

OAR/ARLINGTON - REGISTRATION FORM

PERSONAL INFORMATION

Please complete this form to the best of your ability. If you have questions do not hesitate to ask.

Name: _____ S.S.N.: _____

Date of Birth: _____ Gender: _____ Ethnic Origin: _____

Marital Status: _____ Number of Children: _____

Current Address: _____
Street Apt #

City State Zip Current Telephone: (_____) _____

Permanent Address: _____
Street Apt #

City State Zip Permanent Telephone: (_____) _____

Are you a U. S. citizen? Yes ___ No ___ If No, Green Card Number: _____

Are you a U. S. veteran? Yes ___ No ___ Type of Discharge: _____

How did you hear about OAR? _____

Have you ever been to OAR in the past? _____ If Yes, when?

What services did you receive from OAR in the past? (please circle) Transportation assistance Identification Clothing assistance Shelter referral Rental assistance Food assistance Employment assistance other _____

SIGNIFICANT CONTACT PERSONS

Emergency Contact: _____ Relationship: _____

Permanent Address: _____
Street Apartment Number

City State Zip Telephone: (_____) _____

Probation/Parole Officer: _____ Telephone: (_____) _____

Jurisdiction: _____ Probation/Parole End Date: _____ Frequency of Contact: _____

Attorney: _____ Telephone: (_____) _____

EDUCATIONAL HISTORY

Highest grade completed (Circle One.): 1 2 3 4 5 6 7 8 9 10 11 12

High School Diploma? Yes ___ No ___ Year: _____ GED? Yes ___ No ___ Year: _____

Years of College Attended: _____ Colleges Attended: _____

College Degree(s) received: _____ Year: _____ Major(s): _____

Training Program(s): _____ Certification(s): _____

Other Education or Training: _____

WORK HISTORY

Employer	City, State	Job Title	Calendar Year(s)	Reason Left
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Skills:

CONVICTION HISTORY
CURRENT (If Applicable)

Local Jail Inmate Number: _____ State Inmate Number (if applicable): _____

Inmate Jurisdiction: Is your current charge: State ___ Local ___ Federal ___

Current/most recent correctional facility: _____

Current Charges: _____ Upcoming Trial Date: _____

Sentencing Date: _____ If incarcerated, Estimated Date of Release: _____

Outcome/Sentence: _____

Is this your first offense? Yes ___ No ___ Did you receive an OAR orientation while incarcerated?

Did you meet with anyone from OAR while incarcerated? Yes ___ No ___

What programs did you complete while incarcerated? _____

Did you have a mentor or tutor while incarcerated? Yes ___ No ___

PAST

Past Charges	Circle One	Year	Outcome/Sentence/Time Served
_____	Misd/Felon	_____	_____
_____	Misd/Felon	_____	_____
_____	Misd/Felon	_____	_____
_____	Misd/Felon	_____	_____
_____	Misd/Felon	_____	_____

TREATMENT HISTORY

SUBSTANCE ABUSE

Are you currently using drugs or alcohol? Yes ___ No ___ Date of Last Use: _____

Are you currently in a drug treatment program? Yes ___ No ___

Current Program: _____

Counselor: _____ Phone Number: (_____) _____

Beginning Treatment Date: _____ Estimated End Date: _____

Immediate plans following completion: _____

Drug(s) of Choice: _____

Have you been in a drug treatment program previously? Yes ___ No ___

Previous Program(s)	Dates of Attendance	Completed?	
		Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No

MENTAL/MEDICAL HEALTH

Did you receive mental health services while incarcerated? Yes ___ No ___ Where you taking medication while incarcerated? Yes ___ No ___ If Yes, what medications? _____

Are you currently receiving mental health services? Yes ___ No ___

Agency/Medical Center: _____

Psychiatrist/Therapist: _____ Phone Number: (_____) _____

Diagnosis: _____

Have you previously received mental health services? Yes ___ No ___

Where? _____ When? _____

Number of Hospitalizations: _____ When? _____

Do you have any physical disabilities? Yes ___ No ___ What are they? _____

Current Prescribed Medications: _____

SERVICES REQUESTED

(Circle all that apply.)

Social Security Card	Identification	Shelter	Housing
Transportation	Food	Clothing	Mental Health Services
Employment Services	Work-related tools	Medical Services	Substance Abuse Treatment
Other (Please specify): _____		Other (Please specify): _____	

AGREEMENT TO DO MY PART

Our goal is to assist with your transitional process toward becoming a responsible adult member of the community and to help you not return to jail. It is necessary for you to be honest, cooperative, and willing to make better choices so we can effectively be of service to you.

It is important that you follow the guidelines covered by the OAR case manager and job developer for post-release services. We will continue to assist you during this transition if you remain consistent, are actively seeking employment, and follow through on referrals. When you become stabilized in the community, OAR expects you to repay the funds that have been loaned to you so the money will be available for the next person who needs assistance.

Individuals needing assistance are given appointments to ensure that they receive the highest quality service OAR can provide. If you cannot keep an appointment time, it is important that you call in advance to reschedule or cancel. By not doing so, you prevent others from seeing a case manager or the job developer in a timely fashion. Failing to keep an appointment without prior notice could negatively impact the assistance you can receive from OAR. Walk-in services are reserved for those just getting released from jail.

I have read and understand my responsibilities to OAR. I agree to communicate honestly and promptly with the OAR staff. I understand that I could forfeit services by not maintaining my responsibility.

Client Signature

Date

RELEASE OF INFORMATION AND LIABILITY

Every reasonable effort will be made to maintain confidentiality about all aspects of my participation with OAR.

I hereby authorize the employees or volunteers of OAR to release and receive information about me with personnel of social service agencies, mental health and substance abuse agencies, community service placement sites, probation and parole officers, jail and prison staff, and other relevant service providers.

I will not hold Offender Aid and Restoration of Arlington County, Inc., its employees, or its volunteers liable for my actions or any injury that I might sustain in or out of the OAR office.

I have read (or had read to me) this document. I fully understand its meaning and I agree to its contents.

Client Signature

Staff Signature

Client Name Printed

Date registration received by OAR

Date Signed

New Clients: Please sign both the top and bottom sections of this page.