

**M.A.S.H. Services of the Bluegrass, Inc.**  
**TRANSITIONAL HOUSING PROGRAM**  
540 W Third Street, Lexington, KY 40508

❖ Please save the application onto your computer, type in the information and email it to [Khristy.Parks@metrogrouphomes.com](mailto:Khristy.Parks@metrogrouphomes.com), or print the application and mail it to the above address.

**CLIENT APPLICATION/INFORMATION**

Date \_\_\_\_\_

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Last Name	First Name	Middle Name
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Present Address	City	State	ZIP
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_____	____/____/____	_____	_____
Phone Number	Birthdate	Social Security #	

*\*Please check one of the following:*

Male \_\_\_\_\_ Female \_\_\_\_\_

Asian \_\_\_\_\_ Black \_\_\_\_\_ Hispanic \_\_\_\_\_ White \_\_\_\_\_ Other \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ EyeColor \_\_\_\_\_ Hair Color \_\_\_\_\_ Religion \_\_\_\_\_

Scars/Identifying Marks: \_\_\_\_\_

Disabilities: \_\_\_\_\_

Allergies: \_\_\_\_\_

Please List All Medication / Prescriptions:

Med Name:	Prescribing DR:
_____	_____
_____	_____
_____	_____
_____	_____

Referred to the Transitional Housing Program By:  
(Please Check One)

Metro Group Home / MASH Drop Inn \_\_\_\_\_ Volunteers of America \_\_\_\_\_ Other \_\_\_\_\_

Self \_\_\_\_\_  
Police \_\_\_\_\_

Social Worker \_\_\_\_\_  
Friend/Family \_\_\_\_\_

Probation Officer \_\_\_\_\_  
School \_\_\_\_\_ Community Agency \_\_\_\_\_

**Do you have any children?** Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Name of Child                      M/F                      \_\_\_\_/\_\_\_\_/\_\_\_\_  
Circle                                      Birthdate                      Social Security #

\_\_\_\_\_  
Name of Child                      M/F                      \_\_\_\_/\_\_\_\_/\_\_\_\_  
Circle                                      Birthdate                      Social Security #

\_\_\_\_\_  
Name of Child                      M/F                      \_\_\_\_/\_\_\_\_/\_\_\_\_  
Circle                                      Birthdate                      Social Security #

Is (are) your child(ren) in the custody of the State?

\_\_\_\_\_  
Yes                                      No

\*Please list child.

Scars/ Identifying Marks: \_\_\_\_\_

\_\_\_\_\_

Disabilities: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

Please List All Medications/ Prescriptions:

\*Please list child.

\_\_\_\_\_  
Medication Name

\_\_\_\_\_  
Prescribing Doctor

\_\_\_\_\_  
Medication Name

\_\_\_\_\_  
Prescribing Doctor

\_\_\_\_\_  
Medication Name

\_\_\_\_\_  
Prescribing Doctor

## EDUCATIONAL HISTORY

Last School Attended \_\_\_\_\_

City \_\_\_\_\_

Grade \_\_\_\_\_

*Please Check One:*

Attending \_\_\_\_\_

Dropped Out \_\_\_\_\_

Expelled \_\_\_\_\_

Suspended \_\_\_\_\_

Not Enrolled \_\_\_\_\_

Graduated \_\_\_\_\_

*Educational interests: Check all that Apply:*

GED Training \_\_\_\_\_

Vocational School \_\_\_\_\_

College \_\_\_\_\_

Job Skill Training \_\_\_\_\_

Other \_\_\_\_\_

**Career / Vocational Interests and Goals:** \_\_\_\_\_

**Goals for the Future:** \_\_\_\_\_

## EMPLOYMENT HISTORY

\_\_\_\_\_  
**Name of Previous Employer**

**Job Skills**

\_\_\_\_\_  
Address

\_\_\_\_\_  
Position Held

\_\_\_\_\_  
Dates Employed

\_\_\_\_\_  
**Name of Previous Employer**

**Type of work you enjoy**

\_\_\_\_\_  
Address

\_\_\_\_\_  
Position Held

\_\_\_\_\_  
Dates Employed

\_\_\_\_\_  
**Name of Previous Employer**

**Realistic jobs you want**

\_\_\_\_\_  
Address

\_\_\_\_\_  
Position Held

\_\_\_\_\_  
Dates Employed

## **Mental Health History**

1. Has client had prior thoughts of suicide? \_\_\_\_\_  
When, How often, Etc...? \_\_\_\_\_
2. Does client presently have thoughts of suicide? \_\_\_\_\_  
What precautions are being taken? \_\_\_\_\_
3. Have there been previous suicide attempts? \_\_\_\_\_  
Most recent attempt, What method, What happened/helped? \_\_\_\_\_  
\_\_\_\_\_
4. Has client acted out violently or aggressively? \_\_\_\_\_  
\_\_\_\_\_
5. Has the client been hospitalized for psychiatric reasons? \_\_\_\_\_  
When, where, how long? \_\_\_\_\_
6. Has client previously received counseling? \_\_\_\_\_  
How often, with whom? \_\_\_\_\_
7. Is client currently receiving mental health counseling?  
How often, with whom? \_\_\_\_\_
8. Has client had a psychiatric/psychological evaluation? \_\_\_\_\_  
Where, when, with whom? \_\_\_\_\_
9. What are any current mental health diagnoses? \_\_\_\_\_  
\_\_\_\_\_

**FAMILY BACKGROUND**

**Client Father Figure**

**Client Mother Figure**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

- \_\_\_\_ Biological
- \_\_\_\_ Adoptive
- \_\_\_\_ Stepfather
- \_\_\_\_ Other Relative
- \_\_\_\_ Other Adult Male
- \_\_\_\_ None

- \_\_\_\_ Biological
- \_\_\_\_ Adoptive
- \_\_\_\_ Stepmother
- \_\_\_\_ Other Relative
- \_\_\_\_ Other Adult Female
- \_\_\_\_ None

**Marital Status of Father Figure**

**Marital Status of Mother Figure**

- \_\_\_\_ Divorced
- \_\_\_\_ Married
- \_\_\_\_ Never Married
- \_\_\_\_ # of times Married
- \_\_\_\_ Currently Separated
- \_\_\_\_ Widowed

- \_\_\_\_ Divorced
- \_\_\_\_ Married
- \_\_\_\_ Never Married
- \_\_\_\_ # of times Married
- \_\_\_\_ Currently Separated
- \_\_\_\_ Widowed

**Employment of Father Figure**

**Employment of Mother Figure**

- \_\_\_\_ Full-Time
- \_\_\_\_ Part-Time
- \_\_\_\_ Disabled
- \_\_\_\_ Retired
- \_\_\_\_ Unemployed
- \_\_\_\_ Public Assistance

- \_\_\_\_ Full-Time
- \_\_\_\_ Part-Time
- \_\_\_\_ Disabled
- \_\_\_\_ Retired
- \_\_\_\_ Unemployed
- \_\_\_\_ Public Assistance

Father Figure's Occupation / Employer: \_\_\_\_\_

Mother Figure's Occupation / Employer: \_\_\_\_\_

**Sibling Information (Brothers/ Sisters)**

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

## SOCIAL / CRIMINAL JUSTICE HISTORY

1. Has client ever had a social worker? (Y/N)\_\_\_\_\_

When and name of worker:\_\_\_\_\_

2. Has client ever been placed outside of home? (Y/N)\_\_\_\_\_

Where, when, how long:\_\_\_\_\_

3. Has client ever been arrested? (Y/N)\_\_\_\_\_

What were the charges?\_\_\_\_\_

4. Is client currently on probation / diversion? (Y/N)\_\_\_\_\_

Who is supervising the case?\_\_\_\_\_

5. Has client been in a detention facility? (Y/N)\_\_\_\_\_

Where, when:\_\_\_\_\_

## DRUG AND ALCOHOL EVALUATION

*Check all that have been used in lifetime:*

\_\_\_\_\_Cigarettes

\_\_\_\_\_Smokeless Tobacco

\_\_\_\_\_Beer

\_\_\_\_\_Wine / Wine Coolers

\_\_\_\_\_Liquor

\_\_\_\_\_Inhalants (Glue, Paint, Cleaning Fluid)

\_\_\_\_\_Other\_\_\_\_\_

\_\_\_\_\_Marijuana

\_\_\_\_\_LSD / Acid

\_\_\_\_\_Crack

\_\_\_\_\_Cocaine

\_\_\_\_\_PCP (Angel Dust)

\_\_\_\_\_Heroin

- Has client ever been in drug and alcohol treatment?  
(Y/N)\_\_\_\_\_
- Does client currently smoke?  
(Y/N)\_\_\_\_\_
- Do other family members abuse drugs and/or alcohol?  
(Y/N)\_\_\_\_\_
- When was the last time client was high?\_\_\_\_\_  
What was the drug used?\_\_\_\_\_
- When was the last time client was intoxicated?\_\_\_\_\_  
With what?\_\_\_\_\_

**REFERRAL SOURCE INFORMATION**

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

ZIP

Phone (Office): \_\_\_\_\_

Pager / Cell: \_\_\_\_\_

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*\*I have reviewed the application and to the best of my knowledge everything is correct on the application. I understand that by filling out the application I am not guaranteed entrance into the program, but the opportunity to apply to the program. Upon receipt of the application, the program coordinator will contact you for an interview. After an interview is done, an assessment is performed by the executive director. After this process a decision will be made and you will be notified of the decision.*

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Client Print Name

Date

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Client Signature

Date

**REVIEWED BY:**

**Program Coordinator** \_\_\_\_\_

**Date**