TEEN TRANSITIONAL LIVING PROGRAM (TTLP)
Catholic Charities of Broome County
232 Main St.
Binghamton, NY (revised 2023)

Application for Residency/ Initial Comprehensive Assessment

Please complete this application honestly and as completely as you can. Once complete and received by TTLP staff we will contact you to schedule an interview to review your application. If there are any questions, please call TTLP staff to assist you with the application. TTLP staff can be reached at 729-9166.
While filling out the application and after meeting with staff please keep in mind that we are Mandated Reporters and anything that we feel should get reported we will do so. Thank you.

Applicant Information

For staff use only please

Where did youth sleep the night prior to the admission?

_____

Date and time of admission:

_____

Date of Application: _____

Name: _____

Current Address: _____

Name of individual you are staying with and relationship: _____

What is the best number to reach you at? Cell:_____

Home:_____

Whose phone is this & relationship to you: _____

Additional Phone Number (if applicable): _____

Whose phone is this & relationship to you: _____

Social Security No.: _____

Age: _____ **Date of Birth:** _____/_____/_____

Marital status: _____

Gender: ☐ male ☐ female ☐ transgender male ☐ transgender female

Sexual Orientation: ☐ Gay, Lesbian ☐ Bisexual ☐ Pansexual ☐ Straight ☐ Queer ☐ Questioning, unsure ☐ Non-binary ☐ other

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ American Indian or Alaska Native and White
- ☐ Asian and White
- ☐ Black or African American and White
- ☐ American Indian or Alaska Native and Black or African American
- ☐ Other multiple race combinations greater than one percent: _____

Dependent Information

Do you have any children? ☐ Yes ☐ No If yes, how many? _____ Who has custody? _____
Do you currently have Child Care? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No ☐ Unsure If yes, what is your due date? ____/_____/_____
Are you pregnant with, or parenting a child that will be coming to the program with you?
☐ Yes ☐ No* *If no, please go to page 3

1.) _____ ____ _____ _____
1st Child's First and Last Name | Age | DOB | Biological Parents' First and Last Name

_____ _____
Child's Address | Other Parent's Address

Child's Primary Doctor: _____ Telephone number: _____

Physical state of this child
Does your child have any of the following?

- ☐ physical disabilities
- ☐ health alerts
- ☐ medications
- ☐ doctor
- ☐ dentist
- ☐ special dietary needs
- ☐ learning disabilities
- ☐ allergies
- ☐ _____

If you checked any of the following please explain: _____
_____

Emotional state of this child
Does your child have any of the following?

- ☐ temperament issues
- ☐ behavioral issues
- ☐ mental diagnoses
- ☐ counselor
- ☐ _____
- ☐ _____

If you checked any of the following please explain: _____
_____

2.) _____ ____ _____ _____
2nd Child's First and Last Name | Age | DOB | Biological Parents' First and Last Name

_____ _____
Child's Address | Other Parent's Address

Physical state of this child
Does your child have any of the following?

- ☐ physical disabilities
- ☐ health alerts
- ☐ medications
- ☐ doctor
- ☐ dentist
- ☐ special dietary needs
- ☐ learning disabilities
- ☐ allergies
- ☐ _____

If you checked any of the following please explain: _____
_____

Emotional state of this child

Does your child have any of the following?

☐ temperament issues ☐ mental diagnoses ☐ _____

☐ behavioral issues ☐ counselor ☐ _____

If you checked any of the following please explain: _____

_____

For staff use only please

Comments: _____

_____

Parent/ Legal Guardian and Family Information

Your Birth Father's Name_____

Address _____

Phone No._____

Do you have contact with him? ☐ Yes ☐ No

Are you able to live with them? ☐ Yes ☐ No

Your Step-Father's Name if applicable_____

Address_____

Phone No._____

Do you have contact with him? ☐ Yes ☐ No

Are you able to live with them? ☐ Yes ☐ No

Your Birth Mother's Name _____

Mother's Maiden Name _____

Address _____

Phone No._____

Do you have contact with her? ☐ Yes ☐ No

Are you able to live with them? ☐ Yes ☐ No

Your Step-Mother's Name if applicable_____

Step Mother's Maiden Name_____

Address_____

Phone No._____

Do you have contact with her? ☐ Yes ☐ No

Are you able to live with them? ☐ Yes ☐ No

Name of Legal Guardian (if different than parent) _____

Address _____

Phone No.: _____

Do you have contact with them? ☐ Yes ☐ No

Are you able to live with them? ☐ Yes ☐ No

Did you have religious or spiritual beliefs different from your parent or legal guardian? ☐ Yes ☐ No

Please explain why you are unable to live at home with your parents/family? Please be specific. If you have moved out, please state when you moved out.

_____

_____

_____

_____

_____

_____

_____

Have you looked into any other programs and if so what programs? ☐ Yes ☐ No

_____

How did you find out about our program?_____

Has anyone ever had custody of you other than your birth parents? ☐ Yes ☐ No ☐ Unsure

Do you have any siblings? ☐ Yes ☐ No

Sibling's Name	Age	Where do they live?	Do you have contact?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do your Parents/ Family know you are applying to TTLP? ☐ Yes ☐ No

If yes, how do they feel about it?

_____
_____
_____

For staff use only please

Questions to determine eligibility:

- Is the person under the age of 21? YES or NO If NO, then the person is not eligible
- Does the person have a relative to stay with? YES or NO If YES, then the person is not eligible
- If the person doesn't have a relative to stay with, do they have a safe alternative? YES or NO If YES, then the person is not eligible
- Is the person without proper supervision and care? YES or NO If NO, then the person is not eligible

After answering these questions, does the youth meet the criteria for being homeless? YES or NO

Personal Information

Are you now or have you ever been involved in any of the following:

☐ Arrested	☐ Emergency Shelter	☐ Group Home/ Residential
☐ Probation	☐ Homeless Shelter	
☐ PINS	☐ Counseling	☐ ACR
☐ Lawyer	☐ Mental Health Facility/Hospital	☐ Gangs
☐ Case Manager		☐ CPS
☐ Order of Protection	☐ Foster Care/Home	

If you checked any of the following please explain:_____
_____
_____

Criminal Involvement

Do you have a criminal history?_____
Please list charges:_____

Have you been in placement/detention/ secure facility/jail before? ☐ Yes ☐ No
If yes, please explain when and where:_____

Have you had any court involvement? ☐ Yes ☐ No
☐ Family Court ☐ Criminal Court
If yes, please explain:_____

Are there any current charges pending? ☐ Yes ☐ No
If yes, please explain:_____

Are you on probation or parole? ☐ Yes ☐ No
Dates of Probation/parole:_____ PINS/JD/OTHER_____
Probation Officer:_____County:_____phone number:_____
Parole Officer:_____County:_____phone number:_____

Child Protective Involvement-Self Applicant

Are there any **present/current** abuse or neglect allegations: ☐ Yes ☐ No
If yes, what is the date of the CPS hotline call?_____
Is there any **past history** of CPS involvement? ☐ Yes ☐ No
If yes when?_____Was it founded? ☐ Yes ☐ No

Please list all of your closest friends and the people you associate with:

First and Last name	Age
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How do you know your friends? _____

What do you do when you are hanging out with your friends? _____

What are some activities you are involved in currently?_____

Are you currently involved in any school activities and if so what? (If applicable)_____

What do you like to do on your free time?_____

What are some of your goals that you would like to achieve?_____

What are some of your hobbies?_____

What is something that you are proud of?_____

What is something that you would like to improve on?_____

What do you want to do or be when you get older?_____

What are some areas that you feel you may need extra help with?_____

Educational Information

1.) Are you currently enrolled in school? ☐ Yes ☐ No
If no, are you interested in re-enrolling in school? ☐ Yes ☐ No
What is the last grade you completed: _____
Have you graduated high school or have you received your GED? ☐ Yes ☐ No
☐ High school Diploma ☐ GED
Are you planning on receiving your GED? ☐ Yes ☐ No
Anticipated Graduation/GED date_____

2.) Name of School/Last School attended_____
Address _____
Current grade _____ Special Programs / Trainings _____
Name of Guidance Counselor _____ School Social Worker _____
Can we speak with school staff & counselor? ☐ Yes ☐ No
If yes, what is the best number to reach either your guidance counselor or school social worker?
_____

3.) Are you currently having problems in school? ☐ Yes ☐ No
If yes, please explain: _____
_____
Have you ever had any problems in school? ☐ Yes ☐ No
If yes, please explain: _____
_____
Have you ever had unauthorized absences? ☐ Yes ☐ No
What is your educational goal? _____
_____

4.) Do you plan on attending college or have a career in the Military? ☐ Yes ☐ No
Which one?_____
Have you already taken steps to enroll?_____
Did you complete your Financial Aid?_____

For staff use only please

Comments: _____
_____
_____
_____
_____

Medical/Mental Health History

Do you have/have you had: *Please check all that apply*

- ☐ prescribed medications
- ☐ over the counter medications
- ☐ vitamins, mineral, food supplements
- ☐ rash due to medication
- ☐ rash due to food
- ☐ heart condition
- ☐ rheumatic fever
- ☐ heart murmur
- ☐ heart medication
- ☐ blood disorder
- ☐ bladder control problem
- ☐ burning when urinating
- ☐ blood in urine
- ☐ bladder infection
- ☐ itching/irritation in genital area
- ☐ genitals painful/sore
- ☐ respiratory disease
- ☐ liver disease
- ☐ Hepatitis B
- ☐ any chronic diseases
- ☐ pregnancies
- ☐ STD's/STI's
- ☐ unexplained weight loss
- ☐ unexplained weight gain
- ☐ special diet
- ☐ physical disability
- ☐ mental disability
- ☐ learning disability
- ☐ depression
- ☐ anxiety
- ☐ anger problems
- ☐ severe mood swings
- ☐ health concerns
- ☐ medical problem
- ☐ serious illness
- ☐ serious accident
- ☐ glasses, contacts
- ☐ trouble seeing
- ☐ dental problem
- ☐ trouble sleeping
- ☐ sleep walk
- ☐ sleeping medication
- ☐ asthma
- ☐ cancer
- ☐ diabetes
- ☐ eating disorder
- ☐ heart disease
- ☐ migraines
- ☐ obesity
- ☐ Tuberculosis
- ☐ medication allergies
- ☐ food allergies
- ☐ birth defect
- ☐ epilepsy, seizures, convulsions
- ☐ drug abuse
- Glandular/
- ☐ Thyroid problem
- ☐ high blood pressure
- ☐ mental illness
- ☐ anemia

If you checked off any please explain each:_____

_____

_____

Are you current with immunizations? ☐ Yes ☐ No

Can you provide a copy of your immunization record? ☐ Yes ☐ No

Do you currently have a primary doctor? ☐ Yes ☐ No **who is it?**_____

When was your last physical exam? _____

Do you currently have a dentist? ☐ Yes ☐ No **who is it?**_____

When was your last dental exam? _____

Do you currently have a counselor/therapist? ☐ Yes ☐ No **who is it?**_____

When was your last appointment? _____

Do you currently have a psychiatrist? ☐ Yes ☐ No **who is it?**_____

When was your last appointment? _____

Have you had a history with any of the following?

- ☐ Suicide Attempts
- ☐ Suicide Threats
- ☐ Self Injuries
- ☐ Physically Aggressive Behavior
- ☐ Sexually Aggressive Behavior
- ☐ Verbally Aggressive/Abusive
- ☐ Fire Setting
- ☐ Eating Disorder
- ☐ Family Violence
- ☐ Hurting Animals
- ☐ Anger
- ☐ Sexual Abuse
- ☐ Physical Abuse
- ☐ Mental/Emotional Abuse
- ☐ Bed Wetting

If you checked off any of the following please explain each:_____

_____

_____

For staff use only please

Comments: _____

_____

Safety/Risk

Danger from others

Have you ever been physically abused? ☐ Yes ☐ No
If yes, by whom?_____When?_____

Have you ever been sexually abused? ☐ Yes ☐ No
If yes, by whom?_____When?_____

Have you ever been exposed to domestic violence? ☐ Yes ☐ No
If yes, by whom?_____When?_____

Have you ever had anyone in your household abusing alcohol or drugs? ☐ Yes ☐ No
If yes, by whom?_____When?_____

Have you ever been left alone for 2 or more days? ☐ Yes ☐ No
☐ With food ☐ Without food
If yes, by whom?_____When?_____

Have you ever been hospitalized for medical reasons? ☐ Yes ☐ No
If yes please explain:_____

Have you ever been to CPEP or hospitalized for mental health reasons? ☐ Yes ☐ No
If yes please explain:_____

Have you ever had medical problems not attend to? ☐ Yes ☐ No
If yes please explain:_____

Have you ever not felt safe? ☐ Yes ☐ No
If yes please explain:_____

Have you ever ran away from home? ☐ Yes ☐ No How old were you? _____
Were you ever homeless in the past? ☐ Yes ☐ No
Where did you sleep last night?_____

Danger from self

Have you ever seriously threatened to harm anyone? ☐ Yes ☐ No
If yes, please explain _____

Where there charges against you? ☐ Yes ☐ No
If yes, please explain?_____

Drug and Alcohol History

Have you ever used/tried:

☐ Cigarettes	☐ Prescription drugs for fun	☐ Cocaine	☐ LSD
☐ Tobacco		☐ Heroin	☐ Other
☐ Alcohol	☐ Marijuana	☐ Crack	

How old were you when you first tried drugs or alcohol? _____
When was the last time you used drugs or alcohol? _____
Have you ever been treated for substance use/abuse? ☐ Yes ☐ No
If you checked off any of the following please explain each:_____

Medical Information

Are you sexually active? ☐ Yes ☐ No
Do you have any children? ☐ Yes (please complete page 2) ☐ No
Do you suspect that you or your partner may be pregnant? ☐ Yes ☐ No ☐ Maybe
Have you or your partner had a pregnancy test? ☐ Yes ☐ No
Are you currently receiving prenatal care? ☐ Yes ☐ No
If you or your partner are pregnant, how far along are you? _____
Have you ever been pregnant or fathered a child? ☐ Yes ☐ No
How many times? _____

Females only

How old were you when you had your first period? _____
Are your periods regular? ☐ Yes ☐ No
Have you ever had an internal pelvic exam? ☐ Yes ☐ No
Have you ever had a PAP smear in the past? ☐ Yes ☐ No
If yes, when was your last exam?_____
Do you have a regular OBGYN? ☐ Yes ☐ No
If yes, who is it?_____

Males only

Have you had a yearly physical exam? ☐ Yes ☐ No
If yes, when was your last exam?_____

For staff use only please

Comments: _____
_____
_____

Financial & Employment

1.) Do you receive any of the following as income?

- ☐ Public Assistance
- ☐ Social Security Income (SSI)
- ☐ Survivor Benefits
- ☐ Child Support
- ☐ Wages
- ☐ Other Income (other than work)

2.) Do you have a bank account? ☐ Yes ☐ No

3.) Work History

Have you ever had a job? ☐ Yes ☐ No
Have you ever been fired from a job? ☐ Yes ☐ No

4.) Do you currently have employment? ☐ Yes ☐ No

Place of Employment _____
How long have you worked there _____
Pay per hour _____ How many hours do you work a week? _____

5.) Do you currently receive Medical Assistance or Temporary Assistance? ☐ Yes ☐ No

6.) Do you receive SSD or SSI? ☐ Yes ☐ No

Who currently is your rep payee?_____
How much do you currently receive?_____

7.) If you receive Child Support payments how much do you currently receive?_____

8.) If you receive Public Assistance payments how much do you currently receive?_____

For staff use only please

Comments: _____
_____

Drug Testing Agreement

As part of the application process and participation in the Teen Transitional Living Program you may be asked to schedule a drug screening. You may schedule this though your primary care provider or you may contact New Horizons for a drug/alcohol evaluation. New Horizon's is located at 33 Mitchell Avenue, Binghamton, NY 13903.

I, _____ agree to have voluntary drug tests as a part of my screening process. If accepted to the program I agree that the Teen Transitional Living Program staff may arrange for periodic random tests at will. The test will be conducted/arranged with your primary care physician, any walk in clinic, or hospital. You may be required to have a full drug/alcohol evaluation with New Horizons if the Teen Transitional Living Program staff feel it is necessary. I understand that the staff of the Teen Transitional Living Program and/or the Screening Committee will view the results.

I understand that refusal to submit to a drug screening may lead to denial or discharge from the Teen Transitional Living Program.

Signed: _____ Date: _____

Witness: _____ Date: _____

Comments

Is there anything else that you would like to share? *(Please attach an additional sheet if needed.)*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

- ☐ **I have received a copy of the TTLP Behavior Contract and will review the Behavior Contract prior to my first interview with the TTLP staff.**

Attached are three reference forms, two professional and one personal. Please have the two professional references filled out by a teacher, counselor, mental health provider, physician, case worker, probation officer, or another professional referral source. The personal form can be completed by a family member or friend. If you need help in acquiring a referral, ask TTLP staff for assistance. Once these are completed, please return them to the office.

You will need to schedule an appointment with TTLP staff to complete a suicide and violence/risk assessment with Gateway Center for Youth staff.

Signature of Applicant: _____ Date: _____

Staff Comments

For staff use only please
To be completed on admission

***Reason for Placement** _____
_____

Current ILS Functioning Level _____
Date Daniel Memorial Assessment compled_____

Social/ Recreational strengths and needs _____
_____

Employment _____
_____

Legal _____
_____

Nutritional (ability to grocery shop independently, meal plan, identify healthy vs not healthy food choices, ect) _____
_____
_____

Emotional/Psychological Health _____
_____

Physical Health _____
_____

Financial _____
_____

Clothing _____
_____

Referrals needed/immediately made_____
_____

Safety/ Risk factors _____
_____

Any harm reduction or relapse prevention services needed? _____ **If yes, what?**_____
_____

Youth's Ability to Progress to Independent Living within 18 months
_____
_____
_____

_____ _____
Signature of Staff Date Signature of Supervisor Date

<u>This page to be completed by TTLP Staff</u>

Referred by: _____ Date of Screening: _____
Agency: _____ Date of Admission: _____
Phone No.: _____ Time of Admission: _____

Screening Committee Results:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

To Do:

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

TEEN TRANSITIONAL LIVING PROGRAM

Professional Referral Questionnaire

Name of Applicant: _____
Name of Reference: _____ Relationship to Applicant: _____

- **Give a brief history, including the applicant's involvement with any agencies/services:**

  _____
  _____
  _____

- **What information can you provide about this applicant's peers? Please include names:**

  _____
  _____

- **What important relationships does the applicant have? Please include people the applicant relies on for emotional support:**

  _____
  _____

- **What, if any, are some goals the applicant has set, and which ones are you assisting them with?**

  _____
  _____
  _____

- **What are some of the applicant's strengths?**

  _____
  _____

- **What are some things the applicant needs to work on or improve?**

  _____
  _____

- **What support services does this applicant use or need?**

  _____
  _____

- **What is the applicant's need for substance abuse counseling?** ☐ low ☐ med ☐ high ☐ unknown
  Please provide additional information:

  _____
  _____

- **Will you be continuing with this applicant if he/she is accepted in to the program?** ☐ Yes ☐ No
  If no, what are your suggestions for continuing contact with existing service providers?

  _____
  _____

- **Have you reviewed our program rules and guidelines?** ☐ Yes ☐ No
  Do you feel that the applicant will have any problems following any of our rules? If yes, which ones?

  _____
  _____

Signature of Referral: _____ Date: _____

TEEN TRANSITIONAL LIVING PROGRAM

Professional Referral Questionnaire

Name of Applicant: _____
Name of Reference: _____ Relationship to Applicant: _____

- **Give a brief history, including the applicant's involvement with any agencies/services:**

  _____
  _____
  _____

- **What information can you provide about this applicant's peers? Please include names:**

  _____
  _____

- **What important relationships does the applicant have? Please include people the applicant relies on for emotional support:**

  _____
  _____

- **What, if any, are some goals the applicant has set, and which ones are you assisting them with?**

  _____
  _____
  _____

- **What are some of the applicant's strengths?**

  _____
  _____

- **What are some things the applicant needs to work on or improve?**

  _____
  _____

- **What support services does this applicant use or need?**

  _____
  _____

- **What is the applicant's need for substance abuse counseling?** ☐ low ☐ med ☐ high ☐ unknown
  Please provide additional information:

  _____
  _____

- **Will you be continuing with this applicant if he/she is accepted in to the program?** ☐ Yes ☐ No
  If no, what are your suggestions for continuing contact with existing service providers?

  _____
  _____

- **Have you reviewed our program rules and guidelines?** ☐ Yes ☐ No
  Do you feel that the applicant will have any problems following any of our rules? If yes, which ones?

  _____
  _____

Signature of Referral: _____ Date: _____

TEEN TRANSITIONAL LIVING PROGRAM

Personal Referral Questionnaire

Name of Applicant: _____
Name of Reference: _____ Relationship to Applicant: _____

- **Give a brief history, including the applicant's involvement with any agencies/services:**

  _____
  _____
  _____

- **What information can you provide about this applicant's peers? Please include names:**

  _____
  _____

- **What important relationships does the applicant have? Please include people the applicant relies on for emotional support:**

  _____
  _____

- **What, if any, are some goals the applicant has set, and which ones are you assisting them with?**

  _____
  _____
  _____

- **What are some of the applicant's strengths?**

  _____
  _____

- **What are some things the applicant needs to work on or improve?**

  _____
  _____

- **What support services does this applicant use or need?**

  _____
  _____

- **What is the applicant's need for substance abuse counseling?** ☐ low ☐ med ☐ high ☐ unknown
  Please provide additional information:

  _____
  _____

- **Will you be continuing with this applicant if he/she is accepted in to the program?** ☐ Yes ☐ No
  If no, what are your suggestions for continuing contact with existing service providers?

  _____
  _____

- **Have you reviewed our program rules and guidelines?** ☐ Yes ☐ No
  Do you feel that the applicant will have any problems following any of our rules? If yes, which ones?

  _____
  _____

Signature of Referral: _____ Date: _____