



**Exodus Homes \* Exodus Works**  
**P.O. Box 3311 Hickory, N.C. 28603**  
**828-324-2390 Office**  
**324-7983 FAX**

[www.exodushomes.org](http://www.exodushomes.org)



To Whom It May Concern:

Thank you for your referral and interest in our program.

In order for your client's application to be complete there are several things we need from you.

Please include a verification of homelessness in letter or paragraph form, on agency letterhead, stating that the applicant is either homeless or has no resources that would support his/her recovery. Also, please remember that we do not accept anyone under 26 years old. We, also, don't accept any sex offenders. Applicants should be able to self-administer medication and should be physically able to take care of themselves.

We also need any medical and psychological assessments of the applicant.

Exodus Homes has many applicants, so time is of the essence. If your applicant will need placement within a matter of days, you might want to call 828-324-4870 first to see if we have any openings before taking the time to fill out the application. The sooner we receive this information the faster we can process the application. You can either mail this application back to P.O. Box 3311, Hickory, NC 28603 or FAX it to 828-324-7983. Please allow 72 hours for the application process.

Thank you for your cooperation.



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**RESIDENT APPLICATION**

REFERRING AGENCY/PRISON: \_\_\_\_\_ ADMISSION DATE: \_\_\_\_\_ OPUS #: \_\_\_\_\_

COUNSELOR/CASEWORKER: \_\_\_\_\_ RELEASE DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

TELEPHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_

AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ SEX: \_\_\_\_\_ RACE \_\_\_\_\_ RELIGION: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ MAIDEN NAME: \_\_\_\_\_  
 (If married give spouse name)

OCCUPATION: \_\_\_\_\_ SSN: \_\_\_\_\_

ABLE BODIED \_\_\_ or DISABLED \_\_\_ AMOUNT OF DISABILITY \_\_\_\_\_

DO YOU HAVE MEDICAID? \_\_\_\_\_

U.S. VETERAN: yes \_\_\_ no \_\_\_ IF YES, WHAT BRANCH \_\_\_\_\_

HONORABLE DISCHARGE: \_\_\_\_\_ DISHONORABLE DISCHARGE: \_\_\_\_\_

HAVE YOU EVER BEEN A RESIDENT OF CATAWBA, BURKE, ALEXANDER OR CALDWELL COUNTIES? yes \_\_\_ no \_\_\_

HAVE YOU EVER BEEN HOMELESS? yes \_\_\_ no \_\_\_ IF SO, HOW MANY TIMES? \_\_\_\_\_

WHAT LOCATIONS: \_\_\_\_\_

CHILDREN'S NAME	AGE	WHO HAS CUSTODY?

<b>NOTIFY IN CASE OF EMERGENCY:</b>	
<b>PHONE</b>	
<b>RELATIONSHIP</b>	

**LEGAL:**

HAVE YOU EVER BEEN CONVICTED OF A CRIME? yes \_\_\_\_ no \_\_\_\_

CONVICTION	INCARCERATION?	IF SO, WHERE?	IF SO, WHEN?
	Yes ____ No ____		
	Yes ____ No ____		
	Yes ____ No ____		

HAVE YOU EVER BEEN CONVICTED OF A SEXUAL OFFENSE? yes \_\_\_\_ no \_\_\_\_ IF SO, PLEASE LIST WHERE: \_\_\_\_\_

PAROLE OR PROBATION OFFICER: \_\_\_\_\_ PHONE: \_\_\_\_\_

SOCIAL WORKER: \_\_\_\_\_ PHONE: \_\_\_\_\_

**MEDICAL HISTORY:**

MEDICAL CONDITION	YES	NO	Comments
Diabetes			
High Blood Pressure			
Heart Disease			
Stroke			
Seizure			
Liver or Kidney Disease			
Thyroid or Hormonal			
Cancer			
Infectious Disease (TB, AIDS, HEP C, HIV, etc)			

**SUBSTANCE ABUSE ADMISSION ASSESSMENT**

SUBSTANCE	ROUTE	FREQUENCY WHEN USING	AGE	WITHDRAWAL SYMTOMS/SPECIFY
Alcohol				
Crack/Cocaine				
Marijuana				
Heroin				
Methadone				
Opiates				
PCP				
Hallucinogens				
Amphetamines/Meth				
Benzodiazepines				
Barbiturates				
Inhalants				
Other:				

REASON FOR APPLYING TO EXODUS HOUSE:

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**MENTAL HEALTH HISTORY:**

HAVE YOU EVER BEEN INVOLVED WITH MENTAL HEALTH? yes \_\_\_ no \_\_\_ HOW LONG WAS YOUR INVOLVEMENT? WHAT YEAR(S)? \_\_\_\_\_

WHAT WAS THE DIAGNOSIS? \_\_\_\_\_

WHAT MEDICATIONS, IF ANY, WERE ADMINISTERED? \_\_\_\_\_

ARE YOU CURRENTLY TAKING ANY MEDICATIONS: yes \_\_\_ no \_\_\_ IF SO, NAME AND DOSAGE: \_\_\_\_\_

WE NEED YOU TO BRING ENOUGH MEDICATION WITH YOU WHEN YOU COME TO LAST UNTIL YOU CAN GET RE-FILLS HERE, WHICH WILL BE 3-4 WEEKS. WILL THIS BE A PROBLEM? PLEASE DESCRIBE: \_\_\_\_\_

**WE CANNOT ACCEPT APPLICANTS TAKING BENZODIAZEPINES OR OPIATES.** THESE MEDICATIONS ARE HIGHLY ADDICTIVE AND THE POTENTIAL FOR ABUSE EXISTS. THE RESIDENTS SELF-ADMINISTER THEIR OWN MEDICATION. WE FEEL THESE MEDICATIONS ACTUALLY PROLONG A PERSON'S ADDICTION.

**MENTAL STATUS: (To be filled out by counselor or caregiver) (CHECK AND DESCRIBE)**

DANGER TO SELF	DANGER TO OTHERS	ATTITUDE	EMOTIONAL STATE	THOUGHT FORM	THOUGHT CONTENT
<input type="checkbox"/> None <input type="checkbox"/> Threats of Suicide <input type="checkbox"/> Plan for Suicide <input type="checkbox"/> Preoccupation with Death <input type="checkbox"/> Suicide Attempts <input type="checkbox"/> Inability to Care for Self	<input type="checkbox"/> None <input type="checkbox"/> Threats to Harm Others <input type="checkbox"/> Plan to Harm Others <input type="checkbox"/> Attempts to Harm Others	<input type="checkbox"/> Cooperative <input type="checkbox"/> Uncooperative <input type="checkbox"/> Reserved <input type="checkbox"/> Sarcastic <input type="checkbox"/> Suspicious <input type="checkbox"/> Guarded <input type="checkbox"/> Hostile	<input type="checkbox"/> Good <input type="checkbox"/> Sad <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Feeling Hopeless <input type="checkbox"/> Feeling Helpless	<input type="checkbox"/> Normal <input type="checkbox"/> Unable to Access <input type="checkbox"/> Ideas of Reference <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations	<input type="checkbox"/> Normal <input type="checkbox"/> Tangential <input type="checkbox"/> Loose Association <input type="checkbox"/> Slowness in Thought <input type="checkbox"/> Incoherent <input type="checkbox"/> Confused <input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Preservation <input type="checkbox"/> Other

DESCRIPTIONS: (To be filled out by counselor or caregiver)

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**MISCELLANEOUS:**

HAVE YOU EVER BEEN A VICTIM OF DOMESTIC VIOLENCE? yes \_\_\_ no \_\_\_

IF YES, PLEASE DESCRIBE: \_\_\_\_\_  
\_\_\_\_\_

TRAUMA, INCLUDING HEAD, PHYSICAL/SEXUAL ABUSE:  YES  NO IF YES, PLEASE EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

ALLERGIES TO ENVIRONMENT, FOOD, OR MEDICATION: yes \_\_\_ no \_\_\_ IF YES, PLEASE EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

WILL YOU HAVE YOUR ADMISSION FEES? yes \_\_\_ no \_\_\_ HOW MUCH WILL YOU BRING? \_\_\_\_\_

DO YOU HAVE A VALID NC DRIVERS LICENSE? yes \_\_\_ no \_\_\_  
IF YES, WHAT IS LICENSE NUMBER? \_\_\_\_\_

DO YOU HAVE A PICTURE ID? yes \_\_\_ no \_\_\_  
IF YES, WHAT IS YOUR ID NUMBER? \_\_\_\_\_

DO YOU HAVE FUTURE APPOINTMENTS (i.e. DOCTOR'S, DENTIST, SOCIAL SERVICES) AND/OR COURT DATES? IF YES, PLEASE EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

DO YOU HAVE TRANSPORTATION TO AND FROM THESE APPOINTMENTS? yes \_\_\_ no \_\_\_  
**OUT OF TOWN APPOINTMENTS WILL BE YOUR RESPONSIBILITY IN MOST CASES.**

**APPLICATION IS NOT COMPLETE UNTIL WE RECEIVE A STATEMENT FROM THE REFERRAL SOURCE STATING THAT THE APPLICANT IS EITHER HOMELESS OR LACKS THE NECESSARY RESOURCES FOR A RECOVERY LIFESTYLE. PLEASE REFER TO THE AREA/PARAGRAPH CHECKED AND RESPOND ON FACILITY LETTERHEAD. APPLICANTS WILL NOT BE ADMITTED WITHOUT THIS DOCUMENT.**

**I UNDERSTAND THAT BY COMPLETING THIS APPLICATION, IT ONLY STARTS THE ADMISSIONS PROCESS. I AGREE TO CONTACT EXODUS HOMES WITHIN ONE (1) WEEK, AFTER SUBMITTING THIS APPLICATION, TO SET A DATE FOR THE ADMISSION INTERVIEW, EITHER BY PHONE OR IN PERSON.**

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT OR TYPE NAME: \_\_\_\_\_

COMPLETED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

DIAGNOSTIC IMPRESSION: (DSM-IV)  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE OF QUALIFIED, LICENSED, PROFESSIONAL:

NAME: \_\_\_\_\_

POSITION: \_\_\_\_\_

DATE: \_\_\_\_\_

**INFORMATION FOR EMPLOYMENT**

**PERSONAL INFORMATION**

Name \_\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Are you prevented from lawfully becoming employed in this country because of visa or immigration status? \_\_\_\_\_

**EMPLOYMENT DESIRED**

Position desired \_\_\_\_\_

Do you have experience in this field? yes\_\_\_ no\_\_\_ If yes how many years? \_\_\_\_\_

May we inquire from your previous employer concerning job performance? yes\_\_\_ no\_\_\_

**EDUCATION**

	<b>NAME AND LOCATION</b>	<b>NO. OF YEARS ATTENDED</b>	<b>DID YOU GRADUATED?</b>
High School	_____	_____	_____
College	_____	_____	_____
Trade, Business Or Corres. Sch.	_____	_____	_____

**FORMER EMPLOYERS**

<b>DATES</b>	<b>NAME &amp; ADDRESS</b>	<b>SALARY</b>	<b>POSITION</b>	<b>REASON FOR LEAVING</b>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Which of these jobs did you like best? \_\_\_\_\_

What did you like most about this job? \_\_\_\_\_

**REFERENCES**

Give the names of three persons not related to you, whom you have known at least one year.

<b>NAME</b>	<b>ADDRESS</b>	<b>YEARS ACQUAINTED</b>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____