CARAMORE
COMMUNITY

at The Jack Simonds Center
550 Smith Level Road
Carrboro, NC 27510

Phone: (919) 967-3402
Fax: (919) 942-9732
www.caramore.org

APPLICATION FOR ADMISSION AND ENROLLMENT IN SERVICES

Requested Service:

❑ Individual Support Services ❑ Peer Support Services ❑ Supervised Living Low *(Housing)*
❑ Vocational Services ❑ Combination Vocational and Community Housing Services

Demographic Information *(Please print clearly)*

Applicant Name: _____ Nickname: _____

Social Security Number: _____-_____-_____ Date of Birth: ____/_____/_____ Age: _____
(MM / DD / YYYY)

Street Address: _____ Email: _____

City, State, Zip: _____ County: _____

Primary phone: _____ Secondary phone: _____ Alternate phone: _____

(OPTIONAL SELF-IDENTIFICATION)
Gender: Male/Female/Transgender/Other/NA Single/Committed/Married/Divorced/Widowed/NA
Race: _____ VA status: ❑ Yes ❑ No

Caramore Community, Inc. does not discriminate on the basis of race, color, age, ethnicity, religious or political affiliation, national origin, sexual orientation, gender identity, sex, or military status or service to determine admission.

Current Living Arrangement: ❑ Private Residence ❑ Homeless *(shelter/unsheltered)* ❑ Adult Care Home
❑ Other Independent Rooming House ❑ Residential Facility ❑ Correctional Facility *(prison, jail, etc.)*
❑ Institution *(psychiatric hospital, Wright, ADATC, etc.)* ❑ Other: _____

Legal Guardian

Legal Guardian Name: _____

Relationship to Applicant: _____ Phone Number: _____

Emergency Contact *(Person to be notified in the event of an emergency)*

Emergency Contact: _____ Relationship to Applicant: _____

Address: _____ Phone Number: _____

Referral Information

How did you hear about Caramore? _____

Referral Person: _____ Referral Person Phone #: _____

Referral Source Agency Name (If applicable): _____

- ❑ State Facility
- ❑ Private Practice Psychiatrist/Therapist
- ❑ General Hospital
- ❑ Self / Website
- ❑ Vocational Rehabilitation
- ❑ Family / Friends
- ❑ Cardinal Innovations Healthcare
- ❑ _____

Personal Statement of Goals

Please tell us what goals you desire to achieve while participating in Caramore's program: _____

_____

_____

_____

Insurance and Benefits Information

Do you have private health insurance? ❑ Yes ❑ No

Company Name: _____ Policy Number: _____

Do you have? ❑ Medicare – Policy #: _____ ❑ Medicaid – Policy #: _____

*(**NOTE:** Please attach a copy of insurance cards)*

Do you receive any of the following? ❑ Pension ❑ SSI ❑ SSDI ❑ Other Disability Income

(Please check all that apply) Please indicate the monthly amount received: _____

Food Stamps ❑ Yes ❑ No Please indicate the monthly amount received: _____

Current Treatment

Primary Care Physician *(medical)*: _____ Phone Number: _____

Agency/Provider Name: _____

Therapist Name: _____ Phone Number: _____

Agency Name: _____

Psychiatrist Name: _____ Phone Number: _____

Agency Name: _____

Previous Treatment *(Include Mobile Crisis, ER, Hospital, Detox, Outpatient Therapy, Outpatient Psychiatry, CST, ACTT, MST, PSS, IS, PSR, DSS, Residential, Vocational Rehab, etc.)*

Service Provided	Provider Name	Dates	Reason for Admission

History of Hospitalization

Please list the name and town of hospitals you have attended in the past 12 months. How long was your stay?

Hospitals	Town/City/State	Dates/Length of Stay	Reason for Admission

Clinical/Diagnostic Information

List principal diagnosis *(if known);* other diagnosis in order of importance to treatment, as well as any medical conditions.

Diagnosis	Medical

Medications

Please list all prescribed and over-the-counter medications you take regularly. Please include the dosage and the time of day you take them for all prescriptions, supplements, herbals products, or vitamins.

_____
_____
_____
_____

Are you allergic to anything, including food or medications? ❑ Yes ❑ No
If yes, please explain: _____
_____
_____

Occupational/Educational History

Highest Grade Completed: _____ ❑ Diploma ❑ GED Equivalent

Do you have a college degree? ❑ Yes ❑ No What was your major? _____

Current Employer: _____ Address: _____

Current Position/ Job Title: _____ ❑ Full-Time ❑ Part-Time

Does your current employment cover your living expenses? ❑ Yes ❑ No

Previous Employer: _____ Address: _____

Previous Position/ Job Title: _____ ❑ Full-Time ❑ Part-Time

Court/Legal History

Have you ever been arrested for any crime? ❑ Yes ❑ No Number of Arrests in Last 30 days: _____
If yes, please explain and give dates:

Offenses/Conviction	Dates

Are you currently on probation or parole? ❑ Yes ❑ No Do you have pending charges? ❑ Yes ❑ No
If yes, please explain and give dates and court official contact: _____
_____
_____

Drug History

Have you ever been treated for alcohol or drug problems? ❑ Yes ❑ No
If yes, please describe treatment including dates and names of facility or agency that provided services: _____
_____
_____
_____

Number of times attended a self-help program in the last 30 days? *(i.e., AA, NA, SAA, GA, SMART Recovery, etc.)*

❑ No Attendance
❑ 1–3 times *(less than one time per week)*
❑ 4–7 times *(about one time per week)*
❑ 8–15 times *(2-3 times per week)*
❑ 16 – 30 times *(4 or more per week)*
❑ Some attendance, but frequency unknown

I hereby affirm that all information contained in my application for program or services admission/enrollment with Caramore is true and complete to the best of my knowledge. I understand that any misrepresentation or false statement made by me in connection with the application or any related document which is deemed material by Caramore shall release Caramore from any and all liability for any claim or damage resulting therefrom.

Signed: _____ Date: _____
Applicant

Signed: _____ Date: _____
Person completing application & relationship to applicant
(We strongly prefer that the applicant complete the entire application for themselves, or as much as possible)

NOTE: The following documents are necessary in order to complete the application process for Caramore's programs. Please provide copies now if available. It is not required to submit these with the application; they can be gathered later in the process.

- ❑ **Copy of Photo ID (Driver's License, ID Card, Passport, or U.S. Government Issued ID)**
- ❑ **Copy of Social Security Card**
- ❑ **Copy of Medicaid/Medicare Card or Private Insurance Policy (if applicable)**
- ❑ **Copies of relevant Medical Records**
- ❑ **Copy of SSI or SSDI Benefits Letter (if applicable)**
- ❑ **Original Signed Copy of VR Application (if applicable)**

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