



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

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 believes that people have the right to receive services no matter their age, color, ethnic background, spiritual belief, gender identity, sexual orientation, presence or absence of children, genetic information, socioeconomic status, language, political affiliation, race, religion, national origin, or type of disability. Caramore Community, Inc. does not discriminate on the basis of such characteristics 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

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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

Having a criminal history does not stop you from receiving Caramore Services

Have you ever been convicted in court? Yes No

Have you ever been arrested? Yes No

If yes, please explain and give dates:

Convictions	Dates

Do you have pending charges? Yes No

Drug History

Having a substance use history does not stop you from receiving Caramore Services

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.*)

- | | |
|---|---|
| <input type="checkbox"/> No Attendance | <input type="checkbox"/> 1–3 times (<i>less than one time per week</i>) |
| <input type="checkbox"/> 4–7 times (<i>about one time per week</i>) | <input type="checkbox"/> 8–15 times (<i>2-3 times per week</i>) |
| <input type="checkbox"/> 16 – 30 times (<i>4 or more per week</i>) | <input type="checkbox"/> 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 application shall release Caramore from any and all liability for any claim or damage resulting therefrom.

Signed: _____
Applicant

Date: _____

Signed: _____
Person completing application & relationship to applicant

Date: _____

(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.

- | | |
|---|---|
| <input type="checkbox"/> Copy of Photo ID | <input type="checkbox"/> Copies of relevant Medical Records |
| <input type="checkbox"/> Copy of Social Security Card | <input type="checkbox"/> Copy of SSI or SSDI Benefits Letter (if applicable) |
| <input type="checkbox"/> Copy of Medicaid/Medicare Card or Private Insurance Policy (if applicable) | <input type="checkbox"/> Original Signed Copy of VR Application (if applicable) |

Caramore does not discriminate on the basis of age, color, ethnic background, spiritual belief, gender identity, sexual orientation, presence or absence of children, genetic information, socioeconomic status, language, political affiliation, race, religion, national origin, or type of disability.