Mail Fax, or Email the completed application to:

Donna Y Lucas, Case Manager
832-541-1986 – cell phone
713-652-3850 - fax
mbtlclucas@gmail.com
3410 Drew Street
Houston, TX 77004

No personal interview is necessary at the time you submit the application.

Application Review. MBTLC Program Staff will review the application to ensure it is complete and to determine that the basic eligibility requirements are met. Eligible applicants will be contacted for a screening interview.

Screening Interview. Earliest dated eligible applicants will be called first to schedule an interview. The Review Committee conducts individual interviews with applicants and makes recommendations regarding their eligibility, level of need and readiness for the program.

Selection Process. Applications will be evaluated and a final decision are made by the Review Committee. All decisions of the Review committee are final and are not subject to review or appeal.

Notification of Selection. Applicants will be notified of their selection into the MBTLC Program, generally within two weeks following the interview. Notification is not intended to imply and shall not grant any contract or contractual rights. Prior to entering the program, participants agree to devote the time, attention and effort necessary to perform and complete the requirements set forth in all program policies and procedures, and agree to provide all necessary information and documentation requested upon entry and throughout the duration of the program.

____ ____________________

Referring Agent's Signature Date

____ ____________________

Applicant's Signature Date

This signed page MUST be sent with the application to be considered for housing.

Revised 07/2016

Madge Bush Transitional Living Center

Psychosocial History / Assessment

Date: ______________________________

PERSONAL DATA

Name of Applicant: ________________________________ Date of Birth ___________Age: ______

Maiden Name: ____________________________________

Other Names by which you have been Know: ____

Address: ____

City: _______________________________________ State _____________ Zip: _______________

Telephone Number (Home) ______________________________Cell_________________________

E-mail: ____

Birthplace: ____ Race: __________________________

SS#: ____________________________________ DL# or ID#: _______________________________

Other than Texas, what states have you lived in? ____

Emergency Contact

Name: ____

Relationship: _______________ Telephone Number: ____________________________

Address: ____

City____ State____ Zip Code____________

Referred By

Name: __________________________________ Phone Number: ________________________

Agency____

Address ____

City: ____ State: _____ Zip Code: ______________

Revised 07/2016

Chief Complaint: ***if checking more than one, please prioritize the list.***

___Need a job ___Need to learn skills to help me to manage my life

___Need housing ___Need money ___Need education ___Need transportation

Present Problems (Why you contacted this agency): ____

____

____

____

____

____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Common-Law

Name of Spouse, Ex-Spouse, or Significant Other: ____

Details regarding the children in your custody:

Name ______________________________ DOB: _________Age ______ SS# ____________________

Name ______________________________ DOB: _________Age ______ SS# ___________________

Do you have full custody of those named above? ☐ Yes ☐ No

If no, who has custody? Please explain: ____

____

____

____

Are you currently required to pay Child Support? ☐ Yes ☐ No

If Yes, what is your fee amount? ___________________

Have you ever had any CPS involvement concerning your child (ren)? ☐ Yes ☐ No

If yes, please explain: ____

____

____

____

EDUCATIONAL BACKGROUND (REQUIRED TO PROVIDE TRANSCRIPT)

How would you rate your overall educational experience? On the 1-5 Scale below, circle the number that best describes your educational experience.

☐ BAD ☐ SO-SO ☐ FAIR ☐ GOOD ☐ VERY GOOD

High School ____ City ____________ State: _____

Grade Level Completed: ____________________ Did you graduate? ☐ Yes ☐ No

Year of Graduation ________________________ Did you obtain a GED? ☐ Yes ☐ No

College/Vocational /Other ____

City/State ____

Degree/Program ________________________Graduate? ☐ Yes ☐ No Year: ____________

Did you receive special education services? ☐ Yes ☐ No

If yes, please explain: ____

SOCIAL HISTORY

Did you have friends growing up? ☐ A few ☐ Many ☐ None

What social activities/games did you enjoy as a child? ___________________________________
____
____

Do you *currently* have friends? ☐ A few ☐ Many ☐ None

What social/leisure activities do you ***presently*** enjoy? ___________________________________
____
____

EMPLOYMENT HISTORY:

Do you have any employment limitations that you know of due to physical or mental disabilities that would keep you from returning to work? ☐ Yes ☐ No

If yes, please explain: ____

____

Have you ever been terminated from a job due to alcohol and/or drug use or an inability to perform assigned duties due to a mental impairment or both? ☐ Yes ☐ No

If yes, please explain: ____

____

Have you ever filed a Workman's Compensation Claim while working? ☐ Yes ☐ No

If yes, please explain: ____

____

Have you ever filed a Sexual Harassment charges against your employer/co-worker? ☐ Yes ☐ No

If yes, please explain: ____

____

Have you ever filed a complaint with EEOC while working? ☐ Yes ☐No I

If yes, please explain: ____

____

What is the highest rate of pay you have earned? $__________________________

Would your past employer give you a positive reference? ☐ Yes ☐No

What is the longest length of time you have been without work? Please explain: ___________________

____

____

Please list your last four (4) employers

1) Employer ____
   Address______________________________ Phone____________________
   Date: (month/year) __________________________ Salary ________________
   Job Title: ____
   Job Duties: ____
   ____
   ____
   ____

Reason for Leaving: ____
____

Would You Be Eligible for Rehire: ☐ Yes ☐ No

2) Employer ____
   Address______________________________ Phone____________________
   Date: (month/year) __________________________ Salary ________________
   Job Title: ____
   Job Duties: ____
   ____
   ____
   ____

Reason for Leaving: ____
____

Would You Be Eligible for Rehire: ☐ Yes ☐ No

3) Employer ____
   Address______________________________ Phone____________________
   Date: (month/year) __________________________ Salary ________________
   Job Title: ____
   Job Duties: ____
   ____
   ____
   ____

Reason for Leaving: ____
____

Would You Be Eligible for Rehire: ☐ Yes ☐ No

4) Employer ____
Address_____________________________________ Phone_____________________________
Date: (month/year) _________________________________ Salary _______________________
Job Title: ____
Job Duties: ____
____
____
____

Reason for Leaving: ____
____

Would You Be Eligible for Rehire: ☐ Yes ☐ No

FAMILY BACKGROUND

Did you grow up in a ☐ **healthy** or ☐ **dysfunctional** family?

Explain: ____

____

____

Father's Name ____ ☐ Alive ☐ Deceased

City / State Residing: _____________________Telephone Number: _________________________

Tell us about your Father: Occupation. Is there any history of alcoholism, drug addiction or mental illness?

Details: ____

____

____

Describe your relationship with your father: ____

____

____

Mother's Name ____ ☐ Alive ☐ Deceased

City / State Residing: _____________________Telephone Number: _________________________

Tell us about your Mother: Occupation. Is there any history of alcoholism, drug addiction or mental illness?

Details: ____

____

____

Describe your relationship with your mother: ____

____

____

Do you have regular contact with your parents? ☐ Yes ☐ No

If no, Please explain: ____

____

____

How many siblings do you have? ________ What birth order did you come in? ____________________
Do any of your siblings have any history of alcoholism, drug addiction or mental illness?
If yes, please specify: ____
____
____

Describe your relationship with your siblings: ____
____
____

Do you have regular contact with your sibling(s)? ☐ Yes ☐ No
If no, Please explain: ____
____
____

Has anyone in your family committed suicide? ☐ Yes ☐ No
If yes, please explain: ____
____
____

If you were adopted, answer the following two (2) questions.
By whom were you adopted? ____

How old were you when you learned that you were adopted? _____________________________

HISTORY OF ABUSE

Have you ever been physically, mentally, verbally or sexually abused? ☐ Yes ☐ No

If yes, please explain and indicate by whom (*Example: In 1999, my step father sexually abused me. Between 2010 and 2012 I was verbally and physically abused by my then husband.)*

____
____
____
____

Have you ever attended individual or group therapy in order to address abuse issues, codependency or other related problems? ☐ Yes ☐ No

If yes, please explain (*Example: I attend group therapy sessions at HAWC. I also meet with a counselor once a month for mental health concerns.)*:

____
____
____
____

MEDICAL HISTORY

Do you and your children have medical coverage? ☐ Yes ☐ No

If yes, please indicate which one:

Health Ins	CHIP	Medicaid	Medicare	Gold Care	Other
☐Child ☐Self	☐Child ☐Self	☐Child ☐Self	☐Child ☐Self	☐Child ☐Self	☐Child ☐Self

When was your last physical? ____

Please list and date any pending medical appointments: ______________________________________
____
____

How would you rate your health? ☐ Good ☐ Fair ☐ Poor

Have you ever been treated for any of the following: (Please Circle)

Diabetes	Cancer	Asthma	Tuberculosis	HIV/Aids	Hepatitis C
Vomiting	Dizziness	Hypertension	Head Trauma	STD	Heart Problem
Thyroid Disorder	Stomach Problems	Migraine Headaches	Sickle Cell Anemia	Seizure Disorder	Other Forms of Hepatitis

Other medical conditions ____

MBTLC is a working program. If you have applied or plan to apply for SSI or SSDI you are not eligible for this program. Please return this application to your Case Worker.

Have you ever applied for SSI or SSDI? ☐ Yes ☐ No
Are you planning to apply for SSI or SSDI? ☐ Yes ☐ No
If yes, please explain: ____
____
____

Do you or any member of the family have any physical limitations? ☐ Yes ☐ No
If yes, please specify: ____
____
____

When was the last time you or any member of your family were in the hospital and were you treated?
____
____
____

List History of Surgeries: ____
____
____

Current Medications: (Include over the counter drugs and vitamins) ___________________________
____
____

Who prescribes the above medications? Please provide us with the name and telephone number for the prescribing physician and/or clinic: ____
____
____

Is client capable of self-administering medication? ☐ Yes ☐ No

Allergies to Medications: ____
____
____

Food Allergies: ____
____

MENTAL HEALTH HISTORY

Are you currently under the care of a psychiatrist? ☐ Yes ☐ No
Please provide us with your physician information:

Name_____________________________________ Telephone ______________________________

Address/City/State/Zip Code____

Have you ever been hospitalized in a psychiatric facility? ☐ Yes ☐ No

If yes, when, where and how many times?
____
____

What medication are you currently taking? (Please Circle)

Adderall	Demerol	Librium	Nardil	Respirdal	Stelazine	Vivactil		
Anafranil	Depakote	Lortab	Navane	Revex	Suruiontil	Vellbutrin		
Antabuse	Deysrel	Loxitane	None	ReBia	taractan	Xanax		
Ascendin	Eexedrine	ludiomil	Norpramii	Risperal	Tegretol	Aoloft		
Ativan	Dilaudid	Luvox	Pamelor	Ritalin	Thorazine	Darvon		
Buprenea	Effexor	Marplan	Parnate	Roxinal	Tofanil	Dolophine		
Buspar	Evavil	Mellaril	Paxil	Serax	Trilafon	Phenobarbital		
Catapres	Eskalith	Mepergan	Percodan	Serentil	Tyleno #3,#4	Desoxyn		
Clexa	Haldol	Moban	Prollixin	Seroque	Valium	Unknow		
Colzaril	Klonopin	MSIR	Prozac	Serzone	Versed	Zyperexia		

Were you given a specific diagnosis? ☐ Yes ☐ No Date: ___________

If yes, what is your diagnosis: ____

Have you ever had auditor or visual hallucinations? ☐ Yes ☐ No

If yes, please explain: ____

Do you ever think that people are out to get you? ☐ Yes ☐ No
If yes, do you mean that you are in fear for your life? ☐ Yes ☐ No
If yes, please explain :____

Do you have problems with short-term memory? ☐ Yes ☐ No

Do you have problems with concentration? ☐ Yes ☐ No

Do you have difficult falling and stay asleep? ☐ Yes ☐ No

How would you rate your appetite? ☐ Good ☐ Fair ☐ Poor

Have you experienced a drastic weight gain or loss lately? ☐ Yes ☐ No
If yes, how much? ____

Do you have any history of Bulimia or Anorexia? ☐ Yes ☐ No
If yes, please explain: ____

Do you have a history of Obsessive-Compulsive Disorder? ☐ Yes ☐ No
If yes, please explain:____

Suicidal Ideations:

Are you suicidal now and/or have you been suicidal in the last 6 months to 2 years? ☐ Yes ☐ No

If yes, do you have a plan, please explain:

____

____

Previous Suicide Attempts: ☐ Yes ☐ No

If yes, how many_____ When was the last attempt: ____

Do you self-mutilate? ☐ Yes ☐ No

If yes, please explain: ____

____

Homicidal ideations: Do you have thoughts of hurting someone? Yes ____ No ____ If yes, please explain when was the last time and the circumstances: ____
____
____

Substance Abuse History

Do you smoke cigarettes? Yes___ No ___ How many packs a day ______
Do you presently drink alcohol? Yes ___ No ___ If yes when was the last time you had a drink
____
How much alcohol do you consume? ____
Have you ever been treated for alcoholism? If yes, how many times? ___________________________
Do you have a history of blackouts? Yes____ No _____
Do you have a history of DWI? Yes__ No__ If yes, how many have you had? ______
What street drugs have you used? ____
____
Do you have a history of substance abuse? Yes ___ No ___
Have you ever been treated for substance abuse? Yes ____ No ____

Your choice of drug: (Please Circle)

Alcohol	Amphentamies	Cannabis	Hypnotics	
Crack/Cocaine	Hallucinogens	Inhalants	Anxilytic	
Opiates	Phencyclidine (PCP)	Sedatives,	Crystal Metrodone	

Please list the name, address and telephone number of the last treatment facility: _______________
____
____
Have you ever been treated for detoxification from alcohol or drug? Yes ____ No _____
If yes, where were you treated? ____

How many times have you relapsed? _____________

What is the longest length of time for sobriety? ________

Are you currently attending a 12-step program? Yes ____ No ____
If yes, which program? ____

Do you have a sponsor? Yes _____ No _____

History of Hospitalization/Treatment Program

Name of Hospital	Program	Dates	Diagnosis

Veteran Information I (Skip this section if you are not a veteran)

Are you a veteran? Yes ___ No___ If yes, please provide the following information

Branch of Military: ________________

Number of year Served: ____________

Did you receive and honorable discharge? Yes _____ No ____

Are you eligible for VA benefits?   Yes ____ No_____   DD-214 _______________

Legal
Have you ever been arrested? Yes ____ No ____
If yes, for what? ____

Have you ever been detained in a city or county jail?   Yes ____   No ____
If yes, when and where? ____

Have you ever been locked-up in a State or Federal prison? Yes _____   No _____
If yes, please explain: ____
____
____

Are you currently serving probation or parole? Yes _____ No ____
If yes, what is the length and terms of your sentence? ____
____
____

Are you currently in a community service program? Yes ____   No____
If yes, when will you be finished? ____
Name of Probation office: ________________________________ Phone number__________________

Do you have any outstanding warrants, including warrants for traffic tickets? Yes _____ No_____
If yes, please explain: ____
____
____

Do you have any civil or criminal lawsuits pending? Yes ____ No ____
If yes, please explain: ____

____
____

Are you currently receiving legal advice from and attorney regarding any matter? Yes ____ No _____
If yes, please explain: ____
____
____

Do you have a felony? Yes ___ No ___ Date of felony: ____________________________________

Financial Information

Do you have significant financial obligation? Yes ____ No ____ How much $_________

If you are paying child support, are you current with your payments? Yes ___ No ___
If you are behind, what kind of arrangements for payment have you made? ____________________
____
____

Have you ever filled bankruptcy? Yes ____ No ____ If yes, when ___________________________

Have you ever requested a copy of your credit report? Yes ____ No ____

Spiritual Background (This information is optional)

What is your religious preference?

☐ Christian ☐ Hindu

☐ Jewish ☐ Buddhist

☐ Muslim ☐ Other_____________________________

ENTITLEMENT BENEFITS AND OTHER ASSISTANCE

If you receive any of the following, please write in the monthly amount received.

Social Security $__________	Child Support $__________
SSI $__________	Workman's Com $__________

TANF $___________	Disability $ ___________
Food Stamps $____________________	Other $_______________________________

Personal Information and Assessment…*check all the statements that describe you:*

My difficult area:

- ☐ Can't relax.
- ☐ Don't have any energy.
- ☐ Can't control my anger.
- ☐ Thinking of hurting/killing myself.
- ☐ Lack of interest in anything.
- ☐ Can't sleep.
- ☐ Can't work.
- ☐ Can't find a job.
- ☐ Have no job skills.
- ☐ Don't like myself.
- ☐ Don't like being around others.
- ☐ I always try to please others.
- ☐ Can't get along with my family.
- ☐ Drink too much.
- ☐ Don't feel good physically.
- ☐ Can't manage my time.

My strengths are:

- ☐ Have enough money.
- ☐ Have stable physical health.
- ☐ Have family support.
- ☐ Have a job/work skill.
- ☐ Have an education.
- ☐ I like myself.
- ☐ I have been around a lot.
- ☐ I have friends.
- ☐ I get along well with others.
- ☐ I like my appearance.
- ☐ I am good at doing something.
- ☐ I have hobbies that I enjoy.
- ☐ I am emotionally strong.
- ☐ I am good at________________.
- ☐ I like ______________________.

What I want to work on:

- ☐ How to get along with others.
- ☐ Learn new job skills.
- ☐ Find a job.
- ☐ Get to like myself.
- ☐ Get interested in something.
- ☐ Feel better physically.
- ☐ Get along better with my family.
- ☐ Not being nervous.
- ☐ Not being tense and easily upset.
- ☐ Sleep better.
- ☐ Have more energy to do things.
- ☐ Getting motivated
- ☐ Believe in something.
- ☐ Learn how to enjoy myself.
- ☐ Manage my time.

What do you expect to gain from this program? ____
____
____

Is there any additional information that you feel is important for us to know? _____________________
____
____

Do you understand that this program requires clients to remain drug and alcohol free? You are also required to attend mandatory vocational/educational classes, life skills, meet with a case manager, and observed nightly curfew hours? Yes ___ No ____

Acknowledgement

I acknowledge that I have answered truthfully the question outlined in this assessment/psychosocial history to the best of my knowledge and ability.

Signature of applicant ____

Date _________________

CHILDREN INFORMATION (Please complete for each child)

NAME: ____ Date of Birth __________ Age________

Social Security Number: _________________________ Male______ Female________

Medical History

Have this child been treated for any medical conditions: Yes_____ No _____
If yes, Please explain and list dates. ____
____

Currently Medications: (Include over the counter drugs and vitamins).___________________________
____

Please list History of Surgeries____
____

List any pending medical appointment:____
____

List any allergies ____
____

Mental Health History
Ever been seen at MHMR Yes _________ No_________

List any Mental Health conditions ____
____

List any hospitalized in a psychiatric facility ____
____

List Current/Past Medications ____
____

Education History

Last School attended ______________________________________ Date ___________Grade _______
School Conduct ____
Legal Issues (CPS, Juvenile System, etc.)

List any legal issues Past/Present ____
____
____

CHILDREN INFORMATION (Please complete for each child)

NAME: ____ Date of Birth __________ Age________

Social Security Number: _________________________ Male______ Female________

Medical History

Have this child been treated for any medical conditions: Yes_____ No _____
If yes, Please explain and list dates. ____
____

Currently Medications: (Include over the counter drugs and vitamins).___________________________
____

Please list History of Surgeries____
____

List any pending medical appointment:____
____

List any allergies ____
____

Mental Health History
Ever been seen at MHMR Yes _________ No_________

List any Mental Health conditions ____
____

List any hospitalized in a psychiatric facility ____
____

List Current/Past Medications ____
____

Education History

Last School attended ______________________________________ Date ___________Grade _______
School Conduct ____
Legal Issues (CPS, Juvenile System, etc.)

List any legal issues Past/Present ____
____

____

For office use only (Applicant Do Not Complete)

Name: ____ Intake Date: _________________________

Additional Information Needed: ____
____
____

Major Problems Identified (Emotional, Social, Vocational, Physical) ____________________________
____
____
____
Services Needed: ____
____
____
Strength:____
____
____

☐ Base on the screening information:
Applicant is authorized admission to the Madge Bus Transitional Living Center Program.

☐ Applicant was no admitted, why?
____
____
____
____

______________________________ __________________
Case Manager Date

______________________________ __________________
Program Supervisor Date

______________________________ __________________
Executive Director (If needed) Date

Admission Date ________________