eliminating racism
empowering women
ywca

To:

☐ YWCA of Fort Dodge

☐_____

FROM:

☐ YWCA of Fort Dodge

☐_____

APPLICATION FOR SERVICES

Return (mail, email, or fax) completed application/referral to

Intake Coordinator
YWCA of Fort Dodge, IA
826 1st Avenue North ❖ Fort Dodge, IA 50501
Phone: 515-573-3931 ext. 4 ❖ Email: ywcaintake@ywcafd.org
Fax: 515-573-3950

Application/Referral for:

☐ Residential Treatment Services
☐ Half-Way-House ☐ Outpatient Services IOP/EOP
Medicaid: ☐ Yes ☐ No

Client information is protected by Federal regulations (42CFR, Part 2, 45 CFR HIPPA) which prohibits anyone with knowledge of client information from making any disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of *medical or other information is NOT sufficient* for this purpose. Federal rules prohibit any use of client information to criminally investigate or prosecute any alcohol or drug abuse patient.

Full Name: _____ Date of Birth: _____ Marital Status: _____
Home Address: _____
County of Legal Residence: _____ Social Security #: _____ Title XIX #: _____
MCO: _____ Phone Number: _____

Children:
Are you bringing any children with you to treatment ☐ YES ☐ NO
Number of Children and ages: _____
In mother's custody? (If no, explain) _____

History of DHS Involvement ☐ Yes ☐ No
Current DHS involvement? ☐ Yes ☐ No

History of Substance Use: Have you been through or successfully completed a drug/alcohol treatment program? ☐ Yes ☐ No
Last date of alcohol usage: _____ **Last date of drug usage:** _____

DOC	Age 1st Used	Method of Use	Duration	Date of last use

Treatment History	Location	Dates	Type of Discharge

Physical Health

Please mark as many boxes as apply to you:

History of seizures	☐	Pregnant	☐	HIV/AIDS	☐
Bulimia	☐	Suicide thoughts	☐	Suicide attempt	☐
Anorexia	☐	Diabetes	☐	Suicide Plans	☐
Hepatitis A, B, or C/any other Communicable Disease	☐				

Mental Health

Mental health diagnosis:

_____

Medications:

_____

_____

Are there any warrants out for your arrest? ☐ Yes ☐ No Are you on probation? ☐ Yes ☐ No Parole? ☐ Yes ☐ No
Do you have any pending criminal charges? ☐ Yes ☐ No

Has the court suggested you be here*? ☐ Yes ☐ No

Criminal History:

Date	Conviction	Date	Conviction

Are you related to anyone that works or resides at the YWCA? IF so who? _____

To be completed by the referring agency
The information in this form is totally confidential and will not be disclosed without the applicant's express permission.

Referring Agency Name_____
Name of Individual Making Referral: _____
Level of Treatment Completed at your agency: _____
Client Needs:

- ☐ Mental Health Services
  Explain:_____
- ☐ Daily Living Skills
  Explain:_____
- ☐ Parenting Skills
  Explain:_____
- ☐ Other
  Explain:
  _____

Brief details of known medical conditions/diagnosis?

1. Referred patient has had the following performed within the last 90 days:
   - ☐ Physical Exam
   - ☐ TB Test
2. Other medical information:

Please fax TB results, Health and physical information and referral (If applicable)
Please bring ID, social security card and birth certificate

Next of Kin/Person available to contact in an emergency:
Name: _____ Address: _____ Phone #:_____

I agree to release this information to the YWCA of Fort Dodge IA for to determine if I am eligible for admission into the YWCA programs. Use of this information for any purpose other than program eligibility is strictly prohibited.

Client Signature: _____ Date: _____

For Referring Agency: _____ Date: _____