

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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Worker's Name/No.
Are you involved with Cal-Works?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Worker's Name/No.
Are you in family reunification?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Delivery Date:
Are you homeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe Situation:
Have you used a needle to inject drugs in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

II. LEGAL

Are you currently on Probation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Officer's Name/No.
Are you currently on Parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Officer's Name/No.
Were you referred by?	<input type="checkbox"/> Probation <input type="checkbox"/> Parole	
Are you AB109 funded by Probation/Parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any upcoming court dates?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When:
Do you have any pending charges?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Prescribed:	Dosage:
Do you have health insurance (including Medi-Cal)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Health Insurance Card #:	
Primary Care Physician:	Contact Info:
V. MENTAL HEALTH	
Have you been diagnosed with a psychiatric disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "yes", what disorders?	
Have you ever seen a counselor, therapist, or psychiatrist for any problem? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been hospitalized for a non-physical problem? <input type="checkbox"/> Yes <input type="checkbox"/> No	
VI. TREATMENT ACCEPTANCE / RESISTANCE	
Have you had an ASI done in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who referred you?	Phone #:
Do you feel that you have a need for AOD treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently under the influence? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you likely to continue using AOD in an unsafe/unhealthy manner if you don't receive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you stopped using drugs, are you likely to relapse if you don't receive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
RECOVERY ENVIRONMENT (FAMILY / SOCIAL)	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Are there any dangerous family members, significant others, or others who are threatening your safety, immediate well being, and/or sobriety? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any positive healthy support? <input type="checkbox"/> Yes <input type="checkbox"/> No	
FINANCES / INCOME AND ASSESSMENT	
Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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: