BETHANY HOUSE

"A Place of Healing"

550 Petersburg Road, Carlisle, PA 17015

LAST NAME: _____ DATE: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

CURRENT ADDRESS: _____ CITY/STATE: _____

PHONE NUMBER: _____ E-MAIL: _____

DATE OF BIRTH: _____ SOC. SECURITY NUMBER: _____

Do you anticipate any changes in family composition in the next 12 months? YES or NO

If YES, please explain:_____

_____

Do you live in Cumberland County? YES or NO

EMPLOYMENT/INCOME VERIFICATION

Are you currently working? YES or NO

If YES, Who are you working for? (Name & Address) _____

_____

Do you currently have any source of income? YES or NO If yes, please list the source: _____

_____

Do you receive Public Assistance? (This includes cash assistance or food stamps) YES or NO

DRUG/ALCOHOL HISTORY

Are you currently addicted to illegal or controlled substances? YES or NO

Have you previously been addicted to illegal or controlled substances? YES or NO

If YES, please indicate how long you have been substance free and what type of substance(s):_____

_____

Do you smoke or vape? YES or NO Explain: _____

Are you currently seeking substance abuse treatment or counseling? YES or NO

CRIMINAL HISTORY:

Are you a registered sex offender, under state sex offender registration laws? YES or NO

Have you ever been arrested, charged, convicted of, or plead guilty to any criminal activity anywhere in the U.S.? (This includes any Summary Offenses at the District Justice level where you paid a fine. Examples: Disorderly Conduct, Harassment, DUI's, Etc. These Summary Offenses do not require an arrest and jail time, but they will be listed on your criminal record. You do not need to include Driving Offenses.) YES or NO

If YES, please fill out the following questions:

Where?	Where?
Date?	Date?
Crime?	Crime?

Where?	Where?
Date?	Date?
Crime?	Crime?

MEDICAL INFORMATION/MEDICATIONS:

Are there any on-going medical conditions that we should be aware of? YES or NO

If YES, Please list medical condition(s): _____

_____

_____

Are you currently taking any prescription medication? YES or NO

If YES, Please list all prescribed medications you are currently taking: _____

_____

_____

Who is the current prescribing medical professional?_____

Do you have any allergies or dietary restrictions? _____

Describe your general health: _____

Have you ever had a seizure?_____

EMERGENCY CONTACT

In the event of an EMERGENCY is there someone you would like us to contact? YES or NO

If YES, Please list Name and Contact Information:_____

_____

I understand that this is not a contract and does not bind either party. ***The above information is all true and complete to the best of my knowledge.*** *I have no objections to inquiries being made for the purpose of verifying the statements herein.* ***I further understand my Admission Application will be used to determine my eligibility.***

_____ _____

Signature of Applicant Date