07/18

Catholic Charities of the  Diocese of Lexington

APPLICATION FOR SERVICES

To help us serve you better, please complete this form. (This information is confidential under the laws of the State of Kentucky. Some of the data will be used without any reference to you to create statistics that inform benefactors, grantors and others about our services.)

APPLICANT:

Last name | First Name | Middle Initial

Street (E-911) Address | City | State | Zip Code

Mailing Address (if different from above) | County

Email Address (May we send you email regarding Catholic Charities?) Yes or No

Phone Number/s (Home) (Work) (Cell) (Other)
Please circle number(s) where we may leave a message

Birth Date | Birthplace (City/State) | Social Security Number | Ethnic/Racial Identity

Gender | Marital Status (Single, D, M, Separated) | Military Service (Yes/No)

Religious Affiliation | Church You Attend | Emergency Contact (Name and Phone Number)

Place of Employment/School | Job Title | Annual Household Income & Source/s

Last Education Completed | School/College/Program/Educational Facility

Please list who lives in your household and/or other dependents?

First and Last Name	M/F	Relationship	Birthdate	School (include grade) or Employment/Other Info	Lives with me yes/no

Please state your reason for coming to this agency _____

Who referred you to this agency?_____

Have you had counseling in the past? Yes or No If yes, when & with whom? _____

If yes, would you sign a release of information for us to request records? Yes or No

Please continue with page 2

Do you take any prescribed medications? Yes or No If yes, list medications, dose, & frequency:

_____

_____

Do you use tobacco products? Yes or No If yes, what type, how often? _____

Do you drink alcohol? Yes or No If yes, approximately how many drinks per week? _____

Do you use anything else to change your mood? Yes or No If yes, what and how often?

_____

Have you ever been abused? Yes or No If yes, circle type/s: Physical, Sexual, Emotional, Verbal, Neglect

If you are under the care of a doctor, please state who and for what reason_____

_____

Has there been any history of physical or emotional illnesses in your family? Yes or No

If yes, please describe_____

_____

Please indicate any legal difficulties you are having_____

_____

Day and time you prefer an appointment_____

Do you plan to use health insurance to pay for services? Yes or No

If yes, please complete an Insurance Form for each health insurance you would like billed.

Are you willing to help us evaluate our services by completing a questionnaire? Yes or No
If yes, please indicate address to which questionnaire should be sent if different from home address:

_____

Is there anything else you think we should know to better serve you? _____

_____

Signature of Applicant/s_____
(Parent/Guardian must sign with minor or dependent)

Date_____

Please submit the counseling agreement and ten dollars ($10) with your application for services to the office where you will receive services:

Catholic Charities of the Diocese of Lexington, 1310 West Main Street, Lexington, KY 40508
Fax: 859-255-1134

or

Catholic Charities of the Diocese of Lexington, 60 Martha's Vineyard, Prestonsburg, KY 41653
Fax: 606-874-9170