

1059 Main Street
P.O. Box 30035
Worcester, MA 01603



Jeremiah's Inn

Helping people through our social model
recovery program and nutrition center.

Phone: (508) 755-6403
Fax: (508) 793-9568
E-mail: info@jeremiahsinn.com

Application Form		P.O. Box 30035 1059 Main Street, Worcester, MA 01603-0035 FAX 508.793.9568 PHONE 508.775.6403	
Last Name:	First Name:	Middle Initial:	
Alias:			
Referral Information			
Referred by (agency, institution):	Contact Person/Case Mgr.:	Phone Number(area code and ext):	
Date Admitted to Your Agency	Use of ASAM 3.1 Yes <input type="checkbox"/> No <input type="checkbox"/>		
Have you been admitted here before? Yes <input type="checkbox"/> No <input type="checkbox"/>		If so, when:	

Demographic Information			
Male <input type="checkbox"/> Transgender <input type="checkbox"/>	Height:	Weight:	
Massachusetts Resident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Primary Language:	Are you currently homeless? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Last Known Residence:	Criteria Met? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Date of Birth:	Social Security Number:		
Status: Single <input type="checkbox"/> Married/Partnered <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed <input type="checkbox"/>	Family: Children? Yes <input type="checkbox"/> No <input type="checkbox"/> How many? _____ Ages: _____ Do you have custody? Yes <input type="checkbox"/> No <input type="checkbox"/> Physical <input type="checkbox"/> Legal <input type="checkbox"/> If not, who has custody? _____ Do you have visitation rights? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Education (last grade completed):	Occupation:	Date last worked:	
Specific Needs (i.e. dietary issues, hearing impairment, allergies, etc.):			
Do you have access to a photo ID? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please bring it with you.	Forms of Identification:		

Legal History	
Probation <input type="checkbox"/> Parole <input type="checkbox"/> Case Pending <input type="checkbox"/> Outstanding Warrants <input type="checkbox"/> Restraining Order <input type="checkbox"/> Other <input type="checkbox"/> _____ Describe:	
Attorney:	Phone:
Probation/Parole Officer:	Phone:
Court:	Phone:

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Criminal History

Have you ever been convicted of any of the following? Yes No

Arson Murder Rape Kidnapping Assault Sex Crimes Other: _____

Outcome:

Psychiatric History

Have you ever been diagnosed with a psychiatric illness?
Yes No

Psychiatric Diagnosis/Diagnoses:

Psychiatric Hospitalizations: Yes No

When:

Where:

How many:

Prescribed Medication: Yes No

Prescriber:
Phone:

Medication	Dose	Last Taken

Have you stopped taking any medication in the last 6 months
for any reason?
Yes No

Why?

Are you or have you ever been physically abusive towards
yourself?
Yes No

Are you or have you ever been abusive towards others?
(physically/emotionally/sexually)
Yes No

Are you or have you ever been a victim of violence? Yes No

If you have been a victim, please elaborate:

History of Suicide Attempts Yes No

When:

Outcome:

Substance Use Information

Last Date used:
(any substance)
Number of treatments:
Detox
Outpatient

What Last Used:

Drug(s) of Choice:

Do you attend recovery meetings?

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Methadone <input type="checkbox"/>	Longest Clean Time:	How long ago?
Drunk Driver <input type="checkbox"/>		
Residential <input type="checkbox"/>		
Other <input type="checkbox"/>		
Date(s) of Treatment	Where	Outcome(s)
Do you use tobacco? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you interested in quitting? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Any other addictions?		
Intravenous Drug Use? Yes <input type="checkbox"/> No <input type="checkbox"/>	When:	

Substance Use Information (cont.)				
	Age of First Use	Last Use	Frequency	Usual Route
Alcohol				
Cocaine				
Crack				
Marijuana/Hashish				
Heroin				
Non Rx Methadone				
Other Opiates				
PCP				
Other Hallucinogens				
Methamphetamine				
Other Amphetamines				
Other Stimulants				
Benzodiazepines				
Other Tranquilizers				
Barbiturates				
Other Sedatives/Hypnotics				
Inhalants				
Over-the-Counter				
Ecstasy				
Caffeine				
Other				

In Case of Emergency Notify (obtain release with signature)			
Name:		Phone:	
Address:		Relationship:	

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Military History			
Have you served? Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Enlistment Date:		Discharge Date:	
What branch of service were you in?		Where:	
		Were you involved in armed conflict? Yes <input type="checkbox"/>	
		No <input type="checkbox"/>	
What type of discharge did you receive?			

Medical History	
Primary Care Physician: None <input type="checkbox"/>	Phone:
Date of last physical exam:	Date of last TB test:
Date of last Hepatitis C Test:	Result of last TB test:
Diagnosed Condition(s):	Prescription Medication(s):
If no physical exam in previous 12 months one must be scheduled within 30 days of admission.	

Financial Information	
Current Source of Income:	Amount: \$ _____ Wages <input type="checkbox"/>
	Unemployment <input type="checkbox"/>
SSI <input type="checkbox"/> SSDI <input type="checkbox"/> Worker's comp <input type="checkbox"/> VA <input type="checkbox"/> Savings <input type="checkbox"/> Other _____ <input type="checkbox"/> None <input type="checkbox"/>	

Parenting Information		
		Number of Children:
		Ages
		Genders
DCF Involvement? Yes <input type="checkbox"/> No <input type="checkbox"/> Date:		
Worker Name:		
DCF Office:		
Worker Phone:		Are there custody issues? Yes <input type="checkbox"/>
Planned Reunification? Yes <input type="checkbox"/> No <input type="checkbox"/>		No <input type="checkbox"/>
		Explain:

Please complete the following if applicable	
Probation _____	until(date): _____
Parole _____	until(date): _____
Wrap-up _____	wrap date: _____

Statement of Applicant	
I hereby certify that all questions above have been answered truthfully.	
Name: _____	Date: _____

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Invitation to Self-Identify

Introduction: In order to guarantee that all applicants/residents receive the highest quality of care and to ensure the best services possible, we collect data on race and ethnicity. Please select the category or categories that best describes your background. If you choose not to self-identify at this time the federal government allows us to determine this information by visual survey and/or other available information.

1. What is your ethnicity? (You can specify one or more)

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> African (Specify, _____) | <input type="checkbox"/> African American | <input type="checkbox"/> American |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Brazilian | <input type="checkbox"/> Cambodian |
| <input type="checkbox"/> Caribbean Islander, (specify, _____) | <input type="checkbox"/> Chinese | <input type="checkbox"/> Cape Verdean |
| <input type="checkbox"/> Cuban | <input type="checkbox"/> Dominican | <input type="checkbox"/> Columbian |
| <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Haitian | <input type="checkbox"/> Filipino |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Laotian | <input type="checkbox"/> Honduran |
| <input type="checkbox"/> Middle Eastern (Specify, _____) | <input type="checkbox"/> Mexican, Mexican American, Chicano | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Russian | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Puerto Rican |
| <input type="checkbox"/> Salvadoran | <input type="checkbox"/> Vietnamese | |
| <input type="checkbox"/> Other (Specify, _____) | <input type="checkbox"/> Unknown/not specified | |

2. What is your race? (You can specify one or more)

American Indian/Alaska Native, a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. (Specify tribal nation _____)

Asian, a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Black, a person having origins in any of the black racial groups of Africa.

Hispanic/Latino/Black **Hispanic/Latino/White** **Hispanic/Latino/Other**, a person of Cuban, Mexican, Chicano, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.

Native Hawaiian or other Pacific Islander (specify _____), a person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

White

Other (specify _____)

Unknown/not specified

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3. What languages do you speak? Check as many as applicable. Place 1 next to your primary language.

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Somali | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Albanian |
| <input type="checkbox"/> Cape Verdean Creole | <input type="checkbox"/> Chinese (specify dialect_____) | |
| <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Russian | <input type="checkbox"/> Khmer |
| <input type="checkbox"/> Other (specify_____) | | <input type="checkbox"/> Vietnamese |

4. What language do you prefer to read health-related materials?

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Somali | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Albanian |
| <input type="checkbox"/> Cape Verdean Creole | <input type="checkbox"/> Chinese (specify dialect_____) | |
| <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Russian | <input type="checkbox"/> Khmer |
| <input type="checkbox"/> Other (specify_____) | | <input type="checkbox"/> Vietnamese |

5. Do you consider yourself as having a disability?

- Yes No

6. Are you currently on a Medically Assisted Treatment Program

- Yes No

7. Sexual Orientation: Bi-Sexual Heterosexual Gay A-Sexual Transgender

Signature Optional: _____

Date: _____

Equal Opportunity Employment & Diversity Statement

Jeremiah's Inn is committed to providing a workplace that includes people of diverse backgrounds and fully utilizes their talents to achieve its mission. Jeremiah's Inn believes that a diverse workforce and inclusive workplace culture enhances the performance of our organization and our ability to fulfill the agency's mission.

Jeremiah's Inn is committed to being an organization of individuals who treat coworkers, clients, applicants and vendors with consideration and respect. Jeremiah's Inn is committed to fostering and supporting a workplace culture inclusive of all people regardless of their race, color, ethnicity, national origin, ancestry, gender, sexual orientation, socio-economic status, marital status, veteran status, age, physical or mental disability, political affiliation, religious beliefs or any other non-merit fact, so that all employees feel included, equal valued and supported.

Jeremiah's Inn seeks to recruit persons of diverse backgrounds and support the retention and advancement of diverse persons within the agency. Jeremiah's recognizes that the diverse knowledge, perspectives, ideas, experiences and qualities of all employees are critical to our success and the success of our clients. In accordance with law, all action relating to an individual's employment (e.g. hiring, rate of pay, training opportunities, promotions, performance evaluations, termination) are made according to the individuals capabilities and accomplishments.

The leadership and employees of Jeremiah's are committed to achieve and support the ongoing commitment to a diverse and inclusive workplace. It is the duty of every employee to create an environment conducive to our non-discrimination policies. Any employee found to have acted in violation of this policy will be subject to appropriate disciplinary action, up to and including termination.

Disability Access Notice

All of the programs, services and benefits at Jeremiah's Inn are available on an equal basis to eligible persons with disabilities.

In the event that you have a disability that you would like us to accommodate, it is important for you to let us know as soon as possible.

For clients in the residential program, we encourage you to indicate whether you have a disability for which you are requesting an accommodation on the Residential Program Application form. Also, we encourage you to discuss your request for an accommodation at your interview for placement in the Residential Program. Jeremiah's Inn will attempt to provide you a reasonable accommodation.