Client Name:_______________________
Client ID:_______________________

The Connection Youth Services
Livingston Family Center
Transitional Living Program Application

****
PLEASE NOTE: ALL INFORMATION ON THIS FORM WILL BE TREATED CONFIDENTIALLY
No person or agency, other than yourself and the staff member/agency making your referral, will be contacted without your knowledge and consent.
****

APPLICANT CONTACT INFORMATION

Legal Name (First, Middle, Last):____

Do you go by any other names? Yes No If yes: ____

Gender: Male Female Transgender Age:_____ Date of Birth: (MM/DD/YY):________________________

Birthplace: City:________________________________ State: ______________________

Current Address: Street:______________________________________

City: _______________________________ State:_______________________ Zip Code:_____

County:___________________________ How long at this address?_______________________

Phone Number(s):______________________________ **Alternate Number(s):**_________________________________

E-Mail Address:____

CURRENT STATUS (please circle): Runaway Homeless Potential Runaway On Probation

Juvenile Court Ward Emancipated None of these

MOST RECENT LIVING SITUATION (please circle): Friend's HomeRelative's Home

With Parent/Legal Guardian With Non-Custodial Parent Foster Home Group Home

Substance Abuse Treatment Center Living Independently Psychiatric Hospital Shelter

Residential Program Correction/Detention Center Runaway Other:__________________

BACKGROUND INFORMATION

Mother's Name: _________________________________ **Residence:**___________________________________

Father's Name: _________________________________ **Residence:**___________________________________

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IF UNDER 18: **Are you legally emancipated?** Yes No

If no, who is your legal guardian? Name:____________________________________Phone:________________________

If yes, date of emancipation:____________________________________ *MUST PROVIDE COURT PAPERWORK*

Do you have children? Yes No If yes, please complete the following section:

Child's Name:________________________________Gender:____________Date of Birth:_________________

Child's Name:________________________________Gender:___________ Date of Birth:________________

SUBSTANCE USE HISTORY:

Are you concerned about your alcohol or substance use? No Yes

Have you ever tried to cut back on your use? No Yes

Have you ever been annoyed when questioned about your use? No Yes

Have you ever felt guilty about your use? No Yes

ANSWER THE CHART BELOW FOR USE WITHIN THE PAST SIX MONTHS:

Substance	Never	1 or 2 times	3 – 10 times	11 – 20 times	Over 20 times	Age at first use
Alcohol (beer, wine, liquor)						
Marijuana						
Hallucinogens (LSD,PCP/angel dust, ecstasy, mushrooms)						
Opiates (heroin, morphine, codeine)						
Stimulants (cocaine, crack, speed, meth)						
Over the Counter or Prescription drugs						
Cigarettes/tobacco						
Vaping						
Other:						

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Have you ever been in substance abuse treatment? Yes No If yes, please describe where and when:

Name of Program or Agency *Dates of Service From-To*

____

____

EMPLOYMENT/FINANCIAL HISTORY:

Are you currently employed? Yes No If yes, complete section below:

Where?___________________________________ Job Title:___________________________________

How long?______________Hours per week:__________ **If no, are you willing to seek employment?** Yes No

If you are not willing to work, please explain why and what you plan to do instead of working:__________________

____

Please list any previous employment or vocational training programs you have participated in:

Employer / Training Program *Dates: From – To*

____

____

Please list any job skills or special training you have:____

____

Do you and/or your Parent/Legal Guardian receive any other income such as:

DHHS benefits, Food Stamps/Bridge Card, Cash Assistance, SSI, Adoption Subsidies, Child support, etc.? Yes No

If yes, describe: ____

MEDICAL/MENTAL HEALTH HISTORY:

Do you have healthcare insurance? Yes No If yes, ____

Please list any current medical issues or concerns:____

____

Please list any medications you are currently taking:____

Please list any medications you have taken in the past:____

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Have you ever been hospitalized for psychiatric reasons? Yes No If yes, complete section below:

Name of hospital *Dates: From – To*

____

____

Have you ever participated in therapy? Yes No If yes, complete section below:

Name of Counselor *Agency* *Dates: From – To*

____

____

____

PROFESSIONAL REFERENCE: (Supervisor, Teacher, Counselor, Case Worker, past placement, etc.)

Name:____Relationship:____

Phone Number(s): Cell:_____________________________________Other:_______________________________________

Release of Information on file? Yes No

PERSONAL REFERENCE: (Must be an adult over the age of 21. Can be family, neighbor, clergy, mentor, etc.)

Name:____Relationship:____

Phone Number(s): Cell:_____________________________________Other:_______________________________________

Release of Information on file? Yes No

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The Connection Youth Service Transitional Living Program, is time limited and during that time all participants will set and achieve their own goals. The purpose of goal planning is to help you move toward becoming an independent and sustainable adult. Please answer the following questions. Your answers should be well thought out and take up the majority of the section provided.

-Please create at **least 3 goals** you would like to achieve while in the program. The first goal being a short-term goal (to be completed within the first 90 days) the second being a longer-term goal (to be completed within the first 180 days) and the last being a goal to complete prior to exiting the program (6 to 18 months). Explain how you plan to accomplish your goals.

-Provide examples of how you see the Transitional Living Program helping you achieve your goals.

-Explain any barriers or struggles you see with meeting your goals.

-Provide feedback on how we can best help to motivate you if you begin to struggle in the program.

-Describe what your life would be like at the end of the 18-month program when you've met your goals.

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Youth Signature Date