

Two Recent  
Photos Must Be  
Submitted With  
Application

Two Recent  
Photos Must Be  
Submitted With  
Application

**APPLICANT INFORMATION**

Applicant Preferred Name (First, Last): \_\_\_\_\_

Applicant Name as it appears on your ID (First, Last): \_\_\_\_\_

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

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

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

Applicant Email Address: \_\_\_\_\_

Applicant Home Phone: \_\_\_\_\_ Applicant Cell Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Citizenship: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Please list any known allergies: \_\_\_\_\_

Adopted?  Yes  No If adopted, when? \_\_\_\_\_

Do you have a valid passport?  Yes  No Issuing Country \_\_\_\_\_ Exp Date \_\_\_\_\_

Passport Number \_\_\_\_\_

**FAMILY INFORMATION**

Father's Name: \_\_\_\_\_

Father's Hebrew Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Living: Yes No

If no, cause of death: \_\_\_\_\_

Address (if different from the applicant's): \_\_\_\_\_

Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Father's Email Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Mother's Hebrew Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Living: Yes No

If no, cause of death: \_\_\_\_\_

Address (if different from the applicant's): \_\_\_\_\_

Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Mother's Email Address: \_\_\_\_\_

Parent's Marital Status:  Married  Divorced If Divorced, who has legal custody? \_\_\_\_\_

Please list siblings in chronological order (attach additional sheet if necessary):

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female

Name: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Name: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

### EMERGENCY CONTACT INFORMATION

In case of emergency, contact: \_\_\_\_\_

Emergency Contact's Relationship to Applicant: \_\_\_\_\_

Emergency Contact's Phone: \_\_\_\_\_ or \_\_\_\_\_

How did you learn about Miryam's House? \_\_\_\_\_

Is there a particular person that referred you? \_\_\_\_\_

### ACADEMIC HISTORY

Please outline your academic history, including elementary school, beginning with most recent:

Year(s)	School Name and Contact Information	Last Grade Completed	Reason For Leaving

### Work History

Please provide a full record of all employment – paid and volunteer- Use a separate sheet, if necessary.

Dates	Employer/Supervisor	Address and Phone	Nature of Position

Please describe your current academic and work schedule.

---



---



---



---

Do you foresee changes to your academic and work schedule in the next six months?

---



---



---



---

**MEDICAL OR PSYCHOLOGICAL TREATMENT**

Have you received, or are you presently receiving treatment for any medical condition?

Yes No

If yes, please describe: (Attach additional sheets as necessary)

---



---

Have you received, or are you presently receiving treatment for any psychological condition?

Yes No

If yes, please describe: (Attach additional sheets as necessary)

---



---

Are you currently taking prescription medication? Yes No

Please detail current or past prescribed medications:

---

---

Do you currently see a mental health professional (e.g.: psychiatrist, psychologist, therapist, or social worker)? Yes No

Please list the mental health professionals you have seen in the last 3 years: (attach additional sheets if necessary)

Name: \_\_\_\_\_ Professional Title: \_\_\_\_\_  
Phone: \_\_\_\_\_ Dates of Service: \_\_\_\_\_  
Email: \_\_\_\_\_

Name: \_\_\_\_\_ Professional Title: \_\_\_\_\_  
Phone: \_\_\_\_\_ Dates of Service: \_\_\_\_\_  
Email: \_\_\_\_\_

Name: \_\_\_\_\_ Professional Title: \_\_\_\_\_  
Phone: \_\_\_\_\_ Dates of Service: \_\_\_\_\_  
Email: \_\_\_\_\_

Have you ever been hospitalized for psychiatric/ psychological reasons and /or been diagnosed with a mental disorder? (I.e. depression OCD, ODD, PTSD) Yes No

If yes, please give the diagnosis, describe the circumstances, and provide dates. What events precipitated the admissions and what were the outcomes?

---

---

---

---

---

**Please note that if there is no current therapeutic plan in place, a psychological evaluation may be required pending acceptance to the program.**

### GOAL IDENTIFICATION

Please describe your short term goals.

---

---

---

---

---

Please describe your long term goals.

---

---

---

Please write a paragraph explaining why you would like to live at Miryam's House.

---

---

---

**REFERENCES**

Please provide the names and addresses of three persons [not relatives] having knowledge of your character, experience, and ability. One of the references should be a mental health professional, i.e. social worker or psychiatrist.

<b>Name</b>	<b>Relationship</b>	<b>Address, Phone, and Email</b>

# RESIDENT EMERGENCY MEDICAL FORM

Date: \_\_\_\_\_

Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security No: \_\_\_\_\_ Allergies: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Phone No: \_\_\_\_\_ Address: \_\_\_\_\_

## Current Medications and Dosages:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## EMERGENCY CONTACT #1

Name: \_\_\_\_\_ Relationship to Resident: \_\_\_\_\_

Email: \_\_\_\_\_ Cell: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (office): \_\_\_\_\_

## EMERGENCY CONTACT #2

Name: \_\_\_\_\_ Relationship to Resident: \_\_\_\_\_

Email: \_\_\_\_\_ Cell: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (office): \_\_\_\_\_

**Resident Medical Insurance Information:**

**Resident Legal Name:** \_\_\_\_\_

**Resident Date of Birth:** \_\_\_\_\_

Primary Insurance Name			
Name of Policy Holder		Policy Holder DOB	
Relationship to Patient			
Patient's Policy ID No.		Policy Start Date	

Please place clear copies of the front and back of your insurance card here:



**Resident’s Health History:**

*(check “yes” or “no”)*

	Yes	No		Yes	No		Yes	No
Asthma	___	___	Headaches	___	___	Food Allergies	___	___
Bronchitis	___	___	Heart Trouble	___	___	Hay Fever	___	___
Cancer	___	___	Kidney Trouble	___	___	Insect Fever	___	___
Diabetes	___	___	Tuberculosis	___	___	Penicillin Allergy	___	___
Ear Infections	___	___	Pneumonia	___	___			
Epilepsy	___	___	Rheumatic Fever	___	___			
Sleep Walking	___	___	Thyroid Disorder	___	___			
Mononucleosis	___	___						

**Vaccines:**

OPV:                                      Dates: \_\_\_\_\_  
 DT:                                        Dates: \_\_\_\_\_  
 Hepatitis A:                            Dates: \_\_\_\_\_  
 Hepatitis B:                            Dates: \_\_\_\_\_  
 MMR:                                     Dates: \_\_\_\_\_

Please give all details (including dates) concerning any disease or allergy as to which “yes” is checked above.

---



---



---

Have you or any of your family members suffered: any chronic or recurring illness, tuberculosis, mental illness, epilepsy, heart disease, asthma, diabetes, other diseases?

---



---



---

Have you undergone any operations or sustained any serious injuries? If yes, please give details.

---



---



---

## Medication Regimen

**Date:** \_\_\_\_\_

**Legal Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Medication	Dosage	AM/PM	Prescribing Physician	Physician Phone Number	Special Notes

\*All changes in medication regimen must be recorded

Please list any known allergies: \_\_\_\_\_

Please list past medications (include dose, physician, and dates):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**APPLICATION PROCEDURE:**

1. Fully complete resident application and submit to [simcha@projectextreme.org](mailto:simcha@projectextreme.org).
2. Interview with Rabbi A.Y. Weinberg and Simcha Lebowicz, LMSW at the Project Extreme Office in Lawrence, NY
3. If deemed appropriate, you will be contacted for an Interview with the Miryam's House Residence Manager who will then discuss a time for a House Tour and Invitation to attend a weekly house meeting.
4. A signed and completed contract including emergency medical form and first month's rent must be received prior to receiving a moving date assignment.

PLEASE NOTE: ACCEPTANCE TO MIRYAM'S HOUSE IS ON A THREE MONTH TRIAL BASIS. AFTER THREE MONTHS, ACCEPTANCE WILL BE REEVALUATED.

I hereby certify that all items on this application are answered accurately and completely to the best of my knowledge.

Applicant's Signature: \_\_\_\_\_ Date \_\_\_\_\_