

Independent Living Application

Please check the program to which you are applying (you can check more than one):

Check	Program	Director	Fax # (561)	Email
	Vita Nova	Jeff DeMario	689-0806	jdemario@vitanovainc.org
	Villages of Hope	Linsey Driskill	775-1758	Linseyd@VillagesofHope.net
	Crossroads Transitional Living Program	Kristina Scimeca	844-3577	kscimeca@gocpg.org

I. YOUTH SECTION

(This section MUST only be filled out by youth)

A. INFORMATION

1. Name _____ SS# _____

Present Address _____ Apt # _____

City _____ State _____ Zip _____

Phone: _____ Alternate phone _____

Emergency Contact _____ Phone Number _____

Driver's License/ID # _____

2. Date of Birth _____ Age _____ Male/Female _____

Ethnicity: _____ US Citizen? _____ Primary Language _____

If you are female: Are you pregnant? _____ If you are male: Do you have a baby on the way? _____

How many children do you have? _____ What are their ages? _____ Do they live with you? _____

B. SCHOOL INFORMATION:

1. If currently a student, fill out this section. If you are not in school, skip to question 2.

School name: _____ Grade? _____

Do you want to go to college? _____ If so, where? _____

What would you like to study? _____

2. If you are not in school...

Last grade completed _____ School Name: _____

Why did you stop attending school? _____

Do you plan on going back to school? _____ If so, where? _____

What is your plan for returning to school? Please list 3 steps that will help you achieve this goal:

1. _____ 2. _____ 3. _____

What would you like to study? _____

C. EMPLOYMENT INFORMATION:

1. Where do you work? _____ Job Title _____

How long have you worked there? _____

List 3 Previous Employer(s)	Start/End Date of Job

2. If you are not working where have you been looking for a job?

3. What is your dream job? _____

What is your plan for achieving that goal? Please list 3 steps that will help you achieve this goal:

a. _____ b. _____ c. _____

D. LEGAL HISTORY

Please describe any probation, arrests, or pending charges: _____

E. QUESTIONS TO LET US KNOW MORE ABOUT YOURSELF:

1. If you could spend an hour with any person who ever lived, who would that be and what would you talk about with that person?

2. Why do you want to be in an independent living program?

3. Please list three goals you hope to accomplish in an Independent Living Program?

a. _____

b. _____

c. _____

5. Describe your life in 5 years. Where do you see yourself?

II. CASE MANAGER SECTION

(To be filled out by advocate or guardian for applicant)

A. Referral Source (organization/person) _____ Phone _____

Case Manager: _____ Phone: _____

Email: _____ Reason for referral _____

Current living situation _____

Former foster youth? _____ How long in foster care? _____ Receives RTI Funds? _____

B. Please Complete Chart

Involvement in:	Yes/No	Date	Interview Notes:
Fire-Setting			
Violent Aggression/Assault (Please note if used weapons)			
Property Destruction			
Gang Affiliation			
Sexual Offense			
Criminal Charges pending/ received (Circle one/both)			
Substance Abuse/Addiction		Last Used:	
Last Arrest			
Probation: Please include Officer name and number.			
Suicidal thoughts			
Suicide Attempts			
Baker Acts			

III. CASE MANAGER/THERAPIST SECTION:

A. Current Diagnosis:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V (GAF) _____

Current Medications	Dosage	Reason

Past Medications	Dosage	Reason

Medical Issues	Allergies

Current Therapist: _____ Phone _____

Agency Name: _____

Person Completing Form: _____ Phone _____

Signature: _____ Date: _____

IV. AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Program Applicant Name: _____

DOB: _____

Information to be released by or exchanged with the following:

Referral source such as case manager, foster parent, GAL, mentor, program staff, etc.
Vita Nova, Crossroads, Villages of Hope

Other: _____

The following information may be released and exchanged:

- | | | |
|--|---|---|
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Court/Agency Documents | |
| <input type="checkbox"/> Family System Evaluation | <input type="checkbox"/> Nursing Notes | |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Mental Status | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> School Records |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Educational -Tests & Reports |
| <input type="checkbox"/> Chemical Recovery History | <input type="checkbox"/> Therapist Orders | <input type="checkbox"/> School Attendance |
| <input type="checkbox"/> Dates of Hospitalization | <input type="checkbox"/> Diagnoses | <input type="checkbox"/> Psychosocial Report |
| <input type="checkbox"/> Crisis Intervention Reports | <input type="checkbox"/> Medical Records | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Treatment Team reports | | |
| <input type="checkbox"/> Verbal Exchange | | |

Other (specify):

Program Applicant Signature

Date: _____

Program Applicant Guardian

Date: _____