Supportive Recovery Housing for Parents with Children Referral Form

Date: _____ **Referral Source:** _____

DEMOGRAPHICS:

Name: _____ **Nickname:** _____

Mailing Address:

_____

Contact Number: _____

Race: _____ **Sex:** _____ **D.O.B.:** _____ **Age:** _____ **S.S.N.:** ___ ___ ___-___ ___-___ ___ ___ ___

Has own transportation: ◯ **Yes** ◯ **No**

Marital Status: ◯ **Single** ◯ **Married** ◯ **Divorced** ◯ **Separated** ◯ **Widowed**

Children/Dependents: ◯ **No** ◯ **Yes, how many?** _____

Age and Gender of Children: _____

SUBSTANCE USE:

Drug of Choice: _____ **Route of Administration:** _____

Date of last Use: _____ **Length of Sobriety:** _____

Medical Insurance: ◯ **Uninsured** ◯ **Medical Assistance (State)** ◯ **Private:** _____

MCO: _____

Is there a need/interest to apply for Medical Assistance: ◯ **Yes** ◯ **No**

Is there a mental health diagnosis? ◯ **Yes** ◯ **No If, yes, list diagnosis:** _____

RECOVERY INVOLVEMENT:

List Previous Treatment Providers, if any: _____

_____

List Previous Recovery Housing Providers, if any: _____

_____

Current Self-Help Group participation: ◯ **None** ◯ **Celebrate Recovery** ◯ **SMART Recovery**

◯ **Alcoholics Anonymous** ◯ **Narcotics Anonymous**

◯ **Other Self-Help: Specify:** _____

VOCATIONAL:

Last Grade Completed: _____ **Degree/Diploma/GED Acquired?** ◯ **Yes- Specify:** _____ ◯ **No**

Current Employment: ◯ **Unemployed** ◯ **Employed Part-time** ◯ **Employed Full-time**

◯ **Under the Table** ◯ **Employed PRN** ◯ **Partial Disability**

◯ **Full Disability** ◯ **Need to Apply for Disability**

If Employed, Where: _____

Type of Employment: _____

ENTITLEMENTS CURRENTLY RECEIVING: ◯ **None** ◯ **EBT/SNAP (Food Stamps)**

◯ **TCA (Temporary Cash Asst.)** ◯ **TDAP (Temporary Disability Asst.)** ◯ **Other**

DO YOU HAVE ANY OF THE FOLLOWING VITAL DOCUMENTS: ◯ **Photo ID** ◯ **Birth Certificate**

◯ **Social Security Card** ◯ **Vaccination Records**

MISCELLANEOUS

Other Information Noted: _____

_____

Referred by: _____ **Date:** _____

Name and credentials

Contact information for Referral Source: _____

_____

*****Please Return Completed Referral Form to: *****

Email: Kelly.Marquart1@Maryland.gov

OR

Fax #: 301-609-5749