



MEN'S RECOVERY HOME - APPLICATION

TODAY'S DATE		REFERRAL SOURCE	
CONTACT NAME OF REFERRAL SOURCE		CONTACT PHONE NUMBER EMAIL	

Client FIRST NAME	MIDDLE	LAST
AGE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	PHONE NUMBER	
PRIMARY LANGUAGE	2ND LANGUAGE	
WHAT EMPLOYMENT SKILLS DO YOU POSSESS AND TRAININGS HAVE YOU DONE		
WHAT ARE SOME EMPLOYMENT OPPORTUNITIES YOU HAD THAT YOU ENJOYED	EDUCATION (LAST GRADE COMPLETED) INTRESTED IN CONTINUING EDUCATION/JOB TRAINING	
LAST EMPLOYMENT	# OF HOURS	LENGTH OF EMPLOYMENT
INCOME (SOURCE)	FREQUENCY	AMOUNT
DOES CLIENT RECEIVE ANY MASSACHUSETTS STATE SERVICES		
VETERAN (BRANCH)	DATES	D.C STATUS
MARITAL STATUS	# OF CHILDREN	WHO HAS CUSTODY?

EMERGENCY CONTACT	PHONE NUMBER
GENERAL HEALTH (SYMPTOMS/DIAGNOSIS/TREATMENT/MEDICATION)	
MENTAL HEALTH (SYMPTOMS/DIAGNOSIS/TREATMENT/MEDICATION)	
DRUG REPLACEMENT THERAPY (METHADONE/SUBOXONE/VIVITROL/DOSAGE)	

LEGAL STATUS	PAROLE	INCARCERATED
PROBATION		
SPECIFY IF ANY ARE CHECKED (CHARGES/LENGTH OF STATUS/JURISTRICITION/ CONDITIONS)		
CASES PENDING/ OUTSTANDING WARRANTS		
HAVE YOU EVER BEEN A RESIDENT AT LOWELL HOUSE'S MEN'S RECOVERY HOME?	IF SO, WHEN AND D.C. STATUS	
TREATMENT ADMISSION HISTORY		
PROGRAM NAME	DATE	LENGTH OF STAY/ D.C. STATUS
1.		
2.		
3.		
4.		
5.		
6.		
DRUG OF CHOICE:		
SUBSTANCE USE HISTORY (DRUGS USED/METHOD/ CIRCUMSTANCES SURROUNDING FIRST USE)		
PERIODS OF ABSTINENCE and KNOWN RISK FACTORS FOR RELAPSE		

FAMILY/SUPPORT SYSTEM

CLIENT'S GOALS, MOTIVATION FOR TREATMENT (WHAT DO YOU WANT TO ACHIEVE AT OUR PROGRAM?)

FAX COMPLETED APPLICATION TO: 978-459-9136 or email to: kevans@lowellhouseinc.org

REQUIRED DOCUMENTATION MUST ACCOMPANY YOUR COMPLETED APPLICATION:

- 1. Psychosocial Assessment from a Treatment Facility**
- 2. Medication List**
- 3. TB Assessment**
- 4. CORI (if legal status is pending)**