ASCENT HOMES, LLC
Empowering Others

APPLICATION FOR ADMISSION

You may send the application by mail, fax, or email to the following information:
Address: 13512 Minnieville Rd., Suite 220
Woodbridge, Virginia 22192
Fax: 1-866-854-1333
Email: seb@theascenthomes.com
For program questions please call Sebastian Graham at 202-600-6435.

Date of Application:_____ **Date of Interview:** _____

NAME: _____
(Last) (First) (Middle)

Current location or ADDRESS:_____

CITY: _____ **STATE:** _____ **ZIP:**_____

PHONE NUMBER:_____**SOCIAL SECURITY #** _____

GENDER (check): ☐ **Male** ☐ **Female**

MARITAL STATUS: ☐ **Single/Never Married** ☐ **Divorced**
☐ **Married** ☐ **Separated** ☐ **Widowed**

ETHNICITY (check one):
☐ **African-American** ☐ **Caucasian (White)**
☐ **Asian** ☐ **Native American**
☐ **Hispanic** ☐ **Other**

AGE: _____ **BIRTHDATE:** _____

BIRTHPLACE: _____

Current Residency: County:_____ **City:**_____

State: _____

Please clearly note if person is in the state hospital and a contact name and address.

Are you currently in a State Hospital? ☐ **Yes** ☐ **No**

If yes, which one? _____

HOW DID YOU HEAR ABOUT GATEWAY HOMES?_____

Clinical Information

1. **Current Diagnosis:** _____
   _____
   _____

2. **Current Medications:** _____
   _____
   _____

3. **Do you believe that you have a mental illness now and need to take medications?**

   ☐ **Yes** ☑ **No**

4. **Psychiatric History:**

   A. Age of onset of illness/symptoms: _____

   B. Number of State or Community Psychiatric Hospitalizations: _____

   C. Name and Date of Major Hospitalizations:

   _____
   _____
   _____

   D. Past outpatient treatment history:

   _____
   _____
   _____

5. **Please check all the symptoms that you have previously experienced:**

Auditory/visual hallucinations	☐ Yes	☐ No
Delusional thought processes	☐ Yes	☐ No
Depressed mood	☐ Yes	☐ No
Mania	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Obsessions/Compulsions	☐ Yes	☐ No
Eating-disordered behaviors	☐ Yes	☐ No

6. Have you ever attempted suicide? ☐ **Yes** ☐ **No**

If so, when and by what means?

_____

7. Have you ever engaged in self-harm behaviors (e.g., self-cutting, burning, head banging, etc.)

☐ **Yes** ☐ **No**

8. Have you ever engaged in physical or verbal aggression towards others?

☐ **Yes** ☐ **No**

If so, please explain _____

_____

9. List any history of substance use including the type of substance, amount and date last used:

_____

_____

_____

What programs or steps have you participated in to help maintain and support your sobriety?

_____

_____

10. List any current medical conditions and allergies (include ALL allergies) that you have:

_____

_____

_____

11. List any operations or surgeries that your have had including dates:

_____

_____

_____

12. Have you experienced:

a. Seizures	☐ Yes	☐ No
b. Fainting spells	☐ Yes	☐ No
c. Head injury	☐ Yes	☐ No

Daily Living

1. What is your current living situation? (Please check one)
   - ☐ State hospital
   - ☐ Community/Private Hospital
   - ☐ Group Home
   - ☐ Independent in an apartment/house
   - ☐ With family
   - ☐ Homeless
   - ☐ Other

2. How long have you been in your current living situation? (Please check one)
   - ☐ less than 1 month
   - ☐ 1-6 months
   - ☐ 6 months to one year
   - ☐ more than one year

3. How many different places have you lived during the past year? _____

4. a. Have you ever lived independently?
   - ☐ Yes
   - ☐ No

   b. If Yes, what was the longest time you lived independently?
   - ☐ less than 1 month
   - ☐ 1-6 months
   - ☐ 6 months to one year
   - ☐ more than one year

5. Please describe difficulties that you had while living independently or what has prevented you from living independently.

_____

_____

_____

Please check all of the activities that you are able to complete independently and without assistance from others:

- ☐ personal hygiene
- ☐ personal finance/budgeting
- ☐ medication administration
- ☐ meal preparation
- ☐ housekeeping

Educational/Vocational/Social

1. **What is the highest grade you completed?** _____

2. **Did you attend special education classes?** ☐ **Yes** ☐ **No**

   If Yes, what type? _____

3. **Have you ever served in the Armed Forces?** ☐ **Yes** ☐ **No**

   If Yes, list branch and dates of services:

   _____

   _____

4. **List employment held and dates:**

   _____

   _____

   _____

   _____

5. **What are your hobbies, interests, special talents?**

   _____

   _____

6. **Describe your strengths and perceived limitations:**

   _____

   _____

Future Goals

1. **Why do you want to come to GW:**

   _____

   _____

2. **What do you hope for yourself for the future?**

   _____

   _____

3. **Please use this space to let the clinical team know any other information about you that you would like to share:**

   _____

   _____

   _____

Legal

1. **Have you ever incurred legal charges?** ☐ **Yes** ☐ **No**

   If Yes, please describe and give dates charges incurred:

   _____

   _____

2. **Have you ever physically assaulted someone?** ☐ **Yes** ☐ **No**

   If Yes, please describe any physical altercations you have had, including the date, what started it, and the result:

   _____

   _____

3. **Have you ever engaged in destruction of property?** ☐ **Yes** ☐ **No**

   If Yes, please describe the incident(s), including the date and the result:

   _____

   _____

4. **Have you ever been accused of, charged with, or convicted of a sexual offense?** ☐ **Yes** ☐ **No**

5. **Are you subject to a lifetime sex offender registration requirement in any state?** ☐ **Yes** ☐ **No**

6. **Do you have an advanced directive?** ☐ **Yes** ☐ **No**

7. **Do you have a legal status of Not Guilty by Reason of Insanity?** ☐ **Yes** ☐ **No**

   If so, what is your current level of privilege? _____

   Who is your hospital liaison? _____

8. **Are you on Probation or Parole?** ☐ **Yes** ☐ **No**

   If so, how long are you under supervision? _____

   Who is your direct contact for Probation or Parole?

   Name: _____ **Phone:** _____

Contact Information

1. DESIGNATED CONTACT NAME : _____

CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT PHONE NUMBER: _____

2. NEXT OF KIN - NAME: _____

CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT PHONE NUMBER: _____

3. CASE MANAGER or Hospital Liaison:

NAME: _____

CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT PHONE NUMBER: _____ Email: _____

FINANCIAL INFORMATION

Medicaid Number: _____

Medicare Number: _____

Sources of Income:

1. Monthly amount of income: _____
2. What kind of income? (SSI, SSDI, SSA): _____

Employment: _____ Military / Veterans Benefits: _____

Food Stamps: _____ Any Other Income: _____

3. Who is the payee of benefits?

Name: _____ Phone: _____

4. Who is your Gaurdian or Conservator?

Name: _____ Phone: _____

5. Checking Account: _____ Savings Account: _____

Do you have any:

☐ Certificate of Deposit ☐ Money Market Accounts ☐ Treasury Bills
☐ Stocks, bonds ☐ Retirement or pension ☐ Annuities
☐ Personal Property held as an investment ☐ Other

Have you received any lump sum payments during this past year, such as inheritances, insurance settlements, etc.? ☐ **Yes** ☐ **No**

Have you disposed of any assets for less than fair market value in the last two years? ☐ **Yes** ☐ **No**

Are you the beneficiary of a Trust Fund? ☐ **Yes** ☐ **No**

If so, how much income do you receive from this trust yearly? _____

Who controls the account? Name: _____ Phone:_____

If an applicant is approved for admission, we will need the following before admission:

1. Letter from the Social Security Administration determining the applicant's disability OR statement from Social Security Administration stating current benefit(s).
2. Copy of all insurance cards.
3. Copy of Social Security Card, Birth Certificate, and Picture ID.
4. Copy of Bank Statements.
5. Financial agreement or DAP arrangements made.
6. Physical and PPD test 30 days prior to admission.
7. Current Medical/Psych records.

I certify that the information provided for this application is complete and accurate.

Signature of Applicant: _____ Date: _____