



The Crossroads  
805 Tijeras  
Albq, NM 87102  
Ph: 505-242-1010  
Fax: 505-242-1551

Maya's Place  
640 Grove SE  
Albq, NM 87108  
Ph: 505-266-0110  
Fax: 505-266-0998

Hope House  
720 Vassar NE  
Albq. NM 87106  
Ph: 505-232-6611  
Fax: 505-232-9364

The Pavilions  
735 Don Pasqual  
Los Lunas, NM 87031  
Ph: 505-865-2249  
Fax: 505-865-4134

*Please submit your application directly to the program you are applying to.  
Please visit [www.crossroadsabq.org](http://www.crossroadsabq.org) for more information.*

**Basic Client Information**

1. Legal Name: \_\_\_\_\_ Phone: \_\_\_\_\_
2. Date of Birth: \_\_\_\_\_ 3. Age Today \_\_\_\_\_
4. Social Security Number : \_\_\_\_\_
5. Emergency Contact Person:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_
6. Current Marital Status (circle one): Married Separated Divorced Widowed  
Never Married
7. Current Companion: \_\_\_\_\_ Location: \_\_\_\_\_
8. Where were you born and raised? \_\_\_\_\_
9. How long have you lived in Albuquerque? \_\_\_\_\_
10. Are you a veteran? Yes No
11. Will any children be coming to live with you if you enter the Crossroads program? (This does not apply to the residential programs.) Yes\_\_\_\_ No \_\_\_\_\_

12. List the names, ages and locations of your children:

Name	Age	Location	With Whom?
_____			
_____			
_____			

13. Do you have custody of your children? Yes No Explain:  
\_\_\_\_\_  
\_\_\_\_\_

14. What belongings do you have? (Examples: car, personal items, clothing, other property, house/trailer/condo):  
\_\_\_\_\_

15. Which forms of identification do you have (circle)?  
SS Card Birth Certificate License/State I.D

16. What is your religion/spiritual practice if any? \_\_\_\_\_

17. How would you describe your ethnic/racial background? \_\_\_\_\_

**Legal Information**

1. Are you currently incarcerated? Yes No
2. If yes, where are you incarcerated? \_\_\_\_\_
3. If yes, what are you in jail/prison for? \_\_\_\_\_
4. What was the date you were incarcerated this time? \_\_\_\_\_
5. When do you expect to be released? \_\_\_\_\_
6. Next court date / what for? \_\_\_\_\_
7. Are you asking for reconsideration of sentence? Yes No

8. What are your current legal charges other than probation violation?

\_\_\_\_\_

9. Explain how you received these charges and when? \_\_\_\_\_

\_\_\_\_\_

10. Are you on probation? Yes No How long? \_\_\_\_\_

11. Are you on parole? Yes No How long? \_\_\_\_\_

12. Probation/parole officer name/phone (if assigned): \_\_\_\_\_

13. Name/phone of attorney/public defender/case worker? \_\_\_\_\_

14. To your knowledge, do you have any open arrest warrants? \_\_\_\_\_

15. How many times have you been in jail/prison? \_\_\_\_\_

16. Who referred you to the program?

\_\_\_\_\_

17. What other prior charges/sentences have you had?

\_\_\_\_\_

\_\_\_\_\_

18. Have you had any disciplinary actions in jail/prison?

\_\_\_\_\_

\_\_\_\_\_

19. Have you ever been affiliated with a gang? If so, where and when?

\_\_\_\_\_

\_\_\_\_\_

### Medical and Health History

1. What health insurance do you have (if any)? \_\_\_\_\_

2. Do you have a primary care physician?

Name

Address

Phone

\_\_\_\_\_

3. When/where was your last physical exam? \_\_\_\_\_

4. Last mammogram: \_\_\_\_\_ Last Pap smear: \_\_\_\_\_

5. Known Health Problems/Conditions: \_\_\_\_\_

6. Have you been tested for the following (when, where, results)?

HIV \_\_\_\_\_

Hepatitis \_\_\_\_\_

Tuberculosis (TB) \_\_\_\_\_

7. What medications do you currently take?

Medication

Who Prescribed?

When?

What for?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. List hospitalizations.

When?

Where?

What for?

\_\_\_\_\_

\_\_\_\_\_

9. Are you in pain today? Yes No When did it start? \_\_\_\_\_

10. How would you describe your daily nutrition (circle)? Good Fair Poor

11. Do you have special nutritional needs/follow up needed? \_\_\_\_\_

12. Is there any chance that you may be pregnant right now? Yes No

Housing

1. Where did you live before jail and/or prison? Please list your address/location/site

\_\_\_\_\_

2. Where do you live now? How long have you lived there?

\_\_\_\_\_

3. What city and/or where would you like to live after you complete the program?

\_\_\_\_\_

4. Are you homeless?        Yes    No

5. Have you been homeless for the past consecutive twelve months?    Yes    No

6. Have you had four or more episodes of homelessness in the past three years?    Yes    No

7. Please list all the times you were homeless in the last three years.

Date(s)	Shelter/Site/ Location
_____	_____
_____	_____
_____	_____
_____	_____

8. Do you need protection from anyone when you get out?    Yes    No

9. Are there places you need to stay away from in order to stay safe/clean/sober?    Yes    No

10. Where did you do drugs? \_\_\_\_\_

11. Have you ever been involved in street/sex work? If so, where?

\_\_\_\_\_

12. Do you owe anyone money (credit cards, gas, electric, phone, student loans, payday loans, drug dealers, etc.)?

Yes        No                      How much total do you owe? \_\_\_\_\_

13. Have you ever been evicted from an apartment/ house?    Yes    No

14. Do you owe money to Section 8 housing? \_\_\_\_\_

**Education and Employment**

1. Can you read and write? Yes    No

2. What is the highest level of education you have received? \_\_\_\_\_

3. Where did you go to school? \_\_\_\_\_

4. What was your favorite subject? \_\_\_\_\_

5. Briefly describe any job training, certifications, licenses, or job skills you have. **Please include any certificates and/or programming you have completed while incarcerated.**

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6. Briefly describe what jobs you have held, for how long, and your rate of pay?

Job	How Long	Pay Rate
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. What is your current income? \_\_\_\_\_

8. Do you receive Social Security Benefits? Yes    No

If yes, how much per month? \_\_\_\_\_

9. Do you receive food stamps/welfare? Yes    No

If yes, how much per month? \_\_\_\_\_

10. Do you receive child support? Yes    No

If yes, how much per month? \_\_\_\_\_

**Mental Health History**

1. Have you received mental health or psychiatric treatment in the past? Yes No

Where

When

What for?

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2. Are you currently taking any mental health medications? Yes No

Please list: \_\_\_\_\_

3. Have you been hospitalized for a mental health/psychiatric condition? Yes No

Describe where/when what for: \_\_\_\_\_

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4. Do any family members have a mental health or psychiatric history? Yes No

Explain: \_\_\_\_\_

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5. Have you been involved in or witnessed any violent incidents? Briefly describe:

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6. Have you experienced physical abuse as a child? Yes No As an adult? Yes No

7. Have you experienced sexual abuse as a child? Yes No As an adult? Yes No

8. Have you experienced emotional abuse as a child? Yes No As an adult? Yes No

9. Have you ever attempted to harm yourself or harmed yourself? Yes No

10. Have you ever attempted to harm or have you harmed **someone else**? Yes No

**History of Alcohol and Substance Use**

1. Complete the following chart to tell us about your history of substance use.

	Age at First Use	How Many Years?	Used in Last 30 Days?
Alcohol			
Marijuana			
Cocaine/Crack			
Heroin			
Opioids (Pain Pills)			
Benzos (Tranquilizers)			
Amphetamines/Meth			
Inhalants			
Tobacco			
Spice			

2. What is the longest amount of time you have been clean and sober? \_\_\_\_\_

3. When did this period of sobriety occur? \_\_\_\_\_

4. Describe your clean and sober support system, if any? \_\_\_\_\_

\_\_\_\_\_

4. Briefly describe your family's history of alcohol or substance abuse: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Prior to incarceration/homelessness, were you living with someone who abused alcohol/drugs? Yes No

Explain: \_\_\_\_\_

6. Which of the following have you experienced related to your drinking/drug use?

Blackouts or other periods of memory loss

Injury to your head

Convulsion, seizures, or DTs

Hepatitis or other liver problems

Depression and/or anxiety when not using

Used needles to shoot drugs

Lost your temper or gotten into arguments/fights

Other withdrawal symptoms (explain): \_\_\_\_\_



7. Briefly describe problems with family/friends related to your use of alcohol/drugs:

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8. What legal problems do you have related to your use of alcohol/drugs:

9. What alcohol/drug treatment have you participated in the past:

Where?

When?

How Long?

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10. Tell us something about what you have learned about why you use alcohol/drugs, what progress you have made in recovery from substance use, and what you see as the next steps in your recovery.

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Initial Treatment Plan/Goals

1. I would like help with accomplishing to following goals:

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2. What specific help will you need to accomplish your goals?

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3. What are qualities you have that have helped you get through life (Strengths)?

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4. What has prevented you from achieving your goals in the past (Barriers)?

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I understand that I am providing this information voluntarily to show my interest in the programs of Crossroads for Women. I understand that does not guarantee me an interview or acceptance into the program I am applying for. An interview may be scheduled based on review of the application and space availability in the programs.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Crossroads  
for Women

**AUTHORIZATION FOR THE RELEASE OF  
CONFIDENTIAL & PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, authorize  
(Name of patient)

The Crossroads to:

\_\_\_\_\_ Obtain the following protecting health information from, and/or

\_\_\_\_\_ Disclose the following protected health information to:

\_\_Case Manager and/ or probation officer \_\_\_\_\_ the  
(Name of person or organization to which disclosure is to be made)

following information: related to assessing my application for the Crossroads For  
Women’s programs.

(Specific nature of the information, as limited as possible)

\_\_\_\_\_  
\_\_\_\_\_

The purpose of the disclosure authorization herein is to: coordinate services\_\_\_\_\_  
(Specific purpose of disclosure)

\_\_\_\_\_

I understand that my records are protected under the Federal regulations governing  
Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and that any  
information that identifies me as a patient in an alcohol or other drug abuse program  
cannot be disclosed without my written consent except in limited circumstances as  
provided for in these regulations.

I understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure.

My initials and signature below authorize the release of health care information relating to testing, diagnosis or treatment for:

- \_\_\_\_\_ HIV/AIDS
- \_\_\_\_\_ Mental Health
- \_\_\_\_\_ Alcohol/Drug Services

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

\_\_\_\_\_ 1 year from today's date \_\_\_\_\_  
(Specification of the date, event, or condition upon which this consent expired).

I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrolling or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it signed.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Signature of patient, guardian or authorized Representative, when required