LAKE SHORE
BEHAVIORAL HEALTH, INC.
Mental Health & Substance Abuse Counseling

The Lighthouse Women's Residence
244 Hempstead Avenue
Buffalo, New York 14215
Phone (716) 831-7877
Fax (716) 831-8666

APPLICATION TO PROGRAM

All information must be completed by the referring party before being considered for admission.
Not to be completed by the client.

Date:_____ Person Completing this form:_____

Referral Agency & Address:_____

Phone & FAX #'s: _____

Client Name: _____
(first) (last) (MI)

Client Phone: _____ Cell Phone: _____

Street Address: _____ Perm. Address ❒ Yes ❒ No

City: _____ State: _____ ZIP _____

SS#: _____ Sex: _____ Marital Status: _____

Date of Birth: _____

Names & ages of children in custody: _____

_____

Children projected to live with client at Lighthouse: _____

Names & ages of children NOT in custody: _____

_____

Name & relationship of caretaker of non-custodial children and/or children not projected to live with client at Lighthouse: _____

_____

Current DSM-TR Diagnostic Impression (please include all diagnoses current or by history):

_____

_____

If currently inpatient, pending discharge date: _____

TREATMENT HISTORY

Prior Psychiatric Treatment? ❒ Yes ❒ No

All Inpatient – Place: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

All Outpatient – Place: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Prior Chemical Dependency Treatment? ❒ Yes ❒ No

All Inpatient: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

All Outpatient: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Please note status of discharge: _____

Prior halfway house participation: _____

Does client take methadone? ❒ Yes, location _____ ❒ No

MEDICAL

Is client pregnant? ❒ Yes ❒ No Estimated due date: _____

Current medications: _____

Prescribed by: _____

Primary care physician: _____ Phone: _____

Current Physical/Medical problems:_____

_____

History of Special Education: _____

Learning Disability: _____

Current Use of Alcohol/Other Drugs, including date of last use/amount/frequency: _____

_____

Use began when? _____

LETHALITY: ❒ Yes ❒ No

To Self: ❒ Past ❒ Current

Describe:_____

_____

To Others: ❒ Past ❒ Current

Describe: _____

_____

LEGAL:

Current Legal problem or involvement: ❒ Yes ❒ No

Nature of Problem: _____

Current Legal supervision: (Parole, Probation, Court) Name & Phone/Address: _____

_____

History of Arson: _____

History of Assault: _____

History of sexual abuse: _____

CPS/Social Services/Family Court:

Current or past child neglect problem? ❒ Yes ❒ No

Describe: _____

Current CPS/DSS/Family Court Oversight? Include name/phone/address):_____

_____

Current or past child abuse problem? ❒ Yes ❒ No

Describe: _____

Upcoming Court Dates

Scheduled Court Dates: _____

Nature of Court: _____

Emergency Contact Person, Relationship, & Phone Number: _____

_____

INCOME:

❒ Public Assistance, county: _____

Medicaid #: _____ Seq _____

❒ Supplemental Security Income (SSI) Name of payee, if applicable: _____

❒ Social Security Disability (SSD), monthly income: _____

❒ Wages, estimated monthly income _____

❒ No income (needs to apply for social services)

Does the client have history of welfare fraud? ☐ Yes ☐ No

Explain: _____

THE FOLLOWING IS A REQUIREMENT FOR ADMISSION TO THE LIGHTHOUSE:

- Most recent psychosocial/comprehensive assessment
- History and Physical exam (within 30 days)
- Medical labs & blood work
- Recent tuberculosis test (within 30 days) with medical verification
- Up-to-date immunization records for all children projected to be residing with client at the Lighthouse
- Identified provider of emergency child care

FOR CLIENTS WITH:

- A psychiatric diagnosis – a recent psychiatric evaluation
- An eating disorder diagnosis – blood work within two weeks of admission
- Current pregnancy – OB/GYN paperwork, recent sonogram report (if available)