



Bethesda Project Admissions Intake

Bethesda Project, 1630 South Street, Philadelphia, PA 19146 • Phone (215) 985-1600 • Fax: (215) 732-8214

CONFIDENTIAL: Improper dissemination of this information can result in criminal and civil penalties.

Referred by: _____ of (Agency)

Date:

A. Basic Personal Data of Applicant

1. Last Name: _____ First: _____ M.I.: _____

Current Address:

Phone:

2. Gender: Male (Comments: _____)

3. Date of Birth: _____

4. Social Security Number

5. Race:

<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian & White	<input type="checkbox"/> Black/African American & White
<input type="checkbox"/> American Indian/Alaskan Native & Black/African American	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander
<input type="checkbox"/> American Indian/Alaskan Native & White	<input type="checkbox"/> White	<input type="checkbox"/> Other / Multi-Racial
<input type="checkbox"/> Asian		

6. Ethnicity Hispanic? _____ 7. Religious Affiliation: Religious Affiliation

8. Health Insurance: Health Insurance ID#

Medicare A: _____ Medicare B:

9. Primary Case Worker (ICM, CM, RC)
Affiliation: _____ Phone: _____

B. Social Supports (i.e. friends, family, religious leaders)

1. Name :
Relationship: _____ Phone:

Address:

2. Name :
Relationship: _____ Phone:

Address:

Applicant's Name:

EMERGENCY CONTACT:

Name: _____ Relationship:

Phone:

Address:

C. **Education:** Highest grade completed: _____ High School Diploma High School G.E.D. GED

College Degree College Degree

Training Certifications:

D Family Background:

1. Marital Status: **Marital Status** 2. Number of Dependent Children:

3. Parents: _____ 4. Siblings:

5. Significant Others: _____

E. **Work History**

Types and Places of Employment and Dates From/To (MM/YY)

Reason for leaving last job:

F. **Health**

1. Medical History (Include past and current diagnose – PLEASE CIRCLE “^o” IF CURRENT)

<input type="checkbox"/> Angina	<input type="checkbox"/> Hearing Problem	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease (specify):	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis (specify type)	<input type="checkbox"/> Skin Disease (specify):
<input type="checkbox"/> Back Problem	<input type="checkbox"/> HIV+ <i>without</i> AIDS symptoms	<input type="checkbox"/> S.T.D. (specify):
<input type="checkbox"/> Cancer (of):	<input type="checkbox"/> HIV+ <i>with</i> AIDS symptoms	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Tendonitis
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Kidney/Renal failure	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Dialysis (treatment)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Obesity	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pancreatitis	Other:
<input type="checkbox"/> Gastrointestinal Disease (specify):	<input type="checkbox"/> Peripheral Neuropathy	<input type="checkbox"/>
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Peripheral Vascular Disorder	<input type="checkbox"/>
<input type="checkbox"/> Gout	<input type="checkbox"/> Respiratory Problems (specify):	<input type="checkbox"/>
<input type="checkbox"/> Gum Disease		

Applicant's Name:

2. Any disabilities that interfere with mobility or daily living skills? **Yes or No**

Disabling condition – HUD defines “disabling condition” as “a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. A disabling condition limits an individual’s ability to work or perform one or more activities of daily living.”

3. Hospitalizations (List where, when and why):

4. Current Medications (include purpose of each

4. Current Mental Health Diagnoses:

AXIS I	AXIS II
Clinical Disorders: <input type="checkbox"/> Dementia <input type="checkbox"/> Schizophrenia Mood: <input type="checkbox"/> Bi-Polar <input type="checkbox"/> Depression Other: <input type="checkbox"/> other <input type="checkbox"/> History of Violent Behavior	Personality Disorders, Mental Retardation <input type="checkbox"/> Paranoid <input type="checkbox"/> Schizoid <input type="checkbox"/> Anti-Social <input type="checkbox"/> Borderline <input type="checkbox"/> Obsessive-Compulsive <input type="checkbox"/> Mental Retardation Other: <input type="checkbox"/> _other

5. Hospitalizations (List where, when and why):

7. Current Medications (include purpose of each):

G. Health Current Health Care Providers

a. Name: _____ Affiliation: _____ Phone: _____

Illness(es)

Medication/Treatment(s)

b. Name: _____ Affiliation: _____ Phone: _____

Illness(es)

Medication/Treatment(s)

c. Name: _____ Affiliation: _____ Phone: _____

Illness(es)

Medication/Treatment(s)

Applicant's Name:

H. Substance Abuse Information

1. History of Drug & Alcohol Abuse and *last use*:

<input type="checkbox"/> Alcohol -	<input type="checkbox"/> Heroin -	<input type="checkbox"/> PCP (angel dust) -
<input type="checkbox"/> Cocaine -	<input type="checkbox"/> Marijuana -	<input type="checkbox"/> Prescription drugs -
<input type="checkbox"/> Crack Cocaine -	<input type="checkbox"/> Methamphetamine (speed) -	<input type="checkbox"/> Other: -_other

2. History of D&A Treatments (Specify detox, rehab, recovery house or other. Include dates and duration. If detox, include number of times.)

3. Current D&A Treatment Programs:

I. Living Arrangements

“Chronically homeless person: – HUD defines a chronically homeless person as “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years.” To be considered chronically homeless a person must have been on the streets or in an emergency shelter (i.e. not transitional housing) during these stays.”

1. Describe the events which have led to your current situation of homelessness.

J.

2. Most current two living situations (indicate by: (1) = Most Recent, (2) = Prior to Most Recent):

<input type="checkbox"/> Streets	<input type="checkbox"/> Jail / Prison
<input type="checkbox"/> Emergency Shelter	<input type="checkbox"/> Domestic Violence Situation
<input type="checkbox"/> Transitional Housing for homeless person	<input type="checkbox"/> Living with relatives/friends
<input type="checkbox"/> Psychiatric Facility	<input type="checkbox"/> Rental Housing
<input type="checkbox"/> Substance Abuse Treatment Facility	<input type="checkbox"/> Other
<input type="checkbox"/> Hospital	<input type="checkbox"/> Other

K. Veteran Status

1. Military Veteran? **Military Vet.** 2. Service Branch: _____ 3. Served _____ years

4. Discharge Status: **Discharge Status**

5. Service-related Disabilities:

6. List V.A. services currently used:

Applicant's Name: _____

L. Legal Status

1. List any criminal convictions other than summary offenses:

Crime	Year	Prison Term Served, if any
Crime.	Year	Year
Crime.	Year	Year
Crime.	Year	Year

2. Currently on Probation or Parole?

Probation until: [Click here to enter a date.](#)

Parole Officer:

Parole until: [Click here to enter a date.](#)

3. Describe any other current legal problems.

M. Sources of Income

1. Assistance Sources:

<input type="checkbox"/> SSI (Supplemental Security Income)	<input type="checkbox"/> Employment Income
<input type="checkbox"/> SSDI (Soc. Sec. Disability Insurance)	<input type="checkbox"/> Unemployment Benefits
<input type="checkbox"/> Social Security	<input type="checkbox"/> No Financial Resources
<input type="checkbox"/> General Public Assistance	<input type="checkbox"/> Food Stamps / amount: \$
<input type="checkbox"/> State Children's Health Insurance Program (SCHIP)	<input type="checkbox"/> Other
<input type="checkbox"/> Veterans Benefits	<input type="checkbox"/> Other

2. Total Monthly Cash Income (NOT including Food Stamps): \$

3. Monthly Financial Obligations:

4. Name of Representative Payee, if applicable:

Telephone : _____ Address:

L. History of Homelessness

Many of Bethesda's sites are HUD funded and require background information on an applicant's history of homelessness. Service providers who are making a referral to Bethesda's transitional or permanent housing should complete and sign Form A (next page). Applicants who are completing this application on their own should use Form B (last page). Applicants will not be admitted without one of these forms.

FORM COMPLETED BY: _____ Date:

APPLICANT'S SIGNATURE: _____ Date:



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www.bethesdaproject.org

Bethesda Bainbridge

•
Bethesda N. Broad

•
Bethesda Spruce

•
Domenic House

•
Mary House

•
My Brother's House

•
Our Brothers' Place

•
Sanctuary

•
Shelter Program



By remaining faithful to our mission for 25 years now - to find and care for the abandoned poor and be family with those who have none Bethesda Project has changed the face of homelessness in Philadelphia depicted in this grim 1989 Serge Hollerbach watercolor.

Over the years, it has been many thousands of individual acts of kindness that have made this transformation possible.

Bethesda Project was founded in 1979 by Rev. Domenic A. Rossi, O.P.M. who remains a member of the Board of Directors today.

FORM A Chronically Homeless Third Party Verification

Certification

I certify that _____ stayed at _____
(Applicant's Name) (Facility/Program Name)

for the following period of time:

- 1) between: ___/___/___ and: ___/___/___
- 2) between: ___/___/___ and: ___/___/___
- 3) between: ___/___/___ and: ___/___/___
- 4) between: ___/___/___ and: ___/___/___

Additional detail about the applicant's episodes of homelessness may be written below:

Before coming to this facility, the homeless person resided at _____

This facility is classified as one of the following types of facilities/programs:

- Emergency Shelter
- Transitional Housing
- Permanent Housing
- Medical Institution
- Mental Health Institution
- Correctional Facility
- Substance Abuse Facility
- Other:

Signature: _____ Date: _____
(Signature of Facility Staff)

Title: _____ Phone: _____
Email: _____

Seeking God's guidance and believing that we are responsible to each other as members of one family, the mission of Bethesda Project is to find and care for the abandoned poor and be family with those who have none.