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, 6000 Grand Avenue, Suite G, Des Moines, IA 50312. 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____________________________________

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****.)*

____
____
____
____
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____

Emergency Information

Medical Alerts

☐ Chronic Physical Illness ☐ Asthma ☐ Recent Surgery
☐ Deaf/Hearing Impaired ☐ Other Physical Disability ☐ Diabetes
☐ Blind/Vision Impaired ☐ Severe Allergic Reaction ☐ Hypertension
☐ Epilepsy/Seizure Disorder ☐ New Psychiatric Medication ☐ 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: Relationship:	Email: Phone:
Secondary: Relationship:	Email: Phone:

Additional Information:

____
____
____
____
____
____

Medical Insurance

Primary Insurance **Policy No.___________________**

☐ Medicaid
☐ Medicaid, Managed Care
☐ Medicare
☐ Medicare, Managed Care
☐ Private Insurance
☐ Private Insurance, Managed Care
☐ Veteran's Benefits
☐ Family pay
☐ Self-pay (no insurance)
☐ Other_________________

Secondary Insurance **Policy No.___________________**

☐ Medicaid
☐ Medicaid, Managed Care
☐ Medicare
☐ Medicare, Managed Care
☐ Private Insurance
☐ Private Insurance, Managed Care
☐ Veteran's Benefits
☐ 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		
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