worker you have had in the past 2 years.
- Copies of Original Financial Documentation supporting information provided on any financial status form that you may have attached to this application.
- A substance use evaluation.

If accepted, you will need to provide proof of Maryland Medicaid.

It is your responsibility to keep The Jude House informed of your continued interest in admission to our program. You may designate someone to contact us on your behalf. Please read and answer each question honestly to the best of your knowledge. Anything less that is falsified can result in denial of admission or unsuccessful discharge once admitted. Any Falsified information can result in denial. It is your responsibility to provide $10 monthly for prescription fees. If this money is not used it will be returned upon discharge.

Please Contact us if you need further assistance.

Thank You,

Admissions Coordinator

Application for Admission

Name: _____D.O.B: _____ Age: _____

Gender: Male: _____ Female: _____ Other: _____ Preferred Pronouns: _____

Current Mailing Address: _____

City: _____ County: _____State: _____ Zip: _____

Telephone Number: _____ SS#: ___ ___ ___-___ ___-___ ___ ___ ___

Maryland Medicaid Number: _____

Presenting Problem and why are you requesting treatment for substance use?

_____
_____
_____
_____

Where are you living/residing right now?

_____
_____

Who is recommending/referring you to the Jude House? _____

_____

Have you ever been a patient/client at our facility at our facility? Yes _____No _____, If so, When? _____

MEDICAL

1. Do you have any chronic medical problems that interfere with your life? Yes _____No_____
2. How many times in your life have you been hospitalized for medical treatment? _____
3. How long ago was your last hospitalization? _____

   Were you admitted to hospital Yes _____No_____ Name of Hospital_____

   Reason for hospitalization and dates at the hospital:

   _____

   _____
4. How many times, in the last six (6) months, have you been hospitalized due to problems related to drugs and/or Alcohol? _____
5. Do you have a history of or a current diagnosis of any of the following?

Abscess: _____	Emphysema: _____	Pancreatitis: _____
Cardiac Problems: _____	Fainting: _____	Cancer: _____
Cirrhosis/ Liver Problems: _____	Hepatitis A: _____	Seizures or Epilepsy: _____
High Blood Pressure: _____	Hepatitis B: _____	Hearing Problems: _____
Diabetes: _____	Hepatitis C: _____	Tuberculosis: _____

6. Are you taking any prescribed medications on a regular basis? Yes_____ No _____
If Yes, list medications below: (include all medical and psychiatric medications; if you need more room, please attach a medication list)

NAME OF MEDICATION	DOSE	REASON FOR TAKING

7. Have you ever been diagnosed with TB? Yes _____ No _____
8. What is your current weight? _____ lbs.
9. Have you noticed a recent weight loss? Yes _____ No _____
10. Are you currently able to feed, bathe, Dress, and walk on your own? Yes _____No _____

FEMALES ONLY

11. Are you pregnant? Yes_____ No _____ If Yes, How many weeks? _____
OB's name and date of last visit: _____

MENTAL HEALTH

The following questions require a Yes or No response for both columns

Have you:	Past 30 Days	Lifetime
Experienced serious depression, sadness hopelessness, or lack of interest?		
Experienced serious anxiety, tension, or unreasonable worry?		
Experienced hallucinations or saw or heard things that did not exist?		
Experienced trouble understanding, concentrating, or remembering?		
Experienced trouble controlling violent behavior including rage or violence?		
Experienced serious thoughts of suicide?		
Attempted suicide?		

1. Have you been treated or admitted for any psychological or emotional problems in a hospital or treatment facility? Yes_____No _____ If yes, when? _____

2. If you are currently being treated for a mental health issue, please indicate the Psychiatrist and/or Therapist Information:

Agency: _____ Name: _____
Address: _____ City: _____State: _____ Zip: _____

MEDICATION ASSISTED TREATMENT (MAT)

1. **Are you currently taking any MAT such as Suboxone, Methadone, Vivitrol?** Yes_____ No_____
   If yes, please list Name and dosage of MAT:_____
   **If you are taking Suboxone, you must sign the Sublocade injection agreement prior to being accepted*
   If Methadone, what clinic do you currently use? (include name, address and phone number if known)
   Name of Clinic:_____ Phone number:_____
   Address:_____

Substance Use History

(Please Indicate the substances that are currently problematic)

Substance	Yes	Route: Oral, IV, Nasal, Smoked	Years of Use	Date of last use?	Amount used?
Alcohol					
Amphetamines					
Barbiturates					
Cocaine – Crack					
Cocaine					
Hallucinogens - LSD					
Ketamine (Special K)					
K-2					
Marijuana/hashish					
Opiates/Synthetics - Fentanyl					
Opiates/Synthetics – Heroin					
Opiates/Synthetics– (Vicodin,Hydrocodone,Dilaudid,Oxycodone,Percocet)					
PCP or PCP Combination					
Other not listed:					

Withdrawal Risk Status:

1. Are you currently experiencing any of the following symptoms?
   Abdominal Cramps/Diarrhea_____ Leg Cramps _____
   Anxiety/Depression_____ Nausea, Vomiting _____
   Hallucinations _____ Seizures _____
   Increased Pulse Rate/ Heart racing _____ Tremors _____
   Insomnia, Sleep Disturbances _____ Watery Eyes _____

2. How Many Days in the last 30 days have you been treated for Alcohol and/or Drugs
   Inpatient: _____ Outpatient: _____

Legal Status

1. Was this application prompted or suggested by the criminal justice system? Yes _____No _____
2. Have you been arrested, charged, and/or convicted of the following?

(Please Indicate with a Yes or No)	Arrested	Charged	Convicted
Shoplifting/Theft			
Parole or Probation Violation			
Vandalism			
Drug Charges			
Forgery			
Weapons Offense			
Burglary/Theft/Breaking & Entering			
Assault			
Arson			
Sexual Offense			
Homicide/Manslaughter			
Prostitution			
DWI/DUI			
Contempt of Court			
Other:			

3. Are you on Parole or Probation? Yes_____ No _____
    a. If Yes, please list probation or parole officer:

    Name: _____Telephone: _____
4. Are you presently awaiting trial or sentencing? Yes _____No _____
    a. If Yes, What for? _____
    b. Upcoming court date:_____
5. Are you currently incarcerated? Yes _____ No _____
    a. If Yes, what facility/detention center:_____
6. Are you sentenced to treatment? If yes, please answer the following:
    a. Pre-trial: _____
    b. Detainer: _____
    c. Drug court: _____
    d. Mental health court: _____
7. Have you ever been charged or convicted of a crime in another state? Yes _____No_____
   If yes, what state and what is the charge: _____

Emergency Contact Release

I understand that my treatment records are protected under federal and state laws and regulations and that information about my treatment at any treatment facility cannot be disclosed without my written consent (Unless otherwise stated in law or regulation). I further understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it (e.g. Parole, probation, etc.) and that consent is not a condition of my treatment unless specifically agreed elsewhere. As provided by law, if not revoked before, this authorization will expire one (1) year from the date signed.

In case of emergency or other crisis, I, _____give authorization to The Jude House, Inc. to contact the emergency contacts provided.

Contact #1

Name: _____ Relationship: _____

Address: _____

Telephone #1: _____ Telephone #2: _____

Signature of Applicant: _____ Date: _____

Signature of Witness: _____ Date: _____

The records and information released by this consent are only to be used for the specific purpose stated herein. It is a violation of Federal Law, 42 CFR part 2, for these records to be used for any other purpose or re-disclose in any manner. A general release, medical release, or other information is not sufficient. The Federal regulation, 43 CFR part 2, restricts use of this information to criminally investigate or prosecute any substance use client. In this way, your privacy is protected and cannot be used against you.

Items Allowed Upon Admission

- Seasonal clothing and work clothes. Closet space is limited so no more than ten (10) sets of clothing is permitted. 5 pairs of shoes.
- Toiletries: Toothpaste, toothbrush, soap, shampoo, conditioner, razors, cosmetics, sanitary products, etc. Items may not contain any alcohol.
- Clothes Hangers
- Towels and washcloths
- Twin XL sheets, blanket, and Pillow. (Optional-These items are provided)
- Money to purchase items in the vending machines. Up to $20 can be carried at any time. Any amount over $20 will be deposited into an account for you and can be withdrawn during business office hours.
- Important personal Documents: ID, Social Security Card, Birth Certificate, Health Insurance Card
- Alarm Clock/Watch with no Bluetooth capabilities
- MP3 Player/Radio: Items cannot have recording devices, take photos, or be equipped to access the internet. Headphones must be used at all times.
- Cigarettes: Up to 3 packs may be carried at a time. Any additional packs will be kept by a counselor. No hand rolled cigarettes, chewing tobacco, or E-cigarettes are allowed.

Items Not Allowed

- **Cell Phones**
- Tablets/iPad
- DVD players
- TV's
- Computers
- Pornographic Material
- Food or Snacks
- Candles or Incense
- Aerosol containers
- Weapons, knives, tasers
- Tattoo/piercing equipment
- Energy drinks or Shots
- Lottery, Dice, or gambling
- Cigars or chewing tobacco
- No Vapes or open packs of cigarettes