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

Please mark if you have any of these Chronic Diseases:

Yes No

1. ☐ ☐ Diabetes. If yes, do you take medication for it: ☐ Yes ☐ No
2. ☐ ☐ Hypertension (High Blood Pressure (greater than 130/90),
   i. _____
   f yes, do you take medication for it: ☐ Yes ☐ No
3. ☐ ☐ Hyperlipidemia (LDL greater than 200)
4. ☐ ☐ Heart Disease (Chest pain/Angina/Congestive Heart Failure) If yes, please describe:
   _____
5. ☐ ☐ Asthma. If yes, do you take medication for it: ☐ Yes ☐ No
6. ☐ ☐ Chronic obstructive pulmonary disease (COPD)
7. ☐ ☐ Hepatitis C. If yes, do you take medication for it: ☐ Yes ☐ No Date of Diagnosis: _____
8. ☐ ☐ HIV/AIDS. If yes, do you take medication for it: ☐ Yes ☐ No
9. ☐ ☐ Obesity. Current weight: _____ Height: ___feet ___ inches
10. ☐ ☐ Other (please describe): _____

Please list the medications you are taking:

Name of Medication	Reason for Medication Being Prescribed	Dosage (if known)	Time of Day Medication Taken (e.g., morning only or morning and at night)

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

Yes No

1. ☐ ☐ Any Trouble with Eyes _____
2. ☐ ☐ Worn eye glasses or contact lenses _____
3. ☐ ☐ Do you have vision in both eyes? _____
4. ☐ ☐ Ear, nose and/or throat trouble _____
5. ☐ ☐ Hearing loss _____
6. ☐ ☐ Thyroid trouble _____
*7. ☐ ☐ Coughed-up blood _____
8. ☐ ☐ Gall Bladder trouble or Gallstones _____

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

Yes No

9. ☐ ☐ Stomach, Liver, Intestinal trouble _____
10. ☐ ☐ Have you ever been diagnosed with Hepatitis A, B, C _____
11. ☐ ☐ Piles/Hemorrhoids _____
*12. ☐ ☐ Frequent and/or painful urination _____
13. ☐ ☐ Kidney Stone(s)/Blood in urine _____
*14. ☐ ☐ VD/Syphilis/Gonorrhea and other sexually transmitted diseases _____
*15. ☐ ☐ Swollen and/or painful joints _____
*16. ☐ ☐ Broken bones _____
17. ☐ ☐ Bone/joint/other deformity _____
18. ☐ ☐ Recurrent back pain _____
19. ☐ ☐ Arthritis/Rheumatism/Bursitis _____
*20. ☐ ☐ Neuritis _____
21. ☐ ☐ Gain/Loss of weight _____
22. ☐ ☐ Seizures _____
*23. ☐ ☐ Gain/Loss of weight _____
24. ☐ ☐ Allergies _____
*25. ☐ ☐ Tumor, growth, cyst, Cancer _____
26. ☐ ☐ Hernia _____
27. ☐ ☐ Prior hospitalizations for medical issues within the past three (3) years?
If ***Yes***, reason for Hospitalizations _____
28. ☐ ☐ In the past three (3) years, have you been treated for emotional/psychiatric problems?
If ***Yes***, for what were you treated? _____

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.

Yes No

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. ☐ ☐ Chest Pain/Angina_____
*5. ☐ ☐ Heart Attack_____
*6. ☐ ☐ Heart Surgery_____
*7. ☐ ☐ Heart Rhythm Irregularity (Irregular Heart Beat)_____
*8. ☐ ☐ Heart Valve Replacement_____
*9. ☐ ☐ Endocarditis_____
*10. ☐ ☐ Coronary Artery Bypass or Angioplasty_____
*11. ☐ ☐ Congestive Heart Failure_____
*12. ☐ ☐ Cardiomyopathy or Hypertrophy_____
*13. ☐ ☐ Heart Failure_____
*14. ☐ ☐ Atrial Fibrillation_____
*15. ☐ ☐ Palpitations (extra beats or extra heart beats)_____
*16. ☐ ☐ Rheumatic Fever_____
*17. ☐ ☐ Asthma_____
*18. ☐ ☐ Shortness of Breath_____
*19. ☐ ☐ Emphysema_____
*20. ☐ ☐ Chronic Bronchitis_____
*21. ☐ ☐ Tuberculosis_____
*22. ☐ ☐ Valley Fever_____
*23. ☐ ☐ 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 ☐

Self-Medical History *Continued...*

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

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 your teeth?

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 months 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 RELEASED TO UNAUTHORIZED PERSONS.

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

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 nonstop	
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)	

(3)

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

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

	Yes	No
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

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(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 special 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 see
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 and swearing)

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(5)

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

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(6)

39.	☐	☐ Intense fear of gaining weight or becoming fat, even though you are told you are underweight
40.	☐	☐ Significant weight loss through the reduction and restriction of food intake
41.	☐	☐ Binge eating at least twice a week (during one sitting, eating an amount of food that is definitely 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

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(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 choking
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, lightheaded 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 or experienced a 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 or 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 experienced trouble focusing your attention on tasks
64.	☐	☐	Do you often had difficulty organizing your tasks & 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 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"

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

	Yes	No	(13)
70.	☐	☐ Have bullied, threatened, or harmed others	
71.	☐	☐ Have been cruel to animals	
72.	☐	☐ Have deliberately set fires	
73.	☐	☐ Have deliberately destroyed others' property	
74.	☐	☐ Have broken into someone else's house or car	
75.	☐	☐ Have lied to get something you wanted, i.e., "conned" someone	
76.	☐	☐ Have stolen items or engaged in shoplifting or forgery	
77.	☐	☐ Have had difficulty following the rules set by parental figures or people in authority	
78.	☐	☐ Have run away from home before the age of 13	
79.	☐	☐ Have been suspended or expelled from school	
80.	☐	☐ Have been placed on Juvenile Probation	

(FOR STAFF USE ONLY)

COMMENTS: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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
Rationale 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 made 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 taken: _____

_____

Counselor	***Date***
Clinical Supervisor	***Date***
Patient's Name (Print)	***Medical Record #***