

OPERATION NEW EDEN RESIDENT APPLICATION

Application Date _____

Release Date _____

Operation New Eden Office Use Only)

Approved: _____ Denied: _____ Date Notified: _____

Name: _____ Address: _____

City: _____ State: _____ Date: _____

Have you ever been a resident of Rowan County? Yes _____ No _____

Telephone: Home: _____ Work: _____

Age: _____ Birth Date: _____ Sex: _____ Race: _____ Religion: _____

Marital Status: _____ (If Married, give name of spouse)

Occupation: _____ SSN: _____

Employment History: (from current past)

Employer: _____ Date of Employment _____

Position Held: _____ Number supervised _____

Reason for leaving: _____

Employer: _____ Date of Employment _____

Position Held: _____ Number supervised _____

Reason for leaving: _____

Employer: _____ Date of Employment _____

Position Held: _____ Number supervised _____

Reason for leaving: _____

Education History:

Highest grade completed: _____ Technical Degree: _____

College Degree: _____

(Comments) _____

Able Bodied: _____ Disabled: _____ Amount of Disability: _____
Do you have Medicaid? _____ U.S. Veteran: _____ Branch: _____

Honorable Discharge: _____ Dishonorable Discharge: _____ Medical Discharge: _____

Have you ever been homeless? _____ Yes _____ No _____
If so, how many times? _____ What locations: _____

Who referred you to the program? _____

Children Information:

Name	Age	Location of Child	Financial Obligation to Child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Custody of Children:

Is child currently enrolled in school? _____ Yes _____ No _____
Name of School(s): _____
Other agencies involved: _____ DSS _____ Juvenile Court _____ GAL _____
Other: _____

Notify in case of emergency:

Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: Home: _____ Work: _____
Relationship: _____

Rehab programs completed:

Name	City
_____	_____
_____	_____
_____	_____

Name of current rehab program: _____
Counselor: _____ Telephone No. _____
Social Worker: _____ Telephone No. _____
Sobriety and/or Clean Date: _____

Reason for applying to Operation New Eden:

Thought Content:

- Normal
- Unable to Access
- Ideas of Reference
- Suspiciousness
- Delusion
- Hallucinations
- Feeling hopeless/helpless

Descriptions:

Have you ever been a victim of domestic violence? _____ Yes _____ No

If yes, please describe:

Legal:

Have you ever been convicted of a crime? _____ Yes _____ No (If yes, please give the nature of the charge and date of conviction.) _____

Did any of these convictions lead to incarceration? _____ Yes _____ No

(If so, please list institution and year of confinement: _____

Have you ever been convicted of a sexual offense? _____ Yes _____ No

(If so, please list where and circumstances around the offense: _____

Parole or Probation Officer:

Name: _____

Address: _____

Telephone Number: _____

Miscellaneous

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 your license number? _____

Do you have a picture ID? _____ Yes _____ No

If no, do you have a Social Security Card and your Birth Certificate? _____ Yes _____ No

If no, would you be able to get these documents before coming to ***Operation New Eden*** or shortly after arriving?

_____ Yes _____ No (Please explain)

Do you have any future appointments (i.e., Dentist, Doctor, Social Services and/or Court Dates)?

_____ Yes _____ No (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.)

Substance Abuse Admission Assessment:

Systems: None _____ Attempts to cut down _____ Increased tolerance _____

Substance	Code	Route	Current Frequency	Age at First Use	Withdrawal Symptoms/Specify

Substance Codes:

00 None	06 Opiates/Synthet	12 Benzodiazepine
01 Alcohol	07 PCP	13 Tranquilizers
02 Cocaine/Crack	08 Hallucinogens	14 Barbiturates
03 Marijuana/Hashish	09 Meth Amphetamine	15 Sedatives
04 Heroin	10 Amphet Amines	16 Inhalants
05 Methadone	11 Stimulants	17 Over-the-counter

Route Codes:

1 Oral 2 Smoking 3 Inhaling 4 Injection 5 Other

Frequency Codes:

- 0 Drug not used during the past month
- 1 Drug used 1-3 times in past month
- 2 Drug used 1-2 times per week
- 3 Drug used 3-6 times per week
- 4 Drug used daily

Medical History:

Condition	Yes	No	(If yes, please explain)
Diabetes			
High Blood Pressure			
Heart Disease			
Stroke			
Seizures			
Liver or Kidney Disease			
Thyroid or Hormonal			
Cancer			
Infectious Diseases (TB, AIDS, HIV, Etc.)			
Surgeries			
Pregnant			

List prescribed and over-the-counter medications:

If you are taking medication that requires a psychiatrist for refills and medication reviews, you will be required to become a client of Alcohol and Drug Services.

You need to bring enough medication with you when you come to last until you get refills here. If this will be a problem, please describe: _____

*****WE CANNOT ACCEPT RESIDENTS TAKING THE FOLLOWING MEDICATIONS...*****

ALPROZOLAM (XANAX)
CHLORDIAZPOXIDE (LIBRIUM)
CLONAZAPAM (KLONOPIN)
CLORAZEPATE (TRANXENE)
DIAZEPAM (VALIUM)
FLURAZEPAM (DALMANTE)
LORAZEPAM (ATIVAN)
OXAZEPAM (SERAX)
PRAZEPAM (CENTRAX)
TERNAZEPAM (RESTORIL)
TRIAZOLAM (HALCION)

These medications are highly addictive and the potential for abuse exists since the residents self-administer their own medication. We feel these medications actually maintain a person in their addiction.

Allergies to environment, food medication: _____ Yes _____ No. (If yes, please explain) _____

Mental Status: (Circle and describe)

Danger to Self

None
Threats of suicide
Plan for suicide
Preoccupation with death
Suicide attempts
Inability to care for self

Danger to Others

None
Threats to harm others
Plan to harm others
Attempts to harm others

Attitude

Cooperative
Uncooperative
Reserved
Sarcastic
Suspicious
Guarded
Hostile

Emotional State

Sad/depressed
Euphoric
Hostile

Insight

Good
Fair
Poor

Thought Form

Normal
Tangential Thinking
Loose associations
Slowness in thought
Incoherent
Confused
Flight of ideas
Preservation
Other

OPERATION NEW EDEN

807 Lakeview Street
Kannapolis, NC 28083
(704) 938-7540 - **OFFICE**
(704) 938-6799 – **FAX**

RESIDENT RELEASE FORM

Resident Name: _____ Date of Birth: _____

I hereby authorize: _____
To release specified information in my client record to Operation New Eden. The data shall include:
Alcohol/Drug Assessment results; Recommendations, Treatment Plan Summary, Drug Screen Results and
Prognosis.

Specific Purpose: To monitor and comply with agency assessment and recommendations.

This consent shall be valid for a period of 6 months.

This is a reciprocal agreement between the parties named above and includes telephone calls.

I understand information released regarding my treatment may include information pertaining to psychiatric or
psychological treatment drug abuse and/or alcoholism or Acquired Immunodeficiency Syndrome (AIDS) or
Human Immunodeficiency Virus (HIV).

The doctrine of informed consent has been explained to me, and I understand the contents to be released, the need
for the information, and that there are statutes and regulations protecting the confidentiality of authorized
information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled.

I further acknowledge that I may revoke this consent at any time except to the extent that action has been taken.

Signature of Resident

Aaron R. Wells, Executive Director

Date

Date

I understand that by completing this application, it only starts the admissions process. I agree to contact Operation New Eden within one (1) week, after submitting this application, to set a date for the admission interview. I further understand that any false information given by me on this application could cause my application to be denied or termination from the program.

Signed: _____ Date: _____

Print or type name: _____

Completed by:

Name: _____

Agency: _____

Date: _____

*****IMPORTANT NOTICE*****

Application is not complete until we receive a statement from the referral source stating that the resident is homeless. Please refer to the area/paragraph checked and respond. Residents will not be admitted without this document.

Please use the checklist below to make sure that the type of supporting documentation is maintained in the participant or other appropriate files:

_____ (Places Not Meant for Human Habitation) Certification form signed by the outreach worker or service worker verifying that the person or family is homeless. This could include a letter or certification form signed by an outreach worker or service worker from another organization that can verify that the person or family was, in fact, homeless as described in the above definition.

_____ Written statement prepared by the participant about the participant's previous living place (if unable to verify by outreach worker or service worker). Have the participant sign and date.

_____ (Shelter) Referral agency certification that the participant has been residing on the street or at the emergency shelter (on agency letterhead, signed and dated).

_____ Transitional Housing Certification (on agency letterhead, signed and dated) if the participant is residing at the transitional housing facility as well as written verification that the participant was living on the streets or an emergency shelter prior to living in the transitional housing facility. See above for required documentation.

_____ Short-term institution (up to 30 consecutive days) certification from institution's staff verifying that the participant has been residing in the institution for 30 days or less. There should also be written verification that the participant was residing on the street or in an emergency shelter prior to the short-term stay in the institution.

_____ A Private dwelling eviction statement describing the reason for eviction (signed and dated by person evicting). No formal eviction is required. If unable to obtain an eviction statement, you must obtain a written statement signed and dated by the participant describing the situation. Outreach worker or service worker must document their efforts by providing a verification form documenting they have made every effort to confirm that the circumstances are true and have written verification.

_____ Institution discharge (over 30 days) certification completed by the institution staff stating that the participant was being discharged within the week before receiving SHP assistance. You must also have information on the income of the participant to verify that they lack the financial resources and support networks needed to obtain housing and that without the SHP assistance, the participant would be living on the street or in an emergency shelter.

_____ Prison/jail release certification by staff stating that the person was released from prison with no residence identified and that the person lacks the resources and support networks needed to obtain housing.

_____ Domestic violence statement from the participant that he/she is fleeing a domestic violence situation. If participant is unable to prepare a written statement, staff should prepare the statement about the participant's previous living situation and have the participant sign and date it.

****It is very important to note that homelessness must be documented as described in each situation listed above. A question on an application indicating that the person is homeless is not sufficient evidence of homelessness.**

For more information, contact: Libby G. Stanley, SNAPS Coordinator, US Department of Housing and Urban Development, 2306 W. Meadowview Road, Greensboro, NC 27407, (336)547-4006 – **Phone**, (336)547-4148 – **Fax**