

Two Recent
Photos Must Be
Submitted With
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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.

Name	Relationship	Address, Phone, and Email

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 rikki@projectextreme.org.
2. Interview with Rabbi A.Y. Weinberg and Rikki Biggs at the Project Extreme Office in Lawrence, NY
3. If deemed appropriate, you will be contacted 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 _____