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

To Whom It May Concern:

Thank you for your referral and interest in our program. Please complete the prescreening checklist below before submitting your referral.

Preliminary Criteria	**Yes**	**No**
Is the applicant above the age of 26?		
Is the applicant free of prescription narcotics, including Benzodiazepines?		
Is the applicant able bodied?		
Is the applicant free of any sex charge convictions?		

STOP HERE IF YOU ANSWERED 'NO' TO ANY OF THE ABOVE QUESTIONS. If you answered 'no', your client does not meet criteria for placement at Exodus Homes.

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, do not 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?**

NOTIFY IN CASE OF EMERGENCY:	
PHONE	
RELATIONSHIP	

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:

_____
_____
_____
_____

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:

_____

HAVE YOU HAD A COVID VACCINE? yes__ no__ IF SO, DO YOU HAVE YOUR VACCINE CARD? yes___ no____

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
☐ None ☐ Threats of Suicide ☐ Plan for Suicide ☐ Preoccupation with Death ☐ Suicide Attempts ☐ Inability to Care for Self	☐ None ☐ Threats to Harm Others ☐ Plan to Harm Others ☐ Attempts to Harm Others	☐ Cooperative ☐ Uncooperative ☐ Reserved ☐ Sarcastic ☐ Suspicious ☐ Guarded ☐ Hostile	☐ Good ☐ Sad ☐ Depressed ☐ Euphoric ☐ Feeling Hopeless ☐ Feeling Helpless	☐ Normal ☐ Unable to Access ☐ Ideas of Reference ☐ Delusional ☐ Hallucinations	☐ Normal ☐ Tangential ☐ Loose Association ☐ Slowness in Thought ☐ Incoherent ☐ Confused ☐ Flight of Ideas ☐ Preservation ☐ Other

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

_____
_____
_____

MISCELLANEOUS:

HAVE YOU EVER BEEN A VICTIM OF DOMESTIC VIOLENCE? yes____ no ____

IF YES, PLEASE DESCRIBE: _____
_____

TRAUMA, INCLUDING HEAD, PHYICAL/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

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

FORMER EMPLOYERS

DATES	NAME & ADDRESS	SALARY	POSITION	REASON FOR LEAVING
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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.

NAME	ADDRESS	YEARS ACQUAINTED
1._____		
2._____		
3._____		