Statement: Spirit of Woman is a residential program, all of our participants live here for 90-180 days. We serve pregnant and parenting women who are interested in overcoming alcohol and/or drug abuse and reunifying with their children. Does this fit your current needs?	☐ Yes

BASIC INFORMATION		
Date:	Call-In Name:	Address:
Time:	DOB:	
Staff Name:	Phone #:	Msg. Phone #:

I. Eligibility		
How many children do you have?	Children's Ages:	
How many children are in your care?		
Do you have an open CPS case: ☐ Yes ☐ No	Worker's Name/No.	
Are you involved with Cal-Works? ☐ Yes ☐ No	Worker's Name/No.	
Are you in family reunification? ☐ Yes ☐ No		
Are you pregnant? ☐ Yes ☐ No	Delivery Date:	
Are you homeless? ☐ Yes ☐ No	Describe Situation:	
Have you used a needle to inject drugs in the past year? ☐ Yes ☐ No		

II. LEGAL	
Are you currently on Probation? ☐ Yes ☐ No	Officer's Name/No.
Are you currently on Parole? ☐ Yes ☐ No	Officer's Name/No.
Were you referred by? ☐ Probation ☐ Parole	
Are you AB109 funded by Probation/Parole? ☐ Yes ☐ No	
Do you have any upcoming court dates? ☐ Yes ☐ No	When:
Do you have any pending charges? ☐ Yes ☐ No	Specify:

III. ALCOHOL / DRUG USE	
In the past 30 days what times of AOD have you used?	
What is your primary drug of abuse?	Date of last use:
How long have you used AOD?	
Previous AOD Programs and Date:	

IV. PHYSICAL HEALTH	
Do you have any current, severe, and untreated health problems? ☐ Yes ☐ No	

Are you on any medications? ☐ Yes ☐ No	
Prescribed:	Dosage:
Do you have health insurance (including Medi-Cal)? ☐ Yes ☐ No	
Health Insurance Card #:	
Primary Care Physician:	Contact Info:

V. MENTAL HEALTH

Have you been diagnosed with a psychiatric disorder?	☐ Yes ☐ No
If "yes", what disorders?	
Have you ever seen a counselor, therapist, or psychiatrist for any problem?	☐ Yes ☐ No
Have you ever been hospitalized for a non-physical problem?	☐ Yes ☐ No

VI. TREATMENT ACCEPTANCE / RESISTANCE

Have you had an ASI done in the last 6 months?	☐ Yes ☐ No
If "yes", by whom?	Phone #:
Have you been referred or required to have an assessment and/or enter treatment by the criminal justice system, health or social services, work/school or family members/significant other?	☐ Yes ☐ No
Who referred you?	Phone #:
Do you feel that you have a need for AOD treatment?	☐ Yes ☐ No
Are you currently under the influence?	☐ Yes ☐ No
Are you likely to continue using AOD in an unsafe/unhealthy manner if you don't receive treatment?	☐ Yes ☐ No
If you stopped using drugs, are you likely to relapse if you don't receive treatment?	☐ Yes ☐ No

RECOVERY ENVIRONMENT (FAMILY / SOCIAL)

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	
Are there any dangerous family members, significant others, or others who are threatening your safety, immediate well being, and/or sobriety?	☐ Yes ☐ No
Do you have any positive healthy support?	☐ Yes ☐ No

FINANCES / INCOME AND ASSESSMENT

Are you employed? ☐ Yes ☐ No	Employer:
Length of employment?	Hours worked per week:
Monthly Gross Income (after taxes)	Significant Others Gross Income:

Type	Monthly Amount	Type	Monthly Amount
Checking/Savings Balance		SSI	
Food Stamps		VA Benefits	
Child Support		TANF	
Disability		General Relief	
Unemployment		Trust Funds/Stocks/ Etc.	
Other Income		Total Monthly Income	
Total (add both columns)			

All Referrals Made by SofW:

How did you hear about Spirit of Woman?

DEPARTMENT USE ONLY

Eligibility Criteria:

Client meets the following criteria:

- ☐ Pregnant/Parenting & Substance Abusing
- ☐ Has children ages 0 - 17
- ☐ Is attempting to regain legal custody of child/ren

*****If no boxes are checked perspective client is not eligible for Spirit of Woman's Inpatient Program**

Admissions Priority:

Please check all priority categories that currently apply:

- ☐ 1. Pregnant injection drug abusers
- ☐ 2. Pregnant substance abusers
- ☐ 3. Parenting injection drug users
- ☐ 4. Parenting substance abusers

*****If none of the boxes are checked, perspective participants will be admitted using the order in which they were placed on the waiting list**

Staff Signature: _____ **Date:** _____

Print Name and Title: _____