TARZANA TREATMENT CENTERS, INC.
TRANSITIONAL HOUSING PROGRAM APPLICATION
Reseda Facility

All questions must be answered. Incomplete applications will be returned.

Please indicate N/A on Not Applicable Questions

1. Name of Client: _____ AKA_____
2. Gender: ☐ Male ☐ Female Transgender: ☐ MTF ☐ FTM
3. DOB: _____Ethnicity/Race:_____Sexual Partner's Gender(s):_____
4. Contact Phone Number(s): _____
5. Client's Source of Income:_____ Income Amount: _____
6. Does the Client have Medical? ☐ Yes ☐ No Does the client have Medicare? ☐ Yes ☐ No
7. Has client ever participated in the past in Tarzana Treatment Center's (TTC) services? (☐ Yes ☐ No)
   If "***yes***", please explain service received: _____

5. Current Housing Status:

☐ Streets ☐ Shelter ☐ CD Treatment ☐ Incarcerated ☐ Hospital ☐ Family/friends
☐ Motel ☐ Own Housing Counselor's name_____

6. How long has client been residing under the selected status_____

   Current housing discharge or move out date: _____

7. Is this client disabled by HIV/AIDS or related condition? ☐ Yes ☐ No
   Severe and persistent alcohol and/or drug abuse problems? ☐ Yes ☐ No
   Severe and persistent mental illness? ☐ Yes ☐ No
8. Is this client either continuously homeless for a year or more or has at least four homeless episodes during the last three (3) years in which he or she only resided in the streets or a shelter or a short term institution for less than 31 days and was previously living on the streets or emergency shelter? ☐ Yes ☐ No
9. Is this client a registered sex offender through Megan's Law? ☐ Yes ☐ No
10. Does the client have to wear an ankle bracelet or another device required by the courts?
11. Does the client have a vehicle? ☐ Yes ☐ No
12. If so are they willing to go without use for 30 – 90 days? ☐ Yes ☐ No
13. How many belongings does the client plan to bring? (Limit: Three, 20 gallon Hefty bags or three suitcases. No furniture). _____

ARREST/INCARCERATION

1. Please list all past arrest:

Year_____ and Reason: _____
Year_____ and Reason: _____
Year_____ and Reason: _____
Year_____ and Reason: _____
Year_____ and Reason: _____
Year_____ and Reason: _____
Year_____ and Reason: _____
Year_____ and Reason: _____
Year_____ and Reason: _____
Year_____ and Reason: _____

2. Has client ever received a 128 or 115? ☐ Yes ☐ No ☐ N/A
If "***yes***" please list all write-ups:

Year__,_____ and Reason: _____
Year_____ and Reason: _____
Year_____ and Reason: _____

ALCOHOL/DRUG USE

3. Was client in outpatient or residential drug treatment in the past 6 weeks? ☐ Yes ☐ No

4. Does client have a history of drug treatment, (e.g. Inpatient, Outpatient)? ☐ Yes ☐ No

If "***yes***," please list below:

Year_____ and Agency: _____ Completed: Yes/ No
Year_____ and Agency: _____ Completed: Yes/ No
Year_____ and Agency: _____ Completed: Yes/ No
Year_____ and Agency: _____ Completed: Yes/ No
Year_____ and Agency: _____ Completed: Yes/ No

6. What does client state is primary drug(s) of choice:_____

Route of administration: ☐ oral ☐ nasal ☐ smoking ☐ injection ☐ other: _____

MEDICAL

7. Current Diagnosis: ☐ HIV + Asymptomatic ☐ HIV symptomatic ☐ AIDS ☐ N/A

8. Date of first HIV diagnosis: _____Transmission Category: ☐ MSM
☐ Heterosexual ☐ IV Drug ☐ MSM/IV Drug ☐ Transfusion ☐ Unknown

9. List all medical conditions (Hepatitis, Cancer, TB, Neuropathy, Acute/Chronic Pain, etc.)

1. _____ 2._____

3. _____ 4. _____

10. Can client cook, clean, and bath by themselves? ☐ Yes ☐ No

11. Is client fully ambulatory? ☐ Yes ☐ No

If "***no***", please explain limitations:

_____

12. List all known allergies:

PSYCHIATRIC

13. Has the client ever been seen by a psychiatrist or any mental health professional?
☐ Yes ☐ No

If "***yes***", when was the most recent visit?
Year_____ and Reason: _____

14. Has client ever been hospitalized for mental health reasons? ☐ Yes ☐ No
If "***yes***", please briefly explain when, where and why:

15. Has client ever attempted to harm self or others? ☐ Yes ☐ No
If "***yes***", please briefly explain when, where and why:

MEDICATION

16. List all of client's medication and treating condition:

Medication _____ and Condition: _____
Medication _____ and Condition: _____
Medication _____ and Condition: _____
Medication _____ and Condition: _____
Medication _____ and Condition: _____
Medication _____ and Condition: _____
Medication _____ and Condition: _____
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Medication _____ and Condition: _____
Medication _____ and Condition: _____
Medication _____ and Condition: _____
Medication _____ and Condition: _____
Medication _____ and Condition: _____

17. Name of Staff Completing Application: _____

Name of Staff Agency: _____

Mailing Address: _____

Staff Telephone or Email Contact: _____

TTC STAFF ONLY!

Checklist to verify all required documentation is included

☐ **Completed Application**

☐ **Verification of Homelessness** (Letter from Referring Agency on Letter Head, Love Eviction, proof of domestic violence report, letter from third party proving client lived on streets)

☐ **Proof of HIV Diagnosis (if applicable)**

☐ **Proof of TB Clearance (Chest X-Ray Past 30 days)**

☐ **ASI (If referred from Detoxification or Residential Rehab. Treatment facility)**

☐ **Copy of Medical History (If Available)**

☐ **Copy of Psychiatric/ Psychological History (If Available)**

**** Please note that all of the above must be completed before client is admitted in transitional housing program***

Transitional Housing Program Staff Only:

Date Application Received: _____ Date Application Reviewed: _____

Staff Name: _____

Date client was interviewed _____

Staff present: _____

Accepted for admission: ☐ Yes ☐ No
If "***no***", please explain why and what referrals were provided:

_____

_____

_____

_____

Additional comments and/or concerns:

_____

Signature of Intake Coordinator	***Date***
Signature of Intake & Assessment Specialist	***Date***

TARZANA TREATMENT CENTERS, INC.
TRANSITIONAL HOUSING PROGRAM
BASIC REQUIREMENTS & EXPECTATIONS
Reseda Facility

Transitional Housing Program Requirements

Sign initials between number and requirements

1. ____ Compliance with urinalysis testing as required by staff
2. ____ Minimum of five 12-step groups per week with proof of attendance
3. ____ Mandatory attendance required at weekly House and Community Meetings
4. ____ Mandatory attendance required at Weekly 1:1 appointments with Case Manager, OP Counselor and Therapist
5. ____ Minimum of 4-5 Outpatient groups per week
6. ____ Maintenance of household chores
7. ____ 11:00PM curfew
8. ____ 30% of income paid as fees for services
9. ____ Enrollment and use of Tarzana Treatment Centers Primary Care Clinic for all medical issues.

I have read and understand the basic requirements and expectations of the Tarzana Treatment Center Transitional Housing Program. I also understand that submission of this application does not guarantee me a spot in the program. I acknowledge that if and when my name rises to the top of the waiting list, an interview will be conducted to assess whether or not I am appropriate for the program.

Applicant's Signature *Date*

TARZANA TREATMENT CENTERS, INC.

SELF-MEDICAL HISTORY

All Facilities

Date: _____

Do you now or in the past five (5) years ever had any of the following? If "*Yes*," please explain:

	Yes	No		
1.	☐	☐	Eye Trouble	
2.	☐	☐	Worn eye glasses or contact lenses	
3.	☐	☐	Vision in both eyes	
4.	☐	☐	Ear, nose and/or throat trouble	
5.	☐	☐	Hearing loss	
6.	☐	☐	Thyroid trouble	
*7.	☐	☐	Diabetes	
*8.	☐	☐	Coughed-up blood	
9.	☐	☐	Gall Bladder trouble or Gallstones	
10.	☐	☐	Stomach, Liver, Intestinal trouble	
11.	☐	☐	Have you ever been diagnosed with Hepatitis A, B or C?	
12.	☐	☐	Piles/Hemorrhoids	
*13.	☐	☐	Frequent and/or painful urination	
14.	☐	☐	Kidney Stone(s)/Blood in urine	
*15.	☐	☐	VD/Syphilis/Gonorrhea and other sexually transmitted diseases	
*16.	☐	☐	Swollen and/or painful joints	
*17.	☐	☐	Broken bones	
18.	☐	☐	Bone/joint/other deformity	
19.	☐	☐	Recurrent back pain	
20.	☐	☐	Arthritis/Rheumatism/Bursitis	
*21.	☐	☐	Neuritis	
22.	☐	☐	Seizures	
*23.	☐	☐	Gain/Loss of weight	
24.	☐	☐	Allergies	
*25.	☐	☐	Tumor, growth, cyst, Cancer	
26.	☐	☐	Hernia	
27.	☐	☐	Have you tested positive for HIV?	
28.	☐	☐	Have you been diagnosed with AIDS?	
29.	☐	☐	Prior hospitalizations for medical issues within the past three (3) years? If *Yes*, reason for Hospitalizations	
30.	☐	☐	In the past three (3) years, have you been treated for emotional/psychiatric problems? If *Yes*, for what were you treated?	

Patient's Name: _____ ***Medical Record Number:*** _____

Self-Medical History *Continued...*

	Yes	No	
31.	☐	☐	How you ever had surgery?
			If *Yes* Type and Date _____
32.	☐	☐	In the past year, have you ever used alcohol or drugs more than you mean to? _____
33.	☐	☐	Have you ever neglected some of your usual responsibilities because of using alcohol or drugs? _____
34.	☐	☐	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year? _____
35.	☐	☐	Has anyone objected to your drinking or drug use? _____
36.	☐	☐	Have you ever found yourself preoccupied with wanting to use alcohol or drugs?
37.	☐	☐	Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom? _____
38.	☐	☐	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero or other healer)?
39.	☐	☐	Drink milk, eat yogurt or cheese at least three (3) times each day?
40.	☐	☐	Eat at least five (5) servings of fruits or vegetables each day?
41.	☐	☐	Try to limit the amount of fried or fast foods that you eat?
42.	☐	☐	Exercise or do moderate physical activity such as walking or gardening five (5) days a week?
43.	☐	☐	Think you need to lose or gain weight?
44.	☐	☐	Often feel sad, down or hopeless?
45.	☐	☐	Have friends or family members that smoke in your house?
46.	☐	☐	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?
47.	☐	☐	Think you or your partner could be pregnant?
48.	☐	☐	Think you or your partner could have a sexually transmitted disease?
49.	☐	☐	Have you or your partner(s) had sex without using birth control in the last year?
50.	☐	☐	Have you or your partner(s) had sex with other people in the past year?
51.	☐	☐	Have you or your partner(s) had sex without a condom in the past year?
52.	☐	☐	Have you ever been forced or pressured to have sex?
53.	☐	☐	Have you ever been hit, slapped, kicked or physically hurt by someone?
54.	☐	☐	**Do you have other questions or concerns about your health?**

(please identify) _____

_____

_____

_____

Patient's Name: _____ *Medical Record Number:* _____

SMOKING ASSESSMENT

Yes No

1. ☐ ☐ Do you currently smoke or use tobacco? (If "***No***," go to #2.)
   a. If ***Yes***, do you smoke/use: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco
   How long have you smoked/used tobacco? _____
   How much do you smoke/use daily? _____

   b. Are you interested in quitting at this time?
   ☐ **Yes** (*List referral)* _____
   ☐ **No**, I am aware of the health risks involved and I am not interested in a referral at this time.
2. ☐ ☐ Have you ever smoked?
   If ***Yes***, when did you last smoke?_____ For how long did you smoke?_____

CARDIOPULMONARY HISTORY ASSESSMENT

Do you now or in the past five (5) years ever had any of the following? If "***Yes***," please explain:

Yes No

*1. ☐ ☐ Hypertension (High Blood Pressure)_____
*2. ☐ ☐ Hypotension (Low Blood Pressure)_____
*3. ☐ ☐ Coronary Artery Disease_____
*4. ☐ ☐ Angina_____
*5. ☐ ☐ Chest Pain_____
*6. ☐ ☐ Heart Attack_____
*7. ☐ ☐ Heart Surgery _____
*8. ☐ ☐ Heart Rhythm Irregularity (Irregular Heart Beat)_____
*9. ☐ ☐ Heart Valve Replacement_____
*10. ☐ ☐ Endocarditis_____
*11. ☐ ☐ Coronary Artery Bypass or Angioplasty _____
*12. ☐ ☐ Congestive Heart Failure_____
*13. ☐ ☐ Cardiomyopathy or Hypertropathy _____
*14. ☐ ☐ Heart Failure _____
*15. ☐ ☐ Atrial Fibrillation_____
*16. ☐ ☐ Palpitations (extra beats or extra heart beats) _____

Patient's Name: _____ *Medical Record Number:* _____

Self-Medical History *Continued...*

*17.☐ ☐ Rheumatic Fever _____
*18.☐ ☐ Asthma _____
*19.☐ ☐ Shortness of Breath _____
*20.☐ ☐ Emphysema _____
*21.☐ ☐ Chronic Bronchitis _____
*22.☐ ☐ Tuberculosis _____
*23.☐ ☐ Valley Fever _____
*24.☐ ☐ Any type of heart condition or lung condition _____

FOR WOMEN ONLY

Your last PAP SMEAR occurred: Within a year ☐ 2-3 years ☐ Over 3 years ☐
Have you ever had GYNECOLOGICAL problems? Yes ☐ No ☐
How many pregnancies have you had? None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more_____
*Are you pregnant now? Yes☐ No☐ If pregnant, what is the due date_____
*If you are pregnant, are you seeing a doctor? Yes ☐ No ☐
Name of Doctor_____Phone#_____
If you have been pregnant, have you ever had a miscarriage or delivered a premature baby? Yes ☐ No ☐

DENTAL ASSESSMENT

Yes No

1. ☐ ☐ Have you seen a dentist in the past year?
   If ***Yes,*** name of dentist _____
2. ☐ ☐ Do you currently have any urgent dental problems, such as pain or difficulty chewing?
   If ***Yes,*** please explain _____
3. ☐ ☐ Do you have any dental prostheses, such as dentures?
   If ***Yes,*** do you know how to properly care for them? ☐ Yes ☐ No
4. ☐ ☐ Do you routinely brush you teeth?

Patient's Name: _____ *Medical Record Number:* _____

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Self-Medical History *Continued...*

Physician's Comments: _____

Physician's Signature	*Date*

OUTPATIENT: If you checked "***Yes***" for any item, do you feel you need medical care now for that problem or symptom? ☐ Yes ☐ No

(*FOR OUTPATIENT STAFF USE ONLY*)

Items checked "***yes***" and with an asterisk that are a problem now or have been a problem in the past six month must be referred for a medical evaluation. Other items that are of concern to the patient or to staff should also be referred. Is a referral indicated? ☐Yes ☐ No

If "***no***," there is no need to proceed further. If "***yes,***" complete referral information:

Referred to	*Date*
Signature	*Date*

Rationale for referral: _____

THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASE TO UNAUTHORIZED PERSONS.

Physician's Comments: _____

Based on a thorough review of this patient's medical and substance use history, certify that the patient is medically cleared to enter and participate fully in the program, and a current physical examination is waived at this time.

Physician's Signature (Physician's signature required for DMC patients)	*Date*

Patient's Name: _____ *Medical Record Number:* _____

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TARZANA TREATMENT CENTERS, INC.

PSYCHOLOGICAL SYMPTOM CHECKLIST

All Facilities

Patient's Name:_____ **Date:**_____

Following are symptoms that you may be experiencing or may have experienced in the past. The following questions are related to other areas of concern you may have.

Within the last two (2) weeks have you experienced the following symptoms:

	YES	NO		(1)
1.	☐	☐	Depressed mood most of the day	
2.	☐	☐	Decreased interest or pleasure in all or almost all activities	
3.	☐	☐	Significant decrease in appetite or significant weight loss	
4.	☐	☐	Significant increase in appetite or significant weight gain	
5.	☐	☐	Significantly decreased sleep or insomnia	
6.	☐	☐	Significantly increased sleep	
7.	☐	☐	Fatigue or loss of energy nearly every day	
8.	☐	☐	Feelings of worthlessness or excessive guilt	
9.	☐	☐	Reduced ability to think or concentrate	
10.	☐	☐	Low self esteem	
11.	☐	☐	Recurrent thoughts of death or suicide	
12.	☐	☐	Feelings of hopelessness	
13.	☐	☐	Suicide attempt(s)	
14.	☐	☐	Cutting yourself intentionally	
				(2)
15.	☐	☐	Extremely high self confidence	
16.	☐	☐	Feelings of extreme self-importance	
17.	☐	☐	Not feeling like sleeping for several days	
18.	☐	☐	Awakening several hours earlier than usual, feeling full of energy	
19.	☐	☐	The ability to go for days without sleep and not feel tired	
20.	☐	☐	Being more talkative than usual or feeling able to talk non stop	
21.	☐	☐	Racing thoughts	
22.	☐	☐	Feeling easily distracted to the point that it is difficult to screen out unimportant details of a situation	
23.	☐	☐	An increased desire to meet goals in several areas of your life	
24.	☐	☐	Excessive involvement in pleasurable activities that may have negative consequences (buying sprees, sexual promiscuity, gambling)	

TTC000M023A48

(3)

25. ☐ ☐ Feelings of panic or anxiety in places or situations where you may not be able to escape, or where help may not be available

Within the last two (2) weeks have you experienced the following symptoms

26. ☐ ☐ Intense fear of being in social situations, being in front of a group of people, performing, being with people that are unfamiliar to you, or being judged or scrutinized by others

27. ☐ ☐ Intense fear of being in small spaces, being exposed to germs, insects, heights, or other specific situations

(4)

28. ☐ ☐ Being hospitalized for psychological problems
29. ☐ ☐ Thinking you are being followed, or that others are trying to harm you
30. ☐ ☐ Believing that the television or radio are sending you epical messages
31. ☐ ☐ Believing that you can control others thoughts or that your thoughts are being controlled by others
32. ☐ ☐ Thinking that others can hear your thoughts
33. ☐ ☐ Seeing things that are not there or that other people do not se
34. ☐ ☐ Hearing voices that other people do not hear
35. ☐ ☐ When talking, slipping easily off track from one topic to another unrelated topic
36. ☐ ☐ When talking, not making sense or being understood by others
37. ☐ ☐ Unpredictable agitation for no apparent reason (shouting or swearing)

(5)

38. ☐ ☐ A significant change in mood due to a recent life situation

(6)

39. ☐ ☐ Intense fear of gaining weight or becoming fat even though you are told you are underweight
40. ☐ ☐ Significant weight loss through reduction and restriction of food intake
41. ☐ ☐ Binge eating at least twice a week (during one sitting eating an amount of food that is significantly larger than most people would eat during a similar period of time and under similar circumstances)
42. ☐ ☐ Self induced vomiting, repeated use of laxatives, diuretics, enemas, or other medications, fasting, or excessive exercise to prevent weight gain or to induce further weight loss

(7)

43.	☐	☐	Feelings of Panic
44.	☐	☐	Palpitations, pounding heart, or accelerated heart rate
45.	☐	☐	Sweating, shaking, or trembling, chills, or hot flashes
46.	☐	☐	Sensations of shortness of breath, smothering, or feelings of chocking
47.	☐	☐	Chest pain or discomfort
48.	☐	☐	Nausea or abdominal distress

Within the last two (2) weeks have you experienced the following symptoms:

	YES	NO	
49.	☐	☐	Feeling dizzy, unsteady, light headed, or faint, fear of dying, or numbness or tingling

(8)

50.	☐	☐	Excessive anxiety and worry, occurring more days than not for at least 6 months, about a number of events or activities
51.	☐	☐	Finding it difficult to control the worry
52.	☐	☐	Restlessness or feeling keyed up or on edge, mind going blank, difficulty concentrating, muscle tension

(9)

53.	☐	☐	Having witnessed unexpected traumatic event that involved actual or threatened death or serious injury or a threat to the physical integrity of yourself or others in the past (any time in your life)
54.	☐	☐	Responding to the traumatic event with intense fear, helplessness, or horror
55.	☐	☐	Recurrent and intrusive distressing recollections of the traumatic event including images, thoughts, or perceptions
56.	☐	☐	Recurrent distressing dreams of the traumatic event
57.	☐	☐	Acting or feeling as if the traumatic event were recurring
58.	☐	☐	Experiencing irritability, angry outbursts, or easily startled

(10)

59.	☐	☐	The experience of certain behaviors or thoughts that must be acted upon, having a set of rules that must be applied

(11)

60.	☐	☐	Thoughts of wanting to physically harm others
61.	☐	☐	Having physically harmed others in the past (any time in your life)
62.	☐	☐	Episodes of throwing things or physically acting out

(12)

63. ☐	☐	Do you repeatedly experience trouble focusing your attention on tasks
64. ☐	☐	Do you often have difficulty organizing your tasks and activities
65. ☐	☐	Do you typically avoid or dislike tasks that require sustained attention
66. ☐	☐	Are you often easily distracted by things happening around you
67. ☐	☐	Do you often loose things or are forgetful
68. ☐	☐	Do you have a hard time sitting still or waiting your turn
69. ☐	☐	Do you feel like you are always on the go or driven by a motor

(13)

At any time in your life have you experienced the following symptoms:

YES	NO	
70. ☐	☐	At anytime in your life have you experienced the following symptoms
71. ☐	☐	Have bullied, threatened, or harmed others
72. ☐	☐	Have been cruel to animals
73. ☐	☐	Have deliberately set fires
74. ☐	☐	Have deliberately destroyed others property
75. ☐	☐	Have broken into someone else's house or car
76. ☐	☐	Have tried to get something you wanted by conning someone
77. ☐	☐	Have stolen items or engaged in shoplifting or forgery
78. ☐	☐	Have had difficulty following the rules set by parental figures or people in authority
79. ☐	☐	Have run away from home before the age of 18
80. ☐	☐	Have been suspended or expelled from school
81. ☐	☐	Have been placed on Juvenile Probation

(FOR STAFF USE ONLY)

COMMENTS: _____

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DISPOSITION – TO BE COMPLETED BY CLINICAL SUPERVISOR
(Check one or more, as appropriate):

☐ No significant psychological concerns identified

☐ The symptoms / problems shall be deferred at this point in treatment

☐ Rational for deferment of treatment _____

☐ The symptoms / condition shall be monitored (identify who will monitor and frequency of monitoring) _____

_____

☐ A new problem is being added to the treatment plan or revised

☐ Further assessment(s) is needed (identify assessment(s) needed) _____

_____

☐ A diagnosis has been based on a clinical assessment (specify diagnosis)_____

_____

☐ Patient was referred for treatment or follow-up (identify where / to whom patient was referred) _____

☐ Precautions to be take:_____

_____

Counselor	***Date***
Clinical Supervisor	***Date***
Client Name	***Medical Record #***