Archway Station, Inc.
Women's Recovery Housing

Administrative Office: 45 Queen Street, Cumberland, MD 21502
Phone: (301) 759-2928   Fax: (301) 777-8020

Name: ____
First Middle Last

Telephone: (______) ______-_________   (______) ______-_________   (______) ______-_________
Home Cell Other

Address: ________________________ ________________ ________ __________ ______________
Street City State Zip County

DOB: ______/______/______   Age: ______   SS#: ______-______-______   Veteran: ☐ Yes   ☐ No

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Genderqueer
- ☐ Choose Not to Disclose
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Additional Gender Category or Other *(please specify)* ______________________

Preferred Pronouns: ______________________________   Marital Status: ________________________

Medical Assistance #: ____________________________   MCO *(if known)*: __________________________

Other Insurance: ____

Current Forms of ID:
- ☐ Driver's License
- ☐ ID Card
- ☐ Birth Certificate
- ☐ Social Security Card
- ☐ Passport
- ☐ Other: ______________________

Current Income:
- ☐ Employed
- ☐ Child Support
- ☐ Disability/SSI/SSDI
- ☐ Other: ______________________

How many children do you have? ____________   How many will participate in the program? ____________

Please provide name, age and gender of each child: ____

Are there any custody issues we should be aware of? ____

Is there any CPS involvement? If yes, please explain: ____

Referral Source

________________________ ______________ (______) ______-________ ______________________________
Name License/Credentials Telephone # Agency

Level of Service Requested (check one): ☐ Recovery Residence Level I   ☐ Recovery Residence Level II

Current Outpatient Providers

Primary Care Physician: ______________________________ (_____) _____-_______
Name Telephone #

Mental Health Provider: ______________________________ (_____) _____-_______
Name Telephone #

Addiction Provider: ______________________________ (_____) _____-_______
Name Telephone #

Other Provider: ______________________________ (_____) _____-_______
Name Telephone #

Other Provider: ______________________________ (_____) _____-_______
Name Telephone #

Other Provider: ______________________________ (_____) _____-_______
Name Telephone #

Reason for Referral/Presenting Problem (check all that apply)

Primary Substances
- ☐ Alcohol
- ☐ Cocaine
- ☐ Fentanyl
- ☐ Heroin
- ☐ Hallucinogens
- ☐ Inhalants
- ☐ Marijuana
- ☐ Methamphetamines
- ☐ Tobacco/Nicotine
- ☐ K2/Spice
- ☐ MDMA
- ☐ Other:___________

Mental Health
- ☐ Exposure to Violence
- ☐ Domestic Violence
- ☐ Grief
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Self Harm
- ☐ Suicidal Ideations/Attempts
- ☐ Victim Of Discrimination
- ☐ Eating Disorder
- ☐ Mental Health Disorder

Medical
- ☐ Pregnant
- ☐ Physical Disability
- ☐ Allergies
- ☐ Other: _________

Physical Environment
- ☐ Homeless/Shelter Needs
- ☐ Food Needs
- ☐ Employment Needs
- ☐ Financial Needs
- ☐ Sanitation
- ☐ Safety Needs

Legal Problems
- ☐ Alcohol Crimes
- ☐ Drug Charges
- ☐ Sex Crimes
- ☐ Violent Crimes
- ☐ Cyber Crimes
- ☐ Public Safety Violations
- ☐ Fraud/Financial Crimes
- ☐ Property Crimes
- ☐ Homicide
- ☐ Other: ____________

Any Other Information/Explanation: ____

____

____

Medications

Medications Prescribed: ☐ No Meds Prescribed ☐ List Attached ☐ Written Below

____

____

____

Ability to take Medications: ☐ Medications Not Prescribed ☐ Independently ☐ With Reminders ☐ With Daily Supervision ☐ Refuses Medications

Medical Information

Pregnant:
☐ No
☐ Yes, Due Date: ____/____/____

HIV:
☐ No
☐ Yes

Hepatitis C:
☐ No
☐ Yes

IV Drug Use:
☐ No
☐ Yes

Hx of Seizures:
☐ No
☐ Yes

Mobility Issues:
☐ No
☐ Yes:________________________

Drug Allergies:
☐ No
☐ Yes:________________________

Food Allergies:
☐ No
☐ Yes:________________________

Identify and describe other medical problems or physical limitations: ____

____

____

Substances Used	Age of First Use	Frequency	Method (Orally, Injection, Inhaled, Smoked)	Date of Last Use
1.				
2.				
3.				
4.				

Sober Date: _______/_______/_______

Have you had any attempts at sobriety without treatment? ☐ No ☐ Yes, # of attempts: ________

Have you been in treatment within the last calendar year? ☐ No ☐ Yes, # of times: ________

Are you able to identify successes that help you maintain sobriety and/or triggers? ____________________________

____

____

____

What is your motivation for treatment at this time? ____

____

____

____

Mental Health Information

Primary Diagnosis: ______________________________ ICD-10 Code: __________ Date of Diagnosis: __________

Secondary Diagnosis: ______________________________ ICD-10 Code: __________ Date of Diagnosis: __________

Tertiary Diagnosis:__________________________________ ICD-10 Code: __________ Date of Diagnosis: __________

Do you have a current presentation or history of the following:

Suicide Attempts: ☐ Yes ☐ No
Suicidal Ideations: ☐ Yes ☐ No
Aggressive Behavior/Violence: ☐ Yes ☐ No
Fire Setting/Arson: ☐ Yes ☐ No
Sexual Behaviors: ☐ Yes ☐ No
Self-Injurious Behaviors: ☐ Yes ☐ No

If you answered yes, please provide additional information: ____

____

Legal Information

Are you currently incarcerated: ☐ Yes ☐ No
If yes: Location: ____________________________
Scheduled Release Date: ____/____/____

Currently on Probation/Parole: ☐ Yes ☐ No
If yes: County: ____________________________
Probation Officer Name & Number: ________________________
Probation end date: ____/____/____

Is applicant required to register through the MD Sex Offender Registry: ☐ Yes ☐ No

Please provide any details relating to the person's legal situation that you feel we should be aware of. Please include any pending legal matters: ____

____

____

Signatures

Signature of Applicant: ____ Date: ____/____/____

Referral Source Signature: ____ Date: ____/____/____

Please return this completed form, including a bio-psychosocial, medication list and any other supporting documentation, via fax or e-mail.
Fax to (301) 777-8020 or e-mail to womensrecovery@archwaystation.net

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FOR INTERNAL USE ONLY

Receipt of Referral:

Agency Received On: _____/_____/_____ Received By: ______ _____/_____/_____ Screened By: ______ _____/_____/_____
