Habilitat, Inc.
PO Box 801
Kaneohe, HI 96744
Phone: (808) 235-3691 **Toll-free:** 800-USA-2525 **Fax:** (808) 235-4474 **e-mail:** induction@habilitat.com

Habilitat Admission Application

Please Read:
*Completing our application does not mean the applicant is accepted nor does it guarantee their acceptance.
* If the applicant is dishonest, ommits information or provides inaccurate information, the application can be immediately terminated at Habilitat's discretion.
By signing, the applicant agrees to these terms: **Signature:** _____

Today's Date _____

Name: (First):_____(Middle):_____(Last):_____

Age: _____ DOB: _____ SSN:_____-_____-_____

Place of Birth: (City):_____(State):_____(Country):_____

Height:_____ Weight:_____

Nationality:_____ Gender: □ Male □ Female

Home Address
Street Name:_____
City, State, Zip:_____

Mailing Address
Street Name/PO Box:_____
City, State, Zip:_____

□ **Check this box if you're currently homeless**

Check off the following identifications you possess

□	Birth Certificate	Where is it?_____			
□	Social Security Card	Where is it?_____			
□	State ID	Where is it?_____	Expired	□ yes	□ no
□	Passport	Where is it?_____	Expired	□ yes	□ no
□	Driver License	Where is it?_____	Expired	□ yes	□ no

Does your name on Birth Certificate match the name on your other ID's?
□ Yes □ No

Telephone Contact Information
Home:_____
Cell Phone:_____

Emergency Contact Information
Name:_____Relation to you:_____
Address:_____
City, State, Zip:_____
Telephone:_____
Cell Phone:_____

How did you hear about Habilitat?_____

_____

Why do you want to come to Habilitat? (be specific)_____

_____

_____

_____

_____

Marital Status: □ Single □ Married □ In a relationship
□ Legally Divorced □ Legally Separated

Name of Partner:

(First):_____(Middle):_____(Last):_____

Home Address

Street Name:_____

City, State, Zip:_____

Phone Number:_____

Do you have Children? □ Yes □ No

If yes, provide the following information

Name	Age	Location (City, State)	Who do they live with?

Do you have Brothers and/or Sisters? □ Yes □ No

If yes, please provide the following information

Name	Age	Location (City, State)	Who do they live with?

Parent Information:

Biological Father: □ Alive □ Deceased

Name:_____

Address:_____

City, State, Zip:_____

Telephone:_____

Cell Phone:_____

Occupation:_____

Biological Mother: □ Alive □ Deceased

Name:_____

Address:_____

City, State, Zip:_____

Telephone:_____

Cell Phone:_____

Occupation:_____

Please explain the relationship you have with your family (close, distant, broken, non-existent)

_____

_____

_____

_____

_____

Legal Situation

Current Legal Situation

What were you most recently arrested for? _____

Are you currently in custody? □ yes □ no

If yes, What's the name of the facility? _____

What is the status of your current case?

- □ Released Pending Investigation
- □ Going to Trial
- □ Plead Out (Guilty / No Contest)
- □ Sentenced

What was your sentence? _____

Judges Name:_____

Court Name:_____

Address:_____

Telephone #:_____

What is your Attorney's name?_____

- □ Public Defender
- □ Private
- □ Court Appointed

Contact Information

Address: _____

City _____ State _____

Telephone #_____e-mail:_____

When is your next court date?_____

What is it for?

- □ Arraignment and Plea
- □ Pretrial Conference
- □ Change of Plea
- □ Sentencing
- □ Status
- □ Proof of Compliance
- □ Trial/Jury Trial
- □ Review

Are you currently on Probation? □ Yes □ No

- □ Non-Reporting/Informal/Unsupervised
- □ Regular / Reporting
- □ H.O.P.E. (Hawaii)
- □ Drug Court

Probation Officers Name: _____

Phone #: _____

Are you a repeat offender? □ Yes □ No

Have you ever been convicted of a Sexual Offense? □ Yes □ No

Do you have any warrants? □ Yes □ No

If yes - □ In State □ Out of State

Why do you have a warrant? _____

Have you ever been convicted of a violent crime? □ Yes □ No

If yes, please explain_____

_____

Are you pursuing any lawsuits? □ Yes □ No

Describe the reason: _____

Are you a defendant or witness to a pending case? □ Yes □ No
If yes, please explain_____
_____

How much Prison/Jail time have you served in your life? _____

Disability Benefits

Are you currently receiving benefits from the state? □ Yes □ No
Check which benefits you are receiving
□ Food Stamps
□ Medical Insurance
□ Financial (Cash)

Start date of your benefits_____
End Date of your benefits_____
Office Location you applied for benefits at:_____
Have you ever been denied benefits? □ Yes □ No
If so, why were you denied?_____
Where is your EBT Card and Medical Card?_____

Social Security Disability Benefits □ N/A
What is the disability that you receive benefits for?_____
How long have you had this disability?_____
Is there a beneficiary to the account other than yourself? Yes □ No
How much do you receive per month?_____
Where is your Medicare card?_____

Do you receive □ unemployment
(check if you receive) □ Temporary Disability Income (TDI)

Financial

Do you have a bank account? □ Yes □ No
Name of Bank:_____ City:_____ State:_____
Type of Account: □ Checking □ Savings □ Credit Union
Balance:_____
Is it a joint account? □ Yes □ No
Who is the joint account holder?_____

			Value:	Description
Do you have a	□	Trust Fund		
	□	Stocks/Bonds/401k		
	□	Life Insurance		
	□	Burial Insurance		

Do you own a car? □ Yes □ No

Make:_____ Model:_____ Year:_____

Value:_____

Name of Person on Title:_____

Are there payments due?: □ Yes □ No

Liabilities						
Credit Card Debt	□	Yes	□	No	Amount	
Student Loans	□	Yes	□	No	Amount	
Medical Bills	□	Yes	□	No	Amount	

Addiction Treatment History

List the names of Drug Treatment Centers you've entered in the past

	Name	Length of Stay	Did you Complete?
1			□ yes □ no
2			□ yes □ no
3			□ yes □ no
4			□ yes □ no
5			□ yes □ no
6			□ yes □ no
7			□ yes □ no
8			□ yes □ no
9			□ yes □ no
10			□ yes □ no

Have you ever been a resident at Habilitat? □ Yes □ No

Have you applied to Habilitat in the past? □ Yes □ No

Drug(s) of Choice:

Type of Drug	Age Started	Last Used

Substances currently taking on a daily basis	Dosage

Educational Background:

Highest Grade Completed: _____

Name of School: _____

Do you have a □ GED □ High School Diploma

Did you attend college? □ Yes □ No

Name of College: _____

Degree: _____

Did you graduate? □ Yes □ No

Employment History:

Company Name	Job Description	Length of Employement

If you are self employed, do you file General Excise Tax? □ Yes □ No

Were you in the Military? □ Yes □ No

Length of Service: From:_____ To:_____

Status of Discharge: □ Honorable □ General

□ Dishonorable □ Medical

Do you receive V.A. Coverage or Benefits? □ Yes □ No

Amount _____

Insurance

Do you have Medical Insurance? □ Yes □ No

□ Private

□ State

□ Medicaid/Medicare

If yes, Is it through your employer? □ Yes □ No

Company Name: _____

Address: _____

Telephone Number: _____

Name of Insurance Company: _____

Policy Number: _____

Copayment: _____

Do you have any pending insurance settlements? □ Yes □ No

Psychological

Have you ever been admitted into a psychiatric hospital/mental institution?

□ Yes □ No □ voluntarily □ involuntarily

Date of Admission	Reason for Admission	Length of Stay

Have you ever been diagnosed with the following disorders?

□ Bipolar when _____ Medication _____

□ Schizophrenic when _____ Medication _____

□ Depression: when _____ Medication _____

□ Anxiety: when _____ Medication _____

□ ADD/ADHD when _____ Medication _____

□ Psychosis when _____ Medication _____

Have you ever been treated by a Psychiatrist/Psychologist? □ Yes □ No

Name: _____ City, State _____

Date(s) treated From _____ To _____

Reason(s) for Consultation: _____

Are you currently taking any psychotropic medication? (Antidepressants, Anti-Anxiety, Anti-Psychotics, Mood Stabilizers, etc,)

□ Yes □ No

Name of Medication	Length of Time	Purpose:

Ever attempted suicide? □ Yes □ No

Dates of Attempts	How did you attempt?	Reason for attempting:

For Staff Only

Admission Application Status

□ Accepted □ Denied

Clinical Member running the interview:

The interview participants were:

The Older Brother/Sister is:

Communication Bans:

1 _____ 11 _____
2 _____ 12 _____
3 _____ 13 _____
4 _____ 14 _____
5 _____ 15 _____
6 _____ 16 _____
7 _____ 17 _____
8 _____ 18 _____
9 _____ 19 _____
10 _____ 20 _____

Additonal Comments:

➔PRINT YOUR Name_____

Jeff Nash
EXECUTIVE DIRECTOR

HABILITAT

Vincent C. Marino
FOUNDER

Induction Health Checklist

YOUR Date of BIRTH_____

Directions: 1. Please look at each section carefully. Check NORMAL if you can answer YES to the description.
2. Put an X next to any condition that you have or **had**.
3. Explain **any condition** that may not be listed.

Musculoskeletal/Activity/ Mobility ☐ *Normal*: Able to move all joints without pain. No pain with any movement, normal feeling in body.
I have a problem with: (Check all that apply and describe)
☐ Muscle or Joint Pain _____ ☐ Joint Redness _____
☐ Back Pain _____ ☐ Numbness/ Tingling _____
☐ Arthritis _____ ☐ Osteoporosis_____
☐ Rheumatic Fever_____ ☐ Activity Restrictions_____
☐ Stiffness_____ ☐ Redness or Swelling in Joints_____
Describe past or present injuries or surgeries _____

Skin Integrity ☐ *Normal*: Skin is intact, with no sores, redness, rashes, or open areas.
I have a problem with: (Check all that apply and describe)
☐ Open areas/sores on body _____ ☐ Dryness _____
☐ Psoriasis _____ ☐ Rashes _____
☐ Eczema _____ ☐ Lesions/Lumps _____
Describe any other problems you have with your skin: _____

Respiratory (Breathing) ☐ *Normal*: No problems with catching your breath, coughing, or breathing.
I have a problem with: (Check all that apply and describe)
☐ History of TB or respiratory infections _____
☐ Chest pain with breathing_____ ☐Shortness of Breath _____
☐ Emphysema_____ ☐Sleep Apnea_____
☐ Constant cough/ Coughing up blood_____ _____
☐ Asthma_____
☐ Night Sweats _____ _____
☐ Smoker (Number of Packs Per Day)____ # of Years you have Smoked: _____

EENT (Ears, Eyes, Nose & Throat) ☐ *Normal*: Can see and hear n
ormally, does not need glasses, contacts, eye drops, hearing aid.
I have a problem with: (Check all that apply and describe)
☐ Hard of hearing _____ ☐ Wear glasses or contacts _____
☐ Blindness_____ ☐ Glaucoma _____
☐ Tracheotomy _____ ☐ Cleft lip or palate_____
☐ Allergies (Hay Fever, etc.)_____
Other _____

Cardiovascular (Heart) ☐ *Normal*: Heart beats normally, no problem with chest pain, no high blood pressure, no heart pounding, no shortness of breath, able to exercise.
I have a problem with: (Check all that apply and describe)
☐ Chest pain/discomfort _____ ☐ Swelling of feet _____
☐ Difficulty breathing with activity _____ ☐ Difficulty breathing lying down _____
☐ Dizziness _____ ☐ History of high blood pressure _____
☐ Feels like heart is: ☐ Pounding, ☐ Racing, ☐ Skipping/Irregular Beats
Other _____

Gastrointestinal (Mouth, Stomach and Bowels) ☐ *Normal*: Able to eat and move your bowels regularly. No stomach pain, no diarrhea, no vomiting, no problems swallowing.
I have a problem with: (Check all that apply and describe)
☐ Stomach pain associated with eating _____
☐ Nausea _____ ☐ Heartburn _____
☐ Vomiting _____ ☐ Swallowing Difficulties _____
☐ Mouth lesions _____ ☐ Anorexia/ Bulimia _____
☐ Problems with bowel elimination _____
☐ Abdominal pain _____ ☐ Liver/ Gallbladder problems _____
☐ Blood in stool _____ ☐ Diarrhea _____
☐ Dental problems _____
Other _____

Genitourinary (Urinating and Genitals) ☐ *Normal*: Can urinate without any problems, no discharges or bleeding.
I have a problem with: (Check all that apply and describe)
☐ Painful urination _____ ☐ Blood in urine _____
☐ Frequent urination _____ ☐ Prostate problems _____
☐ Bladder problems _____ ☐ Incontinence _____
☐ Discharge from genitals _____
Other _____

Neurological ☐ *Normal*: No memory problems, no speech problems, no numbness, no history of seizures or fainting, no muscle weakness or twitching, no paralysis (unable to use arms or legs) or tremors.
I have a problem with: (Check all that apply and describe)
☐ Remembering things _____ ☐ Seizures _____
☐ Twitching _____ ☐ Speech problems _____
☐ Muscle Weakness _____ ☐ Paralysis _____
☐ Frequent headaches _____ ☐ Tremor _____
☐ Fainting _____ ☐ Numbness _____
Other _____

Psychiatric ☐ *Normal*: When **NOT** under the influence of drugs or alcohol, no mood swings, no hearing voices, no obsessive thoughts, no difficulty focusing.
I have a problem with: (Check all that apply and describe)
☐ Mood swings _____ ☐ Obsessive thoughts _____
☐ Hearing voices _____ ☐ Compulsive acts _____
☐ Difficulty focusing _____
1. Do you currently take Psych medications? ☐ No ☐ Yes: What are those meds? ___
2. Have you ever attempted suicide? ☐ No ☐ Yes: Describe why: _____
When was this? _____ How did you attempt? _____
3. Have you ever been admitted to a Psychiatric Hospital? ☐ No ☐ Yes: When _____
Describe _____

➔PRINT YOUR Name_____

General Health
Drug/Drugs you were using_____
How long you used them _____
Detox/Treatment Programs you have been in _____
Current Medications (Prescription **and** over-the-counter) _____
_____
Food/Medication/Environmental Allergies (ANYTHING you are allergic to): _____

Insurance
Do you currently have any medical insurance coverage? ☐ No ☐ Yes
If yes, What carrier? _____
Who will be responsible for paying medical bills/copayments (if any)?
Name: _____ Relationship: _____
Address: _____
Contact Number: _____ Fax Number: _____
Email: _____

Endocrine ☐ *Normal*
☐ Diabetes ☐ Recent weight loss or gain ☐ Thyroid problems ☐ Pituitary problems
Describe_____

Hematological (BLOOD) ☐ *Normal*
☐ Abnormal blood tests ☐ Cancer ☐ HIV positive
☐ Blood transfusions ☐ Hepatitis positive (A, B, C, D)
Describe_____

Sexuality/Reproductive ☐ Female ☐ Male
☐ Heterosexual (Straight) ☐ Bisexual ☐ Homosexual (Gay)
☐ **History of STD's** (Sexually Transmitted Diseases):
☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Herpes ☐ Genital warts

WOMEN ONLY
Last Menstrual Period_____ ☐ Breast lumps
Last Pap Smear or GYN Visit_____ ☐ Irregular bleeding or discharge
Possibility of Pregnancy ☐ Yes ☐ No Number of children_____

The above responses are true and correct to the best of my knowledge.

X _____
YOUR Signature Date

_____
Habilitat Induction Staff Signature Date

Based on these responses, the inductee appears to be medically stable to participate in Habilitat's program, but is subject to a physical exam by a Physician.

_____
Habilitat RN Signature Date