Fellowship House PHP
Admissions Application

CLINICAL INTAKE & READINESS ASSESSMENT

1736 Sanderson Avenue, Scranton, PA 18509

A comprehensive admissions packet designed to support clinical clarity, treatment matching, and whole-person recovery planning.

REFERRAL SOURCE / CURRENT PROVIDER

_____

DESIRED LEVEL OF CARE

☐ OP ☐ IOP ☐ PHP

DESIRED CAMPUS / PROGRAM SITE

_____

INSURANCE / GROUP ID

RELEASE OF INFORMATION PERMISSION

☐ YES ☐ NO

APPLICANT INFORMATION

APPLICANT NAME (LAST, FIRST, MIDDLE) _____ DATE _____

DATE OF BIRTH _____ PHONE _____ EMAIL _____

ADDRESS (STREET) _____

CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT

NAME (LAST, FIRST) _____ RELATIONSHIP _____

PHONE _____ ALTERNATE PHONE _____

PREFERRED CONTACT METHOD

☐ PHONE | ☐ EMAIL | ☐ TEXT | ☐ MAIL

SIGNATURE

By signing below, I certify that the information provided is accurate and complete to the best of my knowledge. I understand that this information will be used to determine appropriate level of care and treatment planning.

X _____ DATE _____

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PERSONAL & DEMOGRAPHIC INFORMATION

1736 Sanderson Avenue, Scranton, PA 18509

LEGAL NAME (AS IT APPEARS ON LEGAL DOCUMENTS)

LAST _____ FIRST _____ MIDDLE _____ SUFFIX (JR., SR., III) _____

PREFERRED NAME _____

PRONOUNS (OPTIONAL)
☐ SHE/HER ☐ HE/HIM ☐ THEY/THEM ☐ OTHER _____

DATE OF BIRTH _____ AGE _____

GENDER IDENTITY
☐ FEMALE ☐ MALE ☐ NON-BINARY ☐ OTHER _____
☐ PREFER NOT TO SAY

SOCIAL SECURITY NUMBER _____ - _____ - _____

DRIVER'S LICENSE OR STATE ID NUMBER _____ STATE OF ISSUE _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ OTHER _____

MAILING ADDRESS

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY PHONE (____) _____ ALTERNATE PHONE (____) _____ EMAIL _____

EMERGENCY CONTACT

NAME (LAST, FIRST) _____ RELATIONSHIP _____ PHONE (____) _____

HOUSEHOLD MEMBERS / CHILDREN

Do you have children or other dependents?

☐ YES ☐ NO

If yes, how many? _____

Please list ages of children:

_____

VETERAN STATUS

Are you a veteran of the U.S. Armed Forces?

☐ YES
☐ NO
☐ PREFER NOT TO SAY

EMPLOYMENT STATUS

☐ EMPLOYED FULL-TIME
☐ EMPLOYED PART-TIME
☐ SELF-EMPLOYED
☐ UNEMPLOYED
☐ DISABLED
☐ STUDENT
☐ RETIRED
☐ OTHER _____

EDUCATION LEVEL

☐ LESS THAN HIGH SCHOOL
☐ HIGH SCHOOL DIPLOMA/GED
☐ SOME COLLEGE
☐ ASSOCIATE DEGREE
☐ BACHELOR'S DEGREE
☐ GRADUATE / PROFESSIONAL DEGREE
☐ OTHER _____

PRIMARY LANGUAGE

What is your primary language?

☐ ENGLISH ☐ OTHER _____

TRANSPORTATION TO TREATMENT

How do you plan to get to treatment?

☐ DRIVE MYSELF ☐ PUBLIC TRANSPORTATION
☐ FAMILY / FRIEND ☐ OTHER _____

HOW DID YOU HEAR ABOUT FELLOWSHIP HOUSE?

_____

_____

CURRENT LIVING SITUATION

☐ PRIVATE RESIDENCE (OWN)
☐ PRIVATE RESIDENCE (RENT)
☐ LIVING WITH FAMILY/FRIENDS
☐ SOBER LIVING / RECOVERY HOME
☐ TRANSITIONAL HOUSING
☐ HOMELESS / SHELTER
☐ OTHER _____

INSURANCE SUBSCRIBER INFORMATION (IF DIFFERENT FROM APPLICANT)

NAME (LAST, FIRST) _____ RELATIONSHIP TO APPLICANT _____ DATE OF BIRTH _____

INSURANCE COMPANY _____ MEMBER ID / POLICY NUMBER _____ GROUP NUMBER _____

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Substance Use & Treatment History

1. SUBSTANCE USE HISTORY

SUBSTANCE	AGE OF FIRST USE	RECENT DATE OF USE	ROUTE OF ADMINISTRATION	FREQUENCY OF USE	LONGEST PERIOD OF ABSTINENCE
PRIMARY SUBSTANCE(S) _____					
SECONDARY SUBSTANCE(S) _____					

HISTORY OF OVERDOSE(S)

☐ YES ☐ NO

If yes, how many? _____

NALOXONE (NARCAN®) EVER USED ON YOU?

☐ YES ☐ NO

If yes, when? _____

CURRENT CRAVINGS (0–10 SCALE)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

None Severe

2. PRIOR TREATMENT HISTORY

PRIOR DETOX EXPERIENCE(S)? ☐ YES ☐ NO *If yes, how many?* _____

INPATIENT / RESIDENTIAL TREATMENT? ☐ YES ☐ NO *If yes, how many?* _____

PARTIAL HOSPITALIZATION PROGRAM (PHP)? ☐ YES ☐ NO *If yes, how many?* _____

INTENSIVE OUTPATIENT PROGRAM (IOP)? ☐ YES ☐ NO *If yes, how many?* _____

OUTPATIENT PROGRAM (OP)? ☐ YES ☐ NO *If yes, how many?* _____

3. MEDICATION & WITHDRAWAL HISTORY

CURRENTLY PRESCRIBED MEDICATION FOR ADDICTION (MEDICATION ASSISTED TREATMENT – MAT)? ☐ YES ☐ NO

If yes, which medication(s)? _____

Prescriber / Clinic _____

Dose _____ Frequency _____

HISTORY OF WITHDRAWAL SYMPTOMS? ☐ YES ☐ NO

If yes, please describe symptoms you have experienced:

_____

HISTORY OF WITHDRAWAL COMPLICATIONS? ☐ YES ☐ NO

If yes, please check all that apply:

☐ Seizures ☐ Delirium Tremens (DTs) ☐ Hallucinations

☐ Severe Dehydration ☐ Other: _____

4. TREATMENT ENGAGEMENT

HAVE YOU EVER LEFT TREATMENT AMA (AGAINST MEDICAL ADVICE)? ☐ YES ☐ NO

If yes, please share briefly what led to this decision. _____

_____

_____

5. RECOVERY SUPPORT & HISTORY

RECOVERY MEETINGS ATTENDED (CHECK ALL THAT APPLY)

☐ AA ☐ NA ☐ CA ☐ SMART Recovery ☐ Dharma Recovery ☐ LifeRing ☐ Other: _____

CURRENT SPONSOR / PEER SUPPORT?

☐ YES ☐ NO

IF YES, NAME / RELATIONSHIP _____

PHONE _____

WHAT HAS HELPED YOU MOST IN PAST RECOVERY ATTEMPTS? (CHECK ALL THAT APPLY)

☐ Meetings ☐ Sponsor ☐ Therapy / Counseling ☐ Medication ☐ Faith / Spirituality ☐ Family Support

☐ Peer Support ☐ Structure / Routine ☐ Exercise / Wellness ☐ Other: _____

6. YOUR STORY

WHAT BRINGS YOU TO FELLOWSHIP HOUSE AT THIS TIME?

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Medical, Psychiatric & Safety Review

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PRIMARY CARE PHYSICIAN

NAME _____

PHONE _____

LAST VISIT DATE _____

PSYCHIATRIST / THERAPIST

NAME _____

PHONE _____

LAST VISIT DATE _____

MEDICAL OVERVIEW

CURRENT MEDICATIONS _____

_____

ALLERGIES (MEDICATION / OTHER) _____

CHRONIC PAIN ☐ YES ☐ NO IF YES, LOCATION / TYPE _____

SEIZURE HISTORY ☐ YES ☐ NO IF YES, LAST KNOWN EPISODE _____

INFECTIOUS DISEASE CONCERNS ☐ YES ☐ NO IF YES, PLEASE SPECIFY _____

SLEEP CONCERNS ☐ YES ☐ NO ☐ DIFFICULTY FALLING ASLEEP ☐ FREQUENT AWAKENINGS ☐ EXCESSIVE SLEEPING

APPETITE ☐ NORMAL ☐ DECREASED ☐ INCREASED

PREGNANCY STATUS (IF APPLICABLE) ☐ NOT APPLICABLE ☐ POSSIBLE ☐ PREGNANT DUE DATE _____

RECENT HOSPITALIZATION (WITHIN 12 MONTHS) ☐ YES ☐ NO IF YES, DATE(S) _____ REASON _____

ER VISITS (WITHIN 12 MONTHS) ☐ YES ☐ NO IF YES, HOW MANY? _____ REASON _____

PSYCHIATRIC HISTORY

PSYCHIATRIC DIAGNOSES (CURRENT / PAST) _____

_____

TRAUMA HISTORY ACKNOWLEDGED ☐ YES ☐ NO ☐ PREFER NOT TO ANSWER

PANIC / ANXIETY ☐ YES ☐ NO FREQUENCY _____

DEPRESSION SYMPTOMS ☐ YES ☐ NO DURATION _____

PSYCHOSIS HISTORY ☐ YES ☐ NO IF YES, PLEASE SPECIFY _____

SELF-HARM HISTORY ☐ YES ☐ NO IF YES, LAST OCCURRENCE _____

SUICIDAL IDEATION ☐ CURRENT ☐ PAST ☐ NONE LAST OCCURRENCE _____

HOMICIDAL IDEATION ☐ CURRENT ☐ PAST ☐ NONE LAST OCCURRENCE _____

VIOLENCE RISK ☐ LOW ☐ MODERATE ☐ HIGH DETAILS _____

CLINICAL RISK RATING

To be completed by clinical staff

SUICIDE RISK	☐ LOW	☐ MOD	☐ HIGH
HARM TO OTHERS RISK	☐ LOW	☐ MOD	☐ HIGH
SELF-HARM RISK	☐ LOW	☐ MOD	☐ HIGH
SUBSTANCE USE RISK	☐ LOW	☐ MOD	☐ HIGH
MEDICAL STABILITY	☐ LOW	☐ MOD	☐ HIGH
OVERALL RISK	☐ LOW	☐ MOD	☐ HIGH

IMMEDIATE CLINICAL CONCERNS / NURSING REVIEW

_____

_____

_____

SAFETY & LEGAL CONSIDERATIONS

LEGAL CONCERNS (PENDING CHARGES / COURT DATES) ☐ YES ☐ NO IF YES, PLEASE EXPLAIN _____

OPEN WARRANTS / PROBATION / PAROLE ☐ YES ☐ NO IF YES, PLEASE EXPLAIN _____

ACCESS TO WEAPONS ☐ YES ☐ NO ☐ UNSURE IF YES, TYPE / LOCATION _____

By signing below, I certify that the information provided is accurate and complete to the best of my knowledge.

X _____ DATE _____

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Motivation, Stage of Change & Recovery Capital

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Understanding what motivates change and what resources you have to support recovery helps us personalize your treatment plan and connect you with what matters most.

MOTIVATION & READINESS

Internal Motivation
My own desire to change.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○
Not at all — Extremely

External Motivation
Pressure or encouragement from others.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○
Not at all — Extremely

Readiness for Change
How ready I feel to make changes in my life.

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○
Not at all — Extremely

Stage of Change
Where I am in the change process right now.

Precontemplation	Contemplation	Preparation	Action	Maintenance
○	○	○	○	○
Not thinking about change	Thinking about change	Getting ready to change	Actively making changes	Sustaining change

MOTIVATION CORE PROMPTS

Why now?

_____

_____

What do you most want to protect or rebuild?

_____

_____

What strengths do you bring into treatment?

_____

_____

What would success at Fellowship House look like in 30–90 days?

_____

_____

RECOVERY CAPITAL AREAS

Rate your current level of support, stability, or confidence in each area.

		1 Very Low	2 Low	3 Moderate	4 High	5 Very High	NOTES
Confidence in Recovery	My belief that recovery is possible and sustainable.	○	○	○	○	○	_____
Recovery Environment	My environment supports my recovery.	○	○	○	○	○	_____
Social Support	I have people I can count on.	○	○	○	○	○	_____
Spiritual Support	My spiritual or faith resources support me.	○	○	○	○	○	_____
Employment / School Goals	I have clarity and direction for work or school.	○	○	○	○	○	_____
Legal Pressures	Legal issues, probation, or court involvement.	○	○	○	○	○	_____
Family Pressures	Expectations or stress from family.	○	○	○	○	○	_____
Housing Stability	I have stable and safe housing.	○	○	○	○	○	_____
Financial Stress	My finances are stable and manageable.	○	○	○	○	○	_____
Digital Distraction / Tech Overuse	Technology use supports my life (not a barrier).	○	○	○	○	○	_____
Physical Wellness	My physical health and self-care are strong.	○	○	○	○	○	_____
Meaningful Activities	I engage in activities that give my life purpose.	○	○	○	○	○	_____

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Group Fit, Learning Style & Daily Functioning

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COMFORT PARTICIPATING IN GROUPS
How comfortable are you sharing in a group?

1 2 3 4 5

Not Comfortable — Very Comfortable

CONFLICT STYLE
When there is disagreement, I tend to:

- ☐ Avoid / Withdraw
- ☐ Accommodate / People-Please
- ☐ Assert / Communicate
- ☐ Compete / Take Charge
- ☐ Other: _____

ABILITY TO LISTEN & RECEIVE FEEDBACK
How open are you to feedback from others?

1 2 3 4 5

Not Open — Very Open

PREFERRED LEARNING STYLE
Check all that apply.

- ☐ Visual (seeing / watching)
- ☐ Verbal (listening / speaking)
- ☐ Experiential (doing / hands-on)
- ☐ Written (reading / writing)
- ☐ Other: _____

COGNITIVE CONCERNS
Check any that apply.

- ☐ None
- ☐ Memory / Recall
- ☐ Processing Speed
- ☐ Organization
- ☐ Executive Functioning
- ☐ Language / Word Finding
- ☐ Other: _____

ATTENTION / CONCENTRATION
How would you describe your ability to focus?

1 2 3 4 5

Very Difficult — Very Good

LITERACY / READING COMFORT
How comfortable are you with reading and written materials?

1 2 3 4 5

Very Difficult — Very Comfortable

TIME MANAGEMENT
How would you rate your ability to manage time and meet deadlines?

1 2 3 4 5

Very Difficult — Very Good

DAILY ROUTINE
How consistent is your daily routine?

1 2 3 4 5

Very Inconsistent — Very Consistent

SLEEP SCHEDULE

Typical bedtime: _____

Typical wake time: _____

Average hours of sleep: _____

EXERCISE
How often do you exercise?

- ☐ Daily
- ☐ 3–5 times per week
- ☐ 1–2 times per week
- ☐ Rarely / Never

Type of exercise: _____

NUTRITION
How would you describe your eating habits?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Any dietary restrictions or allergies? _____

DIGITAL / PHONE & SOCIAL MEDIA HABITS
How would you describe your use of phone and social media?

- ☐ Minimal
- ☐ Moderate
- ☐ High / Frequent

Do you feel it impacts your focus or mood?

- ☐ Yes
- ☐ No

If yes, how? _____

HOBBIES & INTERESTS
What activities bring you joy, energy, or a sense of purpose?

_____

_____

VOCATIONAL INTERESTS
What kind of work or career interests you?

_____

_____

_____

_____

SCHOOL / EDUCATIONAL GOALS
What are your current or future educational goals?

_____

_____

_____

_____

FAITH OR MINDFULNESS PRACTICES
Do you engage in any spiritual, faith-based, or mindfulness practices?

- ☐ Yes
- ☐ No

If yes, please describe: _____

_____

WHAT TYPE OF GROUP PROCESS HELPS YOU ENGAGE BEST?

WHAT OFTEN PULLS YOU AWAY FROM RECOVERY?

BARRIERS THAT MAY INTERFERE WITH ATTENDANCE OR PARTICIPATION
Check all that apply.

- ☐ Transportation
- ☐ Work Schedule
- ☐ Childcare / Family Responsibilities
- ☐ Housing Instability
- ☐ Mental Health
- ☐ Physical Health
- ☐ Financial
- ☐ Other: _____

The information provided helps us create a supportive and effective treatment experience.
All responses are confidential.

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RELEASES, POLICIES & APPLICANT SIGNATURES

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By signing below, I acknowledge that I have read, understand, and agree to the following statements.

☐ **CONSENT TO TREATMENT:** *I voluntarily consent to participate in the Partial Hospitalization Program (PHP) at Fellowship House. I understand that treatment may include individual therapy, group therapy, psychiatric services, case management, and other clinical services as deemed appropriate by the treatment team.*

☐ **RELEASE OF INFORMATION PERMISSION:** *I authorize Fellowship House to obtain, use, and disclose information about me as necessary for treatment, care coordination, insurance purposes, and continuity of care. I understand I may revoke this authorization in writing at any time, except to the extent action has already been taken.*

☐ **ACKNOWLEDGEMENT OF PROGRAM EXPECTATIONS:** *I have received and reviewed the program rules and expectations. I agree to actively participate in treatment and abide by all program policies, including respectful conduct and zero tolerance for violence, threats, or substance use within the program.*

☐ **ATTENDANCE EXPECTATIONS:** *I understand that consistent attendance is essential to treatment progress. I agree to notify the program in advance if I am unable to attend and understand that repeated absences may impact my continued participation.*

☐ **MEDICATION DISCLOSURE:** *I agree to provide an accurate and complete list of all medications, supplements, and over-the-counter products I am taking. I will inform the treatment team of any changes.*

☐ **URINE DRUG SCREEN ACKNOWLEDGEMENT:** *I understand that urine drug screens may be conducted randomly as part of treatment. I consent to testing and understand that results will be used to support my care.*

☐ **PHOTOGRAPHY / COMMUNICATION PREFERENCE:** *I prefer the following regarding photos or communications that may include my image for program-related purposes (newsletters, website, social media, etc:):*

☐ I GIVE PERMISSION ☐ I DO NOT GIVE PERMISSION ☐ PLEASE ASK EACH TIME

☐ **FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT:** *I understand that I am responsible for any co-pays, deductibles, or services not covered by insurance. I agree to promptly communicate with Fellowship House regarding any financial concerns that may affect my care.*

☐ **BELONGINGS / VALUABLES ACKNOWLEDGEMENT:** *I understand that Fellowship House is not responsible for lost, stolen, or damaged personal belongings. I agree not to bring weapons, illegal substances, or items that could compromise the safety of others.*

☐ **EMERGENCY CONTACT PERMISSION:** *I authorize Fellowship House to contact the emergency contact(s) I provide in the event of a medical or psychiatric emergency.*

☐ **TELEHEALTH / DIGITAL COMMUNICATION ACKNOWLEDGEMENT (IF APPLICABLE):** *I understand that aspects of my care may be delivered via telehealth or secure digital communication. I understand the risks and limitations of telehealth and consent to its use as part of my treatment when clinically appropriate.*

I understand that the information provided in this application and during treatment will be used to support clinical assessment, treatment planning, and coordination of care.

APPLICANT SIGNATURE _____ DATE _____

STAFF WITNESS (PRINT NAME) _____ STAFF WITNESS SIGNATURE _____

RELATIONSHIP TO APPLICANT (IF ANY) _____

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OFFICE USE ONLY:

Initial Case Conceptualization

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1. PRESENTING PROBLEM	**2. PRECIPITATING FACTORS**	**3. INTERNAL MOTIVATIONS**	**4. EXTERNAL MOTIVATIONS**
5. STAGE OF CHANGE ☐ Precontemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance ☐ Relapse	**6. STRENGTHS / PROTECTIVE FACTORS**	**7. RELAPSE RISKS**	**8. BARRIERS TO TREATMENT**
9. MENTAL HEALTH OBSERVATIONS	**10. BEHAVIORAL OBSERVATIONS**	**11. GROUP-FIT CONSIDERATIONS**	**12. RECOVERY CAPITAL SUMMARY**
13. CBT FORMULATION CUES	**14. MOTIVATIONAL INTERVIEWING FOCUS**	**15. TRAUMA-INFORMED CONSIDERATIONS**	**16. FAMILY / SYSTEMS CONSIDERATIONS**

17. TREATMENT PRIORITIES FOR FIRST 30 DAYS

18. RECOMMENDED LEVEL OF CARE ☐ PHP (Recommended) ☐ IOP (Step-Down) ☐ Higher Level of Care ☐ Other: _____	**19. RECOMMENDED GROUP DYNAMICS** ☐ Standard Groups ☐ Process / Insight-Oriented ☐ Skills-Focused ☐ Trauma-Informed ☐ Other: _____	**20. DISCHARGE RISKS** ☐ High ☐ Moderate ☐ Low Notes: _____	**21. INITIAL CLINICAL IMPRESSION**

22. INITIAL DISPOSITION

☐ **ACCEPTED TO PHP**
Start Date: _____

☐ **REFERRED ELSEWHERE**
Referral To: _____
Reason: _____

☐ **NEEDS FURTHER ASSESSMENT**
Next Steps: _____

PRIMARY CLINICIAN Name: _____ Credentials: _____ Signature: _____	**SUPERVISOR REVIEW** Name: _____ Credentials: _____ Signature: _____	**DATE** Assessment Date: _____ Supervisor Review Date: _____