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 for more information.

Basic Client Information

1. Legal Name: ___________________________________ Phone: ____________
2. Date of Birth: ____________________
3. Age Today __________
4. Sex Assigned at Birth: Female Male
5. Gender Identity: Circle as many as many as are appropriate

Female Non-Binary

Male Agender

Transgender Other (specify)______________________________

Female to Male

Male to Female

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 incarnated 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?

____

____

<u>Medical and Health History</u>

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

<u>Housing</u>

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? ________________________________

<u>Education and Employment</u>

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.**

____

____

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?

____

____

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: ____

____

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

Explain: ____

____

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

____

____

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

<u>History of Alcohol and Substance Use</u>

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:

____

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?

____

____

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.

____

____

____

____

____

____

____

____

Initial Treatment Plan/Goals

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

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

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

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

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: ____________________

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