A BABY'S BREATH INTAKE FORM FOR RESIDENCE

ALL INFORMATION IS KEPT IN STRICT CONFIDENCE

First Name_____Last Name_____

Date of Birth_____

Current Address_____

Former Address_____

Cell Phone Number_____

E-Mail Address_____

Social Security Number_____

PERSONAL REFERENCE

Name_____Relationship_____

Address (Street)_____City_____ZIP_____

Phone_____Occupation_____

EMERGENCY CONTACT: Name_____

Address (Street)_____City_____ZIP_____

Phone_____

MARITAL STATUS: Single_____, Married_____Divorced_____

Separated_____, Widowed_____Engaged_____

EDUCATION: High School: Yes_____No_____GED_____Did Not Complete_____

COLLEGE: Yes_____No_____Some_____

Associate Degree_____Full Degree_____Did Not Complete_____

Trade, Diploma, or Certificate Program (list program type)_____

CHILDREN

Child's Name_____ (M/F) Age_____

Child's Name_____ (M/F) Age_____

Child's Name_____ (M/F) Age _____

SPOUSE/BIRTH FATHER

Name_____Involved (yes/ no)

Family aware of pregnancy? (yes / no)

# of births _____ # of abortions_____ # of miscarriages_____

MEDICAL

Are you currently under the care of an Obstetrician? Yes_____ No_____

If yes, Name of Doctor_____

Address_____

Phone_____

Obstetrician's Hospital Affiliation for Delivery_____

Due Date_____

Do you have any special medical problems? _____

_____

_____

Primary Care Doctor Name_____

Address_____

Phone_____

Have you ever been hospitalized for mental illness, drug, or alcohol problems, or received extensive outpatient therapy for above? Yes_____ No_____

If yes, when,_____ where_____ how long_____

Are you still under treatment? Yes_____No_____

If you have a therapist, may we contact him/her?_____

Are you allergic to any medications or insects? Yes_____ No_____ If yes, explain

_____

Would you voluntarily submit to a random drug test? Yes_____No_____

Any outstanding Warrants or Fines? Yes_____No_____ If yes, explain

FINANCIAL

Are you currently employed? Yes_____No_____ Full-time_____Part-time_____

Name of Employer_____Phone_____

Dates of Employment_____Title_____

Former Employer_____

Are you currently receiving Public Assistance? Yes_____No_____, if yes, type_____

Case Number_____Amount_____County_____

It is expected that each resident would offer an agreed amount of her income for household expenses using a formula based on income versus expenses. The amount is not to exceed $150.00 per month. You would also be required to save $50.00 to $100.00 per month based on your income.

Are you agreeable to this? Yes_____No_____

How did you learn about A Baby's Breath?_____

ARE YOU AWARE THAT A BABY'S BREATH HOUSING SOLUTIONS IS NOT RESPONSIBLE FOR HOUSING AFTER THE BIRTH OF YOUR CHILD? Yes_____No_____ POST HOUSING IS YOUR RESPONSIBILITY AND YOU SHOULD BEGIN WORKING ON IT FROM THE DAY YOU MOVE INTO A BABY'S BREATH HOUSING. A BABY'S BREATH WILL ASSIST YOU, WHEN POSSIBLE WITH PNONE NUMBERS FOR YOU TO SECURE HOUSING ON YOUR OWN.

Family reconciliation is important in this area. A Baby's Breath will assist you in this area as well.

I DECLARE THAT THE ABOVE INFORMATION IS AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT ANY FALSE INFORMATION COULD LEAD TO IMMEDIATE DISMISSAL FROM A BABY'S BREATH HOUSING.

PRINT NAME_____

SIGNATURE_____

DATE_____

DIRECTOR SIGNATURE_____

A BABY'S BREATH MEDICAL HISTORY

FOR RESIEDNTS

HAVE YOU EVER HAD:	YES	NO		YES	NO
TUBERCULOSIS	____	____	OVERWEIGHT	____	____
HIGH BLOOD PRESSURE	____	____	KIDNEY DISEASE	____	____
HEART DISEASE	____	____	DIABETES	____	____
DIPHTHERIA	____	____	EPILEPSY	____	____
GERMAN MEASLES	____	____	ALLERGY	____	____
REGULAR MEASLES	____	____	ARTHRITIS	____	____
CHICKEN POX	____	____	ANEMIA	____	____
RHEUMATIC FEVER	____	____	BLOOD DISEASE	____	____
MUMPS	____	____	TUMORS	____	____
VARICOSE VEINS	____	____	SCARLET FEVER	____	____
SHORTNESS OF BREATH	____	____	ULCERS	____	____
PERSISTENT COUGH	____	____	SKIN DISEASE	____	____
HEARING DIFFICULTY	____	____	SWELLING OF ANKLES	____	____
HOARSENESS	____	____	BACK PROBLEMS	____	____
VENEREAL DISEASE	____	____	HEPATITIS A,B, or C	____	____
VISION PROBLEMS	____	____	MISCARRIAGE	____	____
ABORTION	____	____	MENTAL HEALTH	____	____
BLOOD TYPE	____	____	HIV	____	____

EXPLAIN ANY OF THE ABOVE IF NECESSARY_____

_____

AVE YOU EVER HAD ANY SURGERY?_____IF, YES, WHAT AND WHEN_____

A BABY'S BREATH MEDICAL HISTORY

IF YOU HAVE HAD ANOTHER BABY, DID YOU HAVE A SPECIAL PROBLEM DURING THE PREGNANCY, OR DURING DELIVERY, OR DID YOU HAVE A C-SECTION?

_____

HAVE YOU EVER BEEN TESTED FOR H.I.V.? YES_____ NO_____

IF YES, WHAT WERE THE RESULTS? POSITIVE_____ NEGATIVE_____

LIST ANY AND ALL STAYS IN DETOX, REHAB, OR MENTAL HEALTH FACILITIES:_____

_____

_____

_____

ARE THERE ANY OTHER HEALTH PROBLEMS THAT WE SHOULD BE AWARE OF?_____

_____

_____

_____

I DECLARE THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT ANY FALSE INFORMATION COULD LEAD TO IMMEDIATE DISMISSAL FROM A BABY'S BREATH.

_____ _____

SIGNATURE DATE

PROBATION PERIOD FOR RESIDENTS

I, _____ hereby acknowledge that it has been explained to me that I will have a 30 DAY PROBATION PERIOD in which to follow all the rules that I have read and signed.

I understand that my belongings will be examined upon arrival and returned within 24 hours.

I also understand that my FIRST TWO WEEKENDS of my residency at A BABY'S BREATH will be spent at the RESIDENCE (Exception: Employment)

I also understand that in the event I am asked to leave A BABY'S BREATH for the safety and security of myself and other resident, my belongings may be packed up by STAFF MEMBERS.

_____ _____

Signature of Client Date

URINE TEST

I, _____ ACKNOWLEDGE THAT A BABY'S BREATH WILL ADMINISTER A URINE TEST PRIOR TO ADMISSION AS A RESIDENT. IF THE CLIENT FAILS THE TEST, THEY WILL NOT BE ADMITTED.

IN ADDITION, A RESIDENT MAY BE ASKED TO TAKE AN ADDITIONAL URINE TEST IF THE STAFF HAS ANY REASON TO BELIEVE IT IS NECESSARY.

_____ _____

CLIENT'S SIGNATURE DATE

RULES FOR RESIDENTS' VEHICLES AT A BABY'S BREATH

Residents may have a vehicle at A Baby's Breath only if they produce a VALID driver's license and an UP TO DATE insurance card.

UNDER NO CIRCUMSTANCES is a resident with a vehicle ever to drive another resident ANYWHERE AT ANY TIME.

Any infraction of this vehicle rule by a resident will result in an IMMEDIATE DISMISSAL FROM A BABY'S BREATH.

You may park your car in the Senior Center lot across the street between 3:30 PM and 7:30 AM. Please park on the far right hand side of the lot where the signs state "Parking for Sacred Heart".

_____ _____

Signature Date

REGARDING POST HOUSING

I,_____ hereby state that I have been informed both verbally and in writing by the Housing Director and other staff members that , if I am accepted for residency at A baby's Breath, A BABY'S BREATH WILL NOT BE RESPONSIBLE for securing housing for me after the birth of my child.

I understand that returning to A Baby's Breath is considered a PRIVILEGE, and I will be evaluated on a week-to-week basis. This evaluation will be based on my behavior and cooperation with the rules, as I live at A Baby's Breath free of charge.

_____ _____

SIGNATURE DATE

FOUR WEEK STAY RULE

I, _____ am fully aware and have agreed that if I am accepted for temporary housing at A Baby's Breath, I will be allowed to stay at the RESIDENCE for "four weeks" after my child is born. This is providing I am continuing to follow all the Rules of the home.

I am also aware, and agree, that if I have not found permanent housing for myself and my child by the end of four weeks, then I must have another temporary housing plan in place. I agree to discuss tis plan with the Director at least a month before my due date.

I also understand and agree that it is my responsibility to secure permanent housing for myself and my infant by applying to the Red Cross and other Mother/Child residences.

I accept, understand, and agree to these terms as a condition of temporary housing at A baby's Breath during my pregnancy.

_____ _____

SIGNATURE DATE

DISCLAIMER

I have requested and received used baby furniture form A Baby's Breath.

I am aware these items are in used condition. I do not hold A baby's Breath responsible for any defects or breakage of these items.

_____ _____

SIGNATURE DATE

RESIDENTS

REGARDING CONFIDENTIALITY

Confidentiality is a primary ethical and legal concern for all staff and volunteers at A Baby's Breath. The individual residents have a right to privacy. This right must, at all times, be protected during the collection and release of any information. Some material contained in our resident's records is of a highly personal, sensitive and private nature. Improperly releasing records could damage an individual's reputation, position, and have a chilling effect on counseling and communication with residents. Thus, each resident shall know that everything that is learned about her is held in the utmost of confidence and will remain confidential. Information concerning our residents will only be disclosed to family members, parent(s) or guardians, social agencies, hospitals, clinics, medical providers, health providers or physicians as previously authorized, IN WRITING, by the resident. (Information may also be released in the event of suicide by resident, impending homicide by resident, or if a resident engaging in child abuse (by calling CHILD-LINE). It shall be the policy of A Baby's Breath to safeguard any and all data concerning a resident that is collected during her stay at A Baby's Breath. Such information shall be kept in a secured area. A Baby's Breath also recognizes the right of the resident to question the appropriateness of the services they received at A Baby's breath and also the resident's right to refuse intervention services.

_____ _____

Resident's Signature Date

_____ _____

Director's Signature Date