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Staff Only **Please Do Not Write in This Section** **Staff Only**

Resident Move In Date:	**Resident's Baby's Name:**
Resident Move Out Date:	**Resident's Baby's DOB:**
Resident's Due Date:	**Sex of Baby:**

Hannah House Maternity Home
A Program of the Hannah Center of Bloomington, Inc.
808 N. College Ave.
Bloomington, IN 47404
812-334-2662 / 812-334-0104
Fax: 812-334-0026 / info@hannahcenter.org

Thank you for taking the time to fill out our Application for Admission.
PLEASE REMEMBER ALL INFORMATION PROVIDED IS CONFIDENTIAL!
*An applicant providing false information or omitting information may not be considered.
* If you need more space you may enter information on the back of the application.

APPLICATION FOR ADMISSION

Today's Date:_____ Email Address:_____

Name:_____
Last First Middle

Home Address:_____City & State:_____

Zip Code:_____ County:_____ Telephone Number:_____

Present Age:_____ Date of Birth:_____ Place of Birth:_____

Social Security Number:_____

If you are under 18, who has legal custody of you? Name: _____

Address: _____ City & State:_____

Telephone number:_____ Relationship:_____

With whom are you currently living? _____

Relationship:_____ Phone Number:_____

Address:_____ City & State:_____

Who referred you to our agency? _____

NOTES/COMMENTS:

Why do you want to live at Hannah House?

What goals do you hope to accomplish while at Hannah House?

BABY'S INFORMATION
THIS SECTION WILL BE FILLED OUT AFTER THE BIRTH OF YOUR BABY (ONLY FILL OUT IF YOU HAVE ALREADY GIVEN BIRTH TO THE BABY WHO WILL RESIDE AT HANNAH HOUSE WITH YOU)

Baby's Name:_____
Last First Middle

Baby's Father's Full Name:_____
Last First Middle

Date of Birth:_____Time of Birth: _____

Hospital of Birth:_____

City and State of Birth:_____

Social Security Number:_____

Baby's Height at Birth:_____Baby's Weight at Birth:_____

NOTES:

PERSONAL INFORMATION

Have you ever been arrested and/or convicted of any crime?* YES NO
(Please include all occurrences)

If YES, For what and give dates:_____
(Please list all occurrences)

Have you ever been in jail or prison? YES NO
(Please include all occurrences)

If YES, For what and give dates AND COUNTY:_____
(Please list all occurrences)

Are you on probation? YES NO County/State: _____

Name of Probation Officer: _____

Probation Officer's Telephone Number _____

Do you have any court cases pending? YES NO If yes, date(s): _____

City & State:_____ Charge: _____

Do you smoke?* YES NO How many cigarettes/packs a day? _____

Are you, or have you ever struggled with an addiction (drug, alcohol, sex, etc.)?* YES NO

If Yes, what addiction(s) and give dates:_____

Have you ever taken illegal substances?* YES NO

What kind have you used in the past year? _____

When was the last time you used? _____

How often do you drink alcohol? _____

What do you usually drink? _____

How much do you drink? Heavy Moderate Light

Have you ever been through a "de-tox" program? YES NO

Program: _____

Are you willing to be smoke, drug and alcohol free during your time here? YES NO

Are you willing to take random drug screens? YES NO

*Note: A "Yes" response does not automatically disqualify you, but a dishonest response can.

EDUCATIONAL INFORMATION

Name of the High School you attend(ed):_____

Name of the Guidance Counselor: _____

School Address: _____ City& State:_____

Telephone Number:_____ Last grade completed: _____

Have you completed your GED? YES NO

When and where was your test? _____

INCOME INFORMATION

Do you have any source of income? This may include but may not be limited to employment earnings, child support payments, court settlement monies, social security, disability, TANF, gifts from family or friends.

YES NO

If YES, how often do you receive payments?_____

If YES, how much money do you receive?_____

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MEDICAL INFORMATION

Name of Physician:_____

Address:_____ City & State:_____

Phone number:_____

Please list any medications you are currently taking/any medication you are allergic to:

Taking: _____

Allergic: _____

Have you ever been hospitalized? YES NO

For what reason? _____

List all surgeries you have had and the dates performed:_____

_____

Do you have any physical ailments or disabilities that would inhibit normal physical activity?

YES NO If YES, explain:_____

Do you wear glasses and/or contacts? YES NO BOTH

List all known allergies, other than to medications: _____

Have had a blood transfusion? YES NO If YES, when? _____

Do you have special diet restrictions? YES NO If YES, specify:_____

_____

Do you have any sexually transmitted diseases? YES NO

If YES, please list:_____

Have you been tested for HIV? YES NO

If yes, results: Positive Negative Inconclusive

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Have you ever had or do you have any of the following conditions? Check all that apply.

	YES	NO
Severe or persistent headaches		
Blurred Vision		
Pain in Eyes		
Hearing Loss		
Hay Fever/Asthma		
Sinus Trouble		
Arthritis		
	YES	NO
High Blood Pressure		
Low Blood Pressure		
Racing of the Heart		
Shortness of Breath		
Swelling in Ankles		
Rheumatic Fever		
Heart Trouble		
Blood in Urine		
Kidney Stones		
Stomach Ulcer		
Vomiting Blood		
Diarrhea		
Constipation		
Leg Cramps		
Severe Chest Pain		
Black Out Spells		
Backache		
Fatigue		
Dizziness		
Depression		
Anxiousness		
Weepy		
Seizures		
Diabetic		

Past History: Please check all that apply and list age.

	YES	NO	AGE
Mumps			
Whooping Cough			
Measles			
Chicken Pox			
MRSA / Staph Infection			
Typhoid Fever			
Cancer			
Anemia			
Syphilis			
Gonorrhea			
Nervous Breakdown			
Mental Illness			
Diphtheria			
Hepatitis (A,B, or C)			
AIDS/HIV			
Tuberculosis			
Pneumonia			
Epilepsy			

NOTES:

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MENTAL HEALTH HISTORY

Have you ever been diagnosed with any kind of mental illness? YES NO

If YES, for what, and give dates: _____

Name of agency(ies) that gave diagnosis:_____

Address of agency (ies):_____

City & State:_____

Phone number:_____
(You may use the back if you need more space)

Have you ever been hospitalized due to mental illness? YES NO

If YES, please explain and give dates:_____

_____

Name of Hospital:_____

Address:_____ City & State:_____

Phone number:_____

Have you ever been diagnosed with Bi-polar disorder? YES NO When _____

Have you ever attempted suicide or had suicidal thoughts? YES NO

Have you ever been treated by a psychologist or psychiatrist? YES NO

Name of Psychologist/Psychiatrist:_____

Address:_____ City & State:_____

Phone number:_____

Have you ever attended counseling or mental health therapy for any reason? YES NO

If YES, for what reason, and give dates:_____

Name of agency where you attended counseling or mental health therapy:_____

Please list any medications you are currently taking to treat mental illness:

Taking: _____

PREGNANCY INFORMATION

Have you had any previous miscarriages? YES NO Dates_____

Have you had any abortions? YES NO Dates_____

Have you placed any children for adoption? YES NO Dates_____

Age of child(ren) at adoption:_____

Is this your first full term pregnancy? YES NO

Number of pregnancies:_____ Miscarriages:_____ Abortions:_____

List all complications: _____

Do you have any other children? YES NO How many? _____

Give names and ages:_____

_____

Do you have guardianship and/or custody of your child(ren)? YES NO

Are you currently parenting your child(ren)? YES NO

With whom is/are the child(ren) living?_____

What is your relationship with that person?_____

How was your current pregnancy confirmed? _____

How many weeks are you? _____ Approximate due date:_____

Medical Coverage: _____ Hoosier Healthwise: _____ Other:_____

If other, please specify: _____

Do you know who the father of your child is? YES NO

NOTES:

Your Unborn Baby's Father:

Name: _____

Address/City/State/Zip: _____

Telephone Number: _____ Date of Birth: _____

SS#:_____ Place of Work: _____

Occupation: _____ Work Phone: _____

Education: _____ Emergency Telephone Number: _____

Rate your relationship with this individual at the time: Really good 10 9 8 7 6 5 4 3 2 1 Really bad no contact X

Comments: _____

Unborn Baby's Father's Race: White Black Hispanic Other: _____

Unborn Baby's Father's Present Age: _____

How does he feel about the pregnancy? _____

Is your unborn baby's father abusive? (call you names, threaten you, hit you, etc.) YES NO

NOTES:

RELATIONSHIP INFORMATION

Have you ever been in an abusive relationship with anyone? YES NO

If YES, who and give dates: _____

If YES, are you still in this relationship? YES NO

If YES, are you fearful of this person? YES NO

If YES, does this person know your plans to live at HH? YES NO

Does your current boyfriend/partner/significant other/family member call you names, threaten you, hit you, or touch you inappropriately? YES NO

Please Explain:_____

_____

Are you afraid of your boyfriend/partner/significant other/family member? YES NO

Are you afraid to leave your boyfriend/partner/significant other/family member? YES NO

Your Current Boyfriend/Partner/Significant Other:

Is your Current boyfriend/partner/significant other the father of your unborn baby? YES NO

Name: _____

Address/City/State/Zip: _____

Telephone Number: _____ Date of Birth: _____

SS#:_____ Place of Work: _____

Occupation: _____ Work Phone: _____

Education: _____ Emergency Telephone Number: _____

Rate your relationship with this individual at the time: Really good 10 9 8 7 6 5 4 3 2 1 Really bad X no contact

Comments: _____

NOTES:

FAMILY INFORMATION

Family lifestyle: Single parent Two parents Two parents/One step parent

Homeless Other: _____

Do your parent's know that you are/were pregnant? Mother Father

How do they feel? Mother_____

Father_____

If you are over 18, do your parents know of your plans to be here? YES NO

If no, why? _____

Your <u>Birth</u> Father:

Name: _____ Date of Birth: _____

Address/City/State/Zip: _____

Home Phone Number: _____ Cell Phone: _____

SS#:_____ Place of Work: _____

Occupation: _____ Work Phone: _____

Education: _____ Emergency Telephone Number: _____

Rate your relationship with this individual at the time: Really good 10 9 8 7 6 5 4 3 2 1 Really bad no contact X

Comments: _____

Your <u>Birth</u> Mother:

Name: _____ Date of Birth: _____

Address/City/State/Zip: _____

Home Phone Number: _____ Cell Phone: _____

SS#:_____ Place of Work: _____

Occupation: _____ Work Phone: _____

Education: _____ Emergency Telephone Number: _____

Rate your relationship with this individual at the time: Really good 10 9 8 7 6 5 4 3 2 1 Really bad no contact X

Comments: _____

Your <u>Adoptive</u> Father:

Name: _____ Date of Birth: _____

Address/City/State/Zip: _____

Home Phone Number: _____ Cell Phone: _____

SS#:_____ Place of Work: _____

Occupation: _____ Work Phone: _____

Education: _____ Emergency Telephone Number: _____

Rate your relationship with this individual at the time: Really good 10 9 8 7 6 5 4 3 2 1 Really bad no contact X

Comments: _____

Your <u>Adoptive</u> Mother:

Name: _____ Date of Birth: _____

Address/City/State/Zip: _____

Home Phone Number: _____ Cell Phone: _____

SS#:_____ Place of Work: _____

Occupation: _____ Work Phone: _____

Education: _____ Emergency Telephone Number: _____

Rate your relationship with this individual at the time: Really good 10 9 8 7 6 5 4 3 2 1 Really bad no contact X

Comments: _____

NOTES:

FILL OUT THIS SECTION <u>ONLY</u> IF YOU LIVE WITH SOMEONE OTHER THAN YOUR BIRTH PARENTS OR ADOPTIVE PARENTS.

Please circle the one that applies to your family situation:

Step-Mother Step-Father Other: _____

Name: _____

Address/City/State/Zip: _____

Telephone Number: _____ Date of Birth: _____

SS#:_____ Place of Work: _____

Occupation: _____ Work Phone: _____

Education: _____ Emergency Telephone Number: _____

Rate your relationship with this individual at the time: Really good 10 9 8 7 6 5 4 3 2 1 Really bad no contact X

Comments: _____

FILL OUT THIS SECTION <u>ONLY</u> IF THERE IS SOMEONE ELSE WHO HAS AN <u>IMPORTANT ROLE IN YOUR LIFE</u>.

Name: _____

Relationship to You:_____

Address/City/State/Zip: _____

Telephone Number: _____ Date of Birth: _____

SS#:_____ Place of Work: _____

Occupation: _____ Work Phone: _____

Education: _____ Emergency Telephone Number: _____

Rate your relationship with this individual at the time: Really good 10 9 8 7 6 5 4 3 2 1 Really bad no contact X

Comments: _____