THE CROSSINGS RESIDENTIAL RECOVERY PROGRAM

This is an official application for admission to the The Crossings, a residential addiction and substance abuse recovery program. Information submitted on this application is confidential and stored on a secure server.

The application should take approximately 30 minutes to complete. If possible, we invite you to submit an application online at www.tcserv.org.

Your signature below indicates that you have voluntarily and free of coercion, read and agree to submit to the guidelines of The Crossings. Upon the review of your completed application and the available bed space, you will be notified of the next steps.

Please be as accurate as possible when answering the questions on this application. All questions must be completed for this application to be processed. Adding to or minimizing your history does not influence your application outcome. Incomplete or falsified information submitted on this application is subject to denial.

Applicant's Name (PRINT): _____

Applicant's Signature:_____ Date:_____

Applicant Assistance

If you are completing this application with the prospective client or on their behalf, please submit your information below.

Assistant First Name _____

Assistant Last Name _____

Phone Number _____

Email _____

Relationship to Applicant

☐ Re-entry Navigator ☐ Attorney ☐ Case Worker ☐ Probation Officer

☐ Chaplain ☐ Counselor ☐ Family Member ☐ Friend ☐ OTHER

Applicant Information

First Name: _____ Last Name: _____

M.I.: ____ Maiden Name:_____ DOB: _____

SSN: _____ DC Number: _____

Email Address: _____ Primary Phone: _____

Gender: ☐ Male ☐ Female Veteran? ☐ Yes, I am a US Veteran.

Ethnicity/Race

☐ Asian ☐ Black/African American ☐ Hispanic/Latinx
☐ Native American or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Other: _____

Current Housing Status

☐ I am currently experiencing homelessness ☐ I am living in my own home.
☐ I am currently incarcerated. ☐ I am in a temp. housing situation/program.
☐ Other: _____

Street Address: _____

City: _____ State: _____ Zip:_____

If applicable what is the name of the program, jail, or prison where you are currently located?

_____

Education Level

☐ Some High School ☐ High School ☐ Vocational/Technical Degree
☐ Associates Degree ☐ Bachelor's Degree ☐ Master's Degree or above

Do you have a copy of your:

Drivers License?	Y	N	Social Security Card?	Y	N
Birth Certificate?	Y	N	DD214 (Veterans only)	Y	N

What languages do you speak fluently?

☐ English ☐ Spanish ☐ French
☐ Chinese ☐ Arabic ☐ Other: _____

What other cities have you lived in?

_____

Have you ever been a client of The Crossings before Y N

If so, what program(s) and when? _____

Income

Please indicate any sources of income you receive each month and the amount per month.

Employment:	_____	Unemployment:	_____
Social Security Income (SSI):	_____	WIC:	_____
HUD:	_____	Cash Assistance:	_____
Other:	_____	Other:	_____
TOTAL MONTHLY INCOME:	_____		

Criminal Justice System

Do you have any pending or prior charges? ☐ Pending ☐ Prior ☐ NONE

Date of Charge	City	Charge Type	Disposition

Have you been sentenced? Y N What is your EOS date? _____

Probation or Parole Status?

☐ I am NOT on probation or parole. ☐ I am on probation. ☐ I am on parole.

What are the terms of your probation or parole? _____

_____

_____

Do you currently have an attorney or public defender?

☐ No ☐ Attorney – Appointed ☐ Attorney – Retained ☐ Public Defender

Attorney/Public Defender Name: _____

Attorney/Public Defender Phone: _____

Attorney/Public Defender Email: _____

Was a victim physically harmed in any of your charges or convictions? Y N

If so, please describe the situation. _____

_____

_____

Have you ever been required to register as a sex offender? Y N

If so, when were you required to file and what were the charges? _____

_____

_____

Substance Abuse History

When was the last time you used drugs or alcohol? _____

Do you feel that alcohol or drugs are a problem for you? Y N

Have you ever been arrested while under the influence or high? Y N

Have you ever needed more alcohol or drugs to get the same effect? Y N

Has anyone ever complained about your behavior? Y N

Have you ever tried to cut down or stop using alcohol or drugs? Y N

How old were you when you first noticed that you had a problem with drugs and or/alcohol? _____

[Substance Abuse History continued on the next page]

Substance Abuse Survey

Substance	Have you used this substance?	How long did you use this substance for?	How often did you use it during that time?
Alcohol			
Marijuana			
Hallucinogenic			
Barbiturates			
Amphetamine			
Methamphetamine			
Heroin			
Methadone			
Cocaine			
Opiates			
K2/Spice			
Kratom			

Mental Health History

Do you have a mental health diagnosis? Y N

If so, what is your diagnosis? _____

_____

Are you experiencing auditory or visual hallucinations? Y N

If prescribed psychotropic medication by a medical professional,

are you willing to comply? Y N

Have you been prescribed medication for your diagnosis? Y N

Please list the medications. _____

_____

Do you need assistance getting your medication? Y N

Have you ever attempted suicide? Y N

If so, when? _____

What were the circumstances around this event? _____

Were you hospitalized? Y N

Health and Medical Information

Do you have a medical diagnosis? Y N

If so, what is your diagnosis? _____

_____

Have you been tested for COVID-19?

☐ Yes – I tested positive ☐ Yes – I tested negative ☐ No

When did you take your most recent COVID-19 test? _____

Are you able to carry out daily living activities* without assistance? Y N

**i.e. caring for your personal needs such as preparing meals, cleaning living space, personal hygiene*

If not, please explain why not. _____

_____

Is it possible that you are pregnant? Y N

Are you able to carry out full time work? Y N

Are you currently experiencing a cough, fever, or shortness of breath? Y N

Have you been exposed to anyone who has tested positive for COVID-19 in the last 14 days? Y N

Employment History

Employer	Position	Start Date	End Date

What kind of work are you trained to do? _____

_____

Housing History

How many times have you experienced homeless in the past three years? _____

Where did you sleep last night?

☐ Jail/Prison ☐ Outside ☐ Friends home/Couch

☐ My own home/apt ☐ Shelter ☐ Institution ☐ OTHER _____

When was the last time you had a safe, permanent place to live? _____

How long did you live there? _____

Freedom Program

List three goals that you hope to achieve by participating in this program.

1. _____

   _____

2. _____

   _____

3. _____

   _____

Is there anything else that you would like us to know?

_____

How did you hear about us?

☐ Friend/Family ☐ A Previous Client ☐ Search Engine (ex: Google)

☐ Social Media ☐ Attorney/Public Defender ☐ Another human services agency

☐ Counselor ☐ Other: _____

Your signature below indicates that you have voluntarily and free of coercion read and agree to submit to the guidelines of The Crossings as referenced in this document. Upon the review of your completed application and the available bed space, you will be notified of the next steps.

Print First & Last Name _____

Today's Date _____

How to Submit Your Application

Mail or drop off: The Crossings, 5700 24th ST E, Bradenton, Fl 34203

Email it to admin@tcserv.org

Staff Only

Received by: _____

Date: _____