

# Cronin House

## Intake Information for Individuals

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### **Program Description**

Cronin House is a 34 bed licensed residential facility for men and women. Residents must have both a diagnosis for a mental health disorder and a substance use disorder. Most residents complete the program within 60 days; however treatment may be extended to 90 days.

Cronin House provides education, skills training, intervention, medication support, AA/NA meetings on site, and family education/support. We help our residents develop early recovery skills, social skills, and independent living skills. Our goal is to help people achieve clean and sober living and understand how their substance abuse relates to their mental health and well-being. In addition, we provide a safe and supportive peer environment that includes a Client Council to provide leadership opportunities for residents.

Research and our experience supports group process as the most effective treatment for our residents. In addition, each resident is assigned a counselor to meet with individually.

### **What to expect**

Cronin House is a safe, healthy, structured environment. We provide 3 meals a day and 2 snacks. Counselors are available for one-on-one sessions. Residents are welcomed by a Big Brother/Sister and are able to ask questions about the program rules at the Community Meeting every morning.



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### Common Questions & Answers

#### What does it take to get into Cronin House?

We are looking for individuals who can benefit from a structured mental health and substance abuse recovery program. We screen to see if the person is able to actively participate in educational skill building groups and the community.

We are not able to serve registered arsonists or sex offenders.

#### We Require

- Current TB test (last 30 days) or chest X-ray within last 90 days. For TB testing schedules call the Immunization Assistance Project at 510-267-3230 or the Public Health Clearing House at 888-604-4636.
- California ID and Social Security card. If you do not have an ID or Social Security card we will consider making exceptions on a case-by-case bases.

#### We Request

- That residents bring approximately 30 days-worth of medication. Our program is 60 days so please request at least one refill. Please continue taking your medication while you are waiting to come into the program.

#### Can I smoke?

Yes, we have smoke breaks throughout the day. We allow filtered cigarettes only. We offer smoking cessation classes for residents who wish to quit.

#### How much will it cost?

We charge on a sliding scale according to your income. If you have no income, government assistance is available for those who qualify. If you have MediCal, MediCal covers classes and therapy, the resident pays for the residential portion of the program.

#### Will I have roommates?

Yes, you will have roommates. Our rooms are airy with windows, closets, and fans. We supply bedding, pillows and towels.

#### How soon can I have visitors?

After you have been in the program for 21 days, you are eligible for 2 approved visitors, on the following Sunday. To be approved, visitors must attend the Thursday night Family Group Meeting at 6:30 pm, the Thursday before they visit.

#### How long do I have to wait before I can come in?

If you have *submitted all of the required items*:

1) the Screening form, 2) a TB test in the last 30 days, and 3) *have been notified by our Intake Coordinator that you are approved*, be prepared to enter the program at any time. While you are waiting, take care of yourself by accumulating clean time, seeing your psychiatrist to get your medications updated and going to your doctor and dentist to take care of any physical and dental issues.

PLEASE FAX OR MAIL:  
THE INTAKE SCREENING FORM AND YOUR TB TEST RESULTS,  
ATTENTION INTAKE COORDINAOR, CRONIN HOUSE  
2595 DEPOT ROAD, HAYWARD, CA 94545  
FAX 510-300-3392.

# Cronin House

## Intake Screening Form

Today's Date: \_\_\_\_\_

### PERSONAL INFORMATION

Full Name *Last* \_\_\_\_\_ *First* \_\_\_\_\_ *M.I.* \_\_\_\_\_

Alias or Maiden Name *Last* \_\_\_\_\_ *First* \_\_\_\_\_ *M.I.* \_\_\_\_\_

Preferred Name *Last* \_\_\_\_\_ *First* \_\_\_\_\_ *M.I.* \_\_\_\_\_

What is your preferred gender? \_\_\_\_\_

Address \_\_\_\_\_  
*Street Address* \_\_\_\_\_ *Apartment/Unit #* \_\_\_\_\_

*City* \_\_\_\_\_ *State* \_\_\_\_\_ *ZIP Code* \_\_\_\_\_

Phone \_\_\_\_\_ Message Phone \_\_\_\_\_

Do you give Cronin Staff permission to state what type of agency we calling from?  Yes  No

Birth Date \_\_\_\_\_ Social Security No. \_\_\_\_\_ CA ID or Driver's License# \_\_\_\_\_

Years of Education \_\_\_\_\_ College \_\_\_\_\_ H.S. Graduate \_\_\_\_\_ GED \_\_\_\_\_

Ethnicity  Caucasian/White  African American/Black  Chinese  Vietnamese  Laotian  Cambodian  Japanese  Latino  Native American  Filipino  Other Asian  Other Southeast Asian \_\_\_\_\_  Bi-Racial \_\_\_\_\_  Other \_\_\_\_\_

Hispanic  Not Hispanic  Cuban  Puerto Rican  Mexican/Mexican-American  Other Latino \_\_\_\_\_  Other Hispanic \_\_\_\_\_

Current Marital Status  Never Married  Married  Divorced  Partnered  Separated  Widowed

Total Number of Children Aged 0-17? \_\_\_\_\_  
Total Number of Children Aged 18 & Over? \_\_\_\_\_  
Living With You \_\_\_\_\_

### EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_  
*Street Address* \_\_\_\_\_ *Apartment/Unit #* \_\_\_\_\_

*City* \_\_\_\_\_ *State* \_\_\_\_\_ *ZIP Code* \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### HOUSING INFORMATION

Do you have a permanent, stable residence?  Yes  No

Are you homeless?  Yes  No If yes, how long? \_\_\_\_\_

With whom are you living?

Self  Spouse/Mate  Parents  Shelter  Children  Friends  Relative  Other Program

Who referred you to Cronin House (be specific)? \_\_\_\_\_

**EMPLOYMENT & INCOME**

If employed, your occupation: \_\_\_\_\_ State monthly income: \_\_\_\_\_

Are you receiving:  AFDC  SSI  SDI  General Assistance  Other \_\_\_\_\_

**HEALTH INSURANCE**

Do you have Medi-Cal?  Yes  No If yes, which county? \_\_\_\_\_

**LEGAL**

Are you on Probation?  Yes  No Parole?  Yes  No What County? \_\_\_\_\_

If yes, name of Probation/Parole Officer: \_\_\_\_\_ City: \_\_\_\_\_

Do you have any outstanding warrants?  Yes  No Describe: \_\_\_\_\_

Do you have any restraining or stay away orders?  Yes  No Describe: \_\_\_\_\_

How many arrests in the past 24 months? \_\_\_\_\_

Describe arrest history: \_\_\_\_\_

Are you a registered sex offender?  Yes  No When? \_\_\_\_\_

Any charges/conviction of arson?  Yes  No Describe: \_\_\_\_\_

If any, please describe your past criminal history within 10 years:

Do you have any court dates and/or appointments upcoming?  Yes  No Describe: \_\_\_\_\_

**HEALTH**

Do you have any medical issues such as hypertension, diabetes, lupus, etc?  Yes  No If yes, describe: \_\_\_\_\_

Do you have any physical limitations?  Yes  No If yes, describe: \_\_\_\_\_

Are you pregnant?  Yes  No

Are you currently on Methadone?  Yes  No If yes, which medical clinic: \_\_\_\_\_

Are you currently on Suboxone?  Yes  No If yes, name of prescribing doctor: \_\_\_\_\_

Have you ever experienced any head injuries?  Yes  No If yes, please describe: \_\_\_\_\_

Are you allergic to any medications or food?  Yes  No If yes, please describe: \_\_\_\_\_

Do you have any ailments or conditions for which you would like to seek medical attention within the next six (6) months? If yes, please explain: \_\_\_\_\_

Place of last psychological examination: \_\_\_\_\_

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

Have you ever attempted suicide? Yes No If yes, when? \_\_\_\_\_

Where? \_\_\_\_\_ How many times? \_\_\_\_\_

Have you ever been a victim of violence (physical, verbal, mental)? Yes No If yes, explain: \_\_\_\_\_

Are you currently experiencing hearing voices or hallucinations? Yes No

**MENTAL HEALTH HISTORY**

Mental Health Diagnosis Medication Prescribed

| Mental Health Diagnosis | Medication Prescribed |  |  |
|-------------------------|-----------------------|--|--|
|                         |                       |  |  |
|                         |                       |  |  |
|                         |                       |  |  |
|                         |                       |  |  |
|                         |                       |  |  |

**ALCOHOL AND DRUG HISTORY**

How often do you drink alcohol? Daily 3-6 times in past week 1-2 times in past week  
Whenever I do drugs 1-3 times in past month

What is your drug of choice? \_\_\_\_\_

How often do you use this drug? No use in prior month 1-3 times in past month 1-2 times in past week  
3-6 times in past week Daily

When did you last use? \_\_\_\_\_

Do you use prescription drugs? Yes No Which one(s)? \_\_\_\_\_

What other drugs do you use? \_\_\_\_\_

Are you currently experiencing any detox symptoms such as: Runny Nose Restless Sleep Hallucinations  
Blackouts Diarrhea Seizures Sweats Tremors Paranoia

Are you a cigarette smoker? Yes No

*I certify that my answers are true and complete to the best of my knowledge.*

*If this screening leads to admission to Cronin House, I understand that false or misleading information may invalidate my screening application.*

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

If applicable, signature of Provider: \_\_\_\_\_ Date: \_\_\_\_\_

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