The Lighthouse Women's Residence
244 Hempstead Avenue, Buffalo, New York 142151
(716) 831-7877 | f (716) 831-8666 | BestSelfWNY.org

Caring for individuals, families and the community.

Program Application

All information must be completed by the referring party before being considered for admission.
Not to be completed by the client.

Application Date: ____________________

REFERRAL INFORMATION

Person Completing this form: ____

Referral Agency & Address: ____

____

Phone: ____________________ Fax: ____________________

CLIENT INFORMATION

Client Name: ____
(first) (last) (MI)

Client Phone: ____________________ Client Cell: ____________________

Street Address: ____________________ Permanent Address? ○ Yes ○ No

City: ____________________ State: __________ ZIP: __________

SS#: ____________________ Sex: __________ Marital Status: __________

Date of Birth: ____________________

NAMES & AGES OF CHILDREN IN CUSTODY:

(Name) (Age)

(Name) (Age)

(Name) (Age)

(Name) (Age)

(Name) (Age)

CHILDREN PROJECTED TO LIVE WITH CLIENT AT LIGHTHOUSE:

(Name) (Age)

(Name) (Age)

(Name) (Age)

(Name) (Age)

(Name) (Age)

NAMES & AGES OF CHILDREN NOT IN CUSTODY:

(Name) (Age)

(Name) (Age)

(Name) (Age)

(Name) (Age)

(Name) (Age)

CARETAKER OF NON-CUSTODIAL CHILDREN AND/OR CHILDREN NOT PROJECTED TO LIVE WITH CLIENT AT LIGHTHOUSE:

(Name) (Relationship) (Phone Number)

DIAGNOSIS

Current DSM-TR Diagnostic Impression (please include all diagnoses current or by history):

____

____

____

____

If currently inpatient, pending discharge date: ____________________

TREATMENT HISTORY

PRIOR PSYCHIATRIC TREATMENT? ○ **YES** ○ **NO**

ALL INPATIENT:

Place: ______________________________ Date: ____________

Place: ______________________________ Date: ____________

Place: ______________________________ Date: ____________

Place: ______________________________ Date: ____________

ALL OUTPATIENT

Place: ______________________________ Date: ____________

Place: ______________________________ Date: ____________

Place: ______________________________ Date: ____________

Place: ______________________________ Date: ____________

PRIOR CHEMICAL DEPENDENCY TREATMENT? ○ **YES** ○ **NO**

ALL INPATIENT:

Place: ______________________________ Date: ____________

Place: ______________________________ Date: ____________

Place: ______________________________ Date: ____________

Place: ______________________________ Date: ____________

ALL OUTPATIENT

Place: ______________________________ Date: ____________

Place: ______________________________ Date: ____________

Place: ______________________________ Date: ____________

Place: ______________________________ Date: ____________

Please note status of discharge: __________________________________

Prior halfway house participation: ____________________

____

Does client take methadone? ○ Yes ○ No Location ____________________

MEDICAL

Is client pregnant? ○ Yes ○ No Estimated due date: ____________________

Current medications: ____________________

____

Prescribed by: ____________________

Primary care physician: ____________________ Phone: ____________________

Current Physical/Medical problems: ____________________

____

History of Special Education: ____________________

Learning Disability: ____________________

Current Use of Alcohol/Other Drugs, including date of last use/amount/frequency: ____________________

____

____

____________________ Use began when? ____________________

LETHALITY

To Self: ○ Past ○ Current ○ None

Describe: ____________________

____

____

To Others: ○ Past ○ Current ○ None

Describe: ____________________

____

____

LEGAL

Current Legal problem or involvement: ○ Yes ○ No

Nature of Problem: ____

____

Current Legal supervision: ○ Parole ○ Probation ○ Court ○ None

____ ______________________

(Name) (Phone)

____

(Address)

History of Arson: ____

History of Assault: ____

History of Sexual Abuse: ____

CPS/Social Services/Family Court:

Current or past child neglect problem? ○ Yes ○ No

Describe: ____

____

Current CPS/DSS/Family Court Oversight? Include Name/phone/address): ______________________

____

Current or past child abuse problem? ○ Yes ○ No

Describe: ____

____

UPCOMING COURT DATES

Scheduled Court Dates: ____

Nature of Court: ____

Emergency Contact:

______________________ ______________________ ______________________

(Name) (Relationship) (Phone Number)

INCOME

○ Public Assistance, county: ____________________

Medicaid #: ____________________ Seq: ____________

○ Supplemental Security Income (SSI) Name of payee, if applicable: ____________________

○ Social Security Disability (SSD), monthly income: ____________________

○ Wages, estimated monthly income ____________________

○ No income (needs to apply for social services)

Does the client have history of welfare fraud? ○ Yes ○ No

Explain: ____________________

____

____

THE FOLLOWING IS A REQUIREMENT FOR ADMISSION TO THE LIGHTHOUSE:

- Most recent psychosocial/comprehensive assessment
- History and Physical exam (within 30 days)
- Medical labs & blood work
- Recent tuberculosis test (within 30 days) with medical verification
- Up-to-date immunization records for all children projected to be residing with
- Client at the Lighthouse
- Identified provider of emergency child care

FOR CLIENTS WITH:

- A psychiatric diagnosis – a recent psychiatric evaluation
- An eating disorder diagnosis – blood work within two weeks of admission
- Current pregnancy – OB/GYN paperwork, recent sonogram report (if available)