



Dear Applicant:

We appreciate your interest in Passageway. In order to process your application we need the following information:

1. Referral Application: This application can be filled out by the applicant and their referral source, case manager, and/or psychiatrist/therapist. If you are a self-referral and would like assistance in filling out this application, please contact one of the staff members at Passageway, and they would be glad to assist you.
2. Psychosocial History: This needs to be detailed and up to date. Your case manager /therapist / psychiatrist should be able to supply you with this documentation. However, if you do not work with any of these agencies or individuals, the Passageway will accept a self-written psychosocial history.
3. Recent Psychiatric Assessment: This assessment needs to have occurred within one calendar year of the application date. If you haven't had a recent assessment, you will need to make an appointment with your psychiatrist/therapist to have this done.

If these forms are not all received or completed as much as possible, we will not be able to proceed with the application. Any documentation that is delayed 90 days or more will result in the application being sent back to you for review.

Please be sure to either mail or hand deliver your completed application and corresponding documentation to Passageway, Attn: Intake Coordinator, 305 15th Street, Des Moines, IA 50309. Or you can fax these documents to (515) 243-1747 Attn: Intake Coordinator.

If you have any questions, please feel free to contact any staff member at (515) 243-6929.

Sincerely,
Passageway Intake Committee

Passageway

Referral Application

Enrollment- P. 1

Date of Application: ___/___/___

New Applicant Returning Member

Applicant

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Title 19 #: _____ SSN: _____

Referral Agency-Referral Type

- Self, Family, Friends
- Private Practitioner (Psychiatrist/MD)
- Case Management Agency
- County, Local Hospital
- County Social Services
- State Social Services (DHS)
- Public Shelter for the Homeless
- Police, Courts, Probation Officer
- Other _____

Referral Agency Name: _____

Referral Contact: _____ **Phone:** (____) _____

Referral Notes:

Why would Passageway be a good place for you?: _____

Applicant's Address

Street _____ Apt: _____

City _____ State _____ Zip Code _____

How long have you resided here?: _____

Phone Numbers (check all that apply)

- Home _____
- Parents _____
- Cell _____
- No Phone
- Business _____
- Friend _____
- Other _____
- Email _____

Housing Type

- Own Home/Apartment (Non-subsidized)
- Supported Apartment (Subsidized, Non-Supervised)
- Home of a Family Member (Shared Responsibility)
- Home of a Family Member (Dependent on Family)
- Rooming/Boarding House, Hotel
- Supervised Housing (Part-time Supervision)
- Group Home (24 hour Supervision)
- Nursing Home
- Temporary Housing (YWCA/YMCA)
- Shelter
- Homeless
- Other _____

Passageway

Referral Application

Enrollment- P. 2

Housing Status

- Alone
- With Roommate(s)/Housemate(s)
- With Parents
- With Other Adult Relative(s)
- With Minor Child(ren) Only
- With Partner and Child(ren)
- Institutional Setting

Total number of people in household including applicant: _____

Do you receive housing assistance? Yes No If Yes, what agency: _____ How much: \$ _____

Housing Satisfaction

- Very Satisfied
- Somewhat Satisfied
- Neutral
- Somewhat Unsatisfied
- Very Unsatisfied

Gender Male Female Other _____

Ethnicity (check all that apply)

- African-American (Black)
- African e.g. Sudanese, Kenyan
- American Indian/Native American
- Asian e.g. Chinese, Japanese, Korean
- Caribbean e.g. Haitian, Jamaican
- Caucasian (White)
- Latino/Hispanic e.g. Puerto Rican, Cuban, Mexican
- Middle Eastern e.g. Indian, Turkish, Iranian
- Pacific Islander e.g. Samoan, Fujian
- Other _____

Language

- English Speaking
- Primary Other: (please specify) _____

Marital Status Single Divorced Separated Permanent Partner Married Widowed

Veteran Status Are you a veteran? Yes No

Case Management Yes No If Yes, what agency: _____
Case Manager: _____ phone #: _____
Other services you receive: _____

Education Level (check all that apply)

- Less than High School
- Some High School
- GED
- High School Diploma
- Trade School
- Some College
- Associate's Degree
- Bachelor's Degree
- Some Graduate Work
- Master's Degree
- Advanced Graduate Degree

Schools Attended	Years	Major	Did you Graduate?

Primary Weekday Activity

- Independent Employment
- Supported Employment
- Volunteer Work
- No Structured Daytime Activity
- School- Trade School/College
- Transitional Employment
- Drop-In Program
- Other _____
- Parenting/Care Taking at Home
- Enclave/Sheltered Workshop
- Partial Hospitalization

Employment History

Have you ever worked for pay? Yes No

Have you worked in the last 12 months? Yes No

Estimated TOTAL YEARS you have worked for pay: _____

Estimated TOTAL NUMBER OF JOBS worked for pay: _____

Please List All Employment. Be sure to include the most recent and longest job:

Dates	Employer	Title/Type of work	Wage & Hours per week

Notes:

Income (enter amounts for all that apply)

SSI: _____ Family Support: _____ Veteran's Benefits: _____

SSDI: _____ Friend Support: _____ Public Assistance: _____

Wages: _____ Retirement Benefits: _____ Other: _____

In process of applying for SSI/SSDI/Medicaid: Yes No

Previously denied: Yes No If denied, are you appealing?: Yes No Total Income: _____

Legal History

Have you ever been in jail? Yes No In prison? Yes No On probation? Yes No

Have you ever been convicted of a misdemeanor? Yes No

Have you ever been convicted of a felony? Yes No

Have you every physically injured another person? Yes No

Do you have any history of violent behavior? Yes No

Legal History Notes (dates, behaviors, legal actions, etc. Please elaborate on any aggressive behavior.)

Emergency Information

Medical Alerts

- | | | |
|--|---|---|
| <input type="checkbox"/> Chronic Physical Illness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Deaf/Hearing Impaired | <input type="checkbox"/> Other Physical Disability | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blind/Vision Impaired | <input type="checkbox"/> Severe Allergic Reaction | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> New Psychiatric Medication | <input type="checkbox"/> Other _____ |

Alert Memo

Medical & Psychiatric Contacts *(fill in as appropriate and include address and phone number.)*

Psychiatrist:	Address:	Phone:
Therapist:	Address:	Phone:
Primary Care MD:	Address:	Phone:
Clinic:	Address:	Phone:

Emergency Contacts

Primary:	Email:
Relationship:	Phone:
Secondary:	Email:
Relationship:	Phone:

Additional Information:

Medical Insurance

Primary Insurance

- Medicaid
- Medicaid, Managed Care
- Medicare
- Medicare, Managed Care

- Private Insurance
- Private Insurance, Managed Care
- Veteran's Benefits

Policy No. _____

- Family pay
- Self-pay (no insurance)
- Other _____

Secondary Insurance

- Medicaid
- Medicaid, Managed Care
- Medicare
- Medicare, Managed Care

- Private Insurance
- Private Insurance, Managed Care
- Veteran's Benefits

Policy No. _____

- Family pay
- Self-pay (no insurance)
- Other _____

Date of Last Physical Exam: ____/____/____

Date of Last Dental Exam: ____/____/____

Psychiatric History

Number of Hospital Admissions in the last five years: _____

Estimated Length of Hospitalizations in the last five years: _____

Length of LONGEST Hospitalization: _____

Age at FIRST Hospitalization: _____

List all Hospitals: (list all, name and location please)

Please indicate reasons for all hospitalizations in the last five years (symptoms, behaviors, etc.):

Most Recent Psychiatric Hospitalization

Admission Date: ____/____/____

Discharge Date: ____/____/____

Hospital Name: _____

City: _____ State: _____ Zip Code: _____

Notes:

Psychiatric Information *(please have your doctor/psychiatrist/case manager assist you with this info.)*

Primary Diagnosis:

- Schizophrenia
 Schizoaffective Disorder
 Bi-Polar Disorder
 Major Depression
 Other Psychotic Disorder
 Other Major Mental Illness

Written Diagnosis

Diagnosis Code

DSM IV Axis I	Written Diagnosis	Diagnosis Code
DSM IV Axis II		
DSM IV Axis III		
DSM IV Axis IV		
DSM IV Axis V		

Please List ALL Psychiatric Medications *(include dosage and frequency)*

Please List ALL Other Medications *(include dosage and frequency)*

Drug/Alcohol History

History with Alcohol

- Have you ever had a problem with alcohol? Yes No
 Have you ever been in treatment for an alcohol problem? Yes No
 Are you currently in treatment or a support group? Yes No
 Do you want help with an alcohol problem? Yes No

How long have you been clean and sober? _____

History with Drugs

- Have you ever had a problem with drugs? Yes No
 Have you ever been in treatment for a drug problem? Yes No
 Are you currently in treatment or a support group? Yes No
 Do you want help with a drug problem? Yes No

How long have you been clean and sober? _____

Drug/Alcohol Notes: *(include type of drug, amount and frequency)*

It is very important that all three components* (application, psychiatric assessment and psychosocial history) are received and as complete as possible. If any of the three components are missing, this will, unfortunately, delay the application process.

We find it helpful for applicants if they complete this application with the person/agency that is recommending them or with a knowledgeable friend or family member. However, if you are a self-referral without these resources and would like help in filling out this document, please contact Passageway staff at (515)243-6929 and they will be happy to assist you.

If you have any questions please contact the members and staff of Passageway at (515)243-6929 We want to make this process as quick an easy as possible for you. We look forward to meeting with you.

Thank you for applying to Passageway.

*Note: Referral applications can only be processed when submitted with *detailed psychosocial history* and *psychiatric assessment*. Submitting an application without this corresponding documentation will delay the application process. Applications received without additional documentation will be held no longer than 90 days, after which applicants must complete a new application.

Did you remember to include:

- 1.) a current and detailed psychosocial history (this can be written by a provider, i.e. therapist/psychiatrist/case manager or self-written if you have no current provider)
- 2.) a current psychiatric assessment (within one calendar year of the application date)
- 3.) a completed application

Applicant's Signature

Date

Referral Source Signature

Date