

INITIAL RESIDENT REQUEST FORM

DATE _____ RECEIVED BY _____

NAME _____ AGE _____

DISCHARGE DATE _____ REFERRING CENTER _____

ADDRESS _____ CITY _____ STATE _____

RESIDENT'S PHONE _____

COUNSELOR _____ LEGAL STATUS _____

ABLE TO WORK HARD IN HOT FACTORY _____

FINANCIAL STATUS _____

VEHICLE _____ DRIVERS LICENSE _____

DRUG OF CHOICE _____ NUMBER OF TREATMENTS _____

PREVIOUS HALFWAY HOUSE PLACEMENTS _____

PICTURE ID _____ SS CARD _____ LENGTH CLEAN TIME _____

MEDICAL STATUS _____

DO YOU HAVE BACK PROBLEMS? _____

PRESCRIPTION DRUGS _____

COMMENTS _____

BED SAVED _____ APPROVED BY _____ ARRIVAL DATE _____

I certify that the above information is true and correct and will be asked to leave without any refund of money paid if not.

RESIDENT _____
Signature Date

WITNESS _____
Signature Date