Soulful Living for Recovery Grant Program

811 W Jericho TPKE, Suite 203 E

Smithtown, N.Y. 11787

HOLISTIC INTAKE FORM
(All information will be held in confidentiality)

Name:	
Full Name at Birth:	
Date of Birth:	
Address:	
Home Phone:	Cell Phone:
Email Address:	
Emergency Contact Name:	Emergency Contact Phone:

1. How did you hear about our healing services?

2. What attracted you to our Center's Program?

3. In one sentence, please describe why you are here?

4. Do you experience problems with addiction?

5. Is there a history of addiction in your family?

6. Are you currently working and what is your work history? (What is fulfilling about your job and/or what was fulfilling about your past jobs?)

7. What do you do in your free time?

8. Have you had any past or do you have any present medical issues (surgeries)?

9. Are you taking any medications? Including any holistic remedies?

10. Have you tried any traditional or non-holistic therapies? If so which ones and what was your experience?

11. Do you have any self-care rituals involving eating habits, meditation, yoga and/or exercise? Are there areas in which you would like to improve upon or explore?

12. What are your normal sleeping hours? Do you sleep well? Do you often wake up at night?

13. What are some of the major stressors in your life? How do they impact you?

14. Do you have a circle of support including family, friends, work contacts or any support programs?

15. Please list any areas in which you struggle (Food, Alcohol, Drugs, Sex, Technology, Shopping, Relationships, and/or Gambling). Please describe how you struggle in these areas?

16. What are your treatment goals and expectations for your healing?

17. Which of the following is the MOST important to you?
    1. Being loved unconditionally? _____
    2. Feeling understood? _____
    3. Feeling respected and appreciated? _____
    4. Feeling reassured that everything is going to be ok? _____
    5. Having a sense of direction? _____

18. Keeping in mind your biggest dream, what would you attempt to do if you knew you could not fail?

19. Please state in your own words: Do you believe that you are a good candidate for the Grant Program? Given limited slots and inability to accept all applicants, why should we choose you for this opportunity?

FINANCIAL ELIGIBILITY FORM
(All information will be held in confidentiality)

Name:	
Full Name at Birth:	
Date of Birth:	
Address:	
Home Phone:	Cell Phone:
Email Address:	

1. Within the last 12 months, have you been a beneficiary of any of the following Government-sponsored assistance programs? (Circle "Yes" for any/all that apply):
   - General Assistance Yes No
   - Medicaid Yes No
   - Food Stamps/Supplemental Nutritional Assistance Program (SNAP) Yes No
   - Commodity Supplemental Food Program (CSFP) Yes No
   - Supplemental Security Income (SSI)
     Yes No
   - Temporary Assistance for Needy Families (TANF) Yes No
   - Federal Public Housing Assistance (FPHA) or Section 8 Yes No
   - Low Income Home Energy Assistance Program (LIHEAP) Yes No
   - National School Lunch Program's Free Lunch Program Yes No
   - Other (if selected, provide specific details below) Yes No

   Provide details if "other" was selected from the list:
   _____
   _____
   _____

2.

Household Size	
Combined Annual Household Income	$
Describe your living situation (i.e, live at home with parents, etc)	

3. Attach proof of household size and combined annual household income (e.g.; tax returns, W-2s, bank records, etc.)

4. Tell us anything else we need to know about your financial situation (i.e. extenuating circumstances that may be contributing to economic hardship).

_____
_____
_____
_____
_____
_____
_____
_____
_____

5. I confirm that all information stated on this form, as well as the documents I have provided are, to the best of my knowledge, representative of my financial situation.

Signature: _____

Date: _____

Please email your completed application to **soulfulliving.grantprogram@gmail.com**

The Holistic Center for Soulful Living
811 W Jericho TPKE, Suite 203 E
Smithtown, N.Y. 11787
(631) 261-3503

Who referred you to our office?_____

PATIENT

Last Name :	**First Name:**		**Date of birth :**
Street :			**Home Phone:**
City :	**State:**	**Zip:**	**Work Phone:**
E-Mail:			**Cell Phone:**

INSURED/POLICYHOLDER INFO

Last Name :	**First Name:**		**SS # of Insured:**
Street :			**Apt#:**
City :	**State:**	**Zip:**	**Phone# :**

Date of Birth:	**Relationship to Patient:**	**Employer:**

Name of Insurance Company :	**Policy # :**
Phone Number:	**Group #:**
Secondary Insurance Carrier:	**Policy #**
Name of Policyholder for Secondary coverage:	**Group #**
May we contact your physician? **If so please enter name and phone number of your doctor:**	**Phone :**
Emergency contact name and phone number:	**Relationship to Patient:**

PLEASE READ CAREFULLY: I authorize the release of any medical or other information necessary to process this claim. I request payment of medical benefits to the party who accepts assignment for services. I understand that there is a 24 hour cancellation policy and if sufficient notice is not given, I will be responsible for the complete payment for appointment.

The privacy and security of your mental health information if important to our office. A confidential record of your care is maintained in compliance with HIPAA regulations.

_____ _____

PATIENT OR GUARDIAN'S SIGNATURE **DATE**

THIS SPACE FOR OFFICE USE

THERAPIST'S NAME:_____

INITIAL DOS: 90801= _____ DIAGNOSIS:_____

AUTH MANAGED BY: _____ PHONE FOR AUTHS: _____

EFFECTIVE DATE OF PATIENT'S COVERAGE : _____ MAXIMUM # VISITS PER YEAR _____

CO-PAY AMOUNT _____ DEDUCTIBLE INFO IF ANY_____

AUTH START DATE :_____ AUTH END DATE : _____

VISITS AUTHORIZED : _____ AUTHORIZATION NUMBER : _____