The Farm
IN GALONG

APPLICATION FORM

Instructions: The following form is required to begin the application process to The Farm. The form should be printed and completed by hand, then scanned and emailed or mailed to The Farm (info below).

Mailing Address: The Farm in Galong, c/o Admissions, PO Box 151 HARDEN NSW 2587

Email: office@galongfarm.org

Website: Detailed information on our programs and the assessment process can be found at: www.thefarmingalong.com.au

Applicant Unique Identifier ____________

Applicant Date of Birth ________________

ABOUT YOU:

First let us know something about your hopes for the future.

Answer these questions:

1. What is my intention in coming to the Farm?

2. How do I want to change how I live my life?

3. How do I want this to benefit the people in my life?

4. What are my deepest hopes and aspirations?

PERSONAL DETAILS:

Full Name: ____ Date: ______________
Last *First* *M.I.*

Address: ____
Street Address *Unit*

____
City *State* *Postcode*

Phone: ___________________________ Email: ________________________________

Medicare no: ________________ **CRN:** ______________

Cultural background: _____________________ Language spoken: ____________________

Interpreter required? (Yes/No) ____________

Name of Emergency Contact: ____

Emergency Phone contact number: ____

Relationship: ____

Is it OK to leave a message? ☐Yes ☐No

REFERRAL INFORMATION:

Please specify referring agency: ____

Contact name at referring agency: ____

Time in treatment: ____

EDUCATION (highest level achieved):

☐No formal schooling
☐Some Primary School
☐Completed Primary School
☐Some Secondary or High School
☐Completed Secondary or High School
☐Some College/TAFE/University (not complete)
☐Completed University Degree/Masters/PhD

INCOME SOURCE:

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☐Disability Support Allowance
☐Newstart Allowance
☐Childcare Benefit
☐Parenting Payment
☐None
☐Other (please specify) ___________________________________

NB: Costs: Residents contribute 80% of their Centrelink benefit or equivalent. The remainder of the benefit is held in a trust account.

FAMILY:

Name of family member	Relationship	Age	Do you have contact with them?

If you have children, please complete the information below.

Name of child	Age	Who do they live with?

Are you currently involved with any of the following services?

☐Department of Community and Justice Services NSW
☐Child and Youth Protection Services ACT
☐Other (please specify) ___________________________________

LEGAL MATTERS:

Lawyers Name: ___________________________________

Phone no.: _______________________________________

Are you currently on parole? ☐Yes ☐No

If yes, please provide the name of your parole officer: _____________________________________

Phone no.: _______________________________________

Do you have any requirements you have to satisfy for DCJ or CYPS? ☐Yes ☐No

If yes, please provide the name of your case worker: ______________________________

Phone no.: ______________________________

Do you have any fines, charges or warrants outstanding or pending? ☐Yes ☐No

If yes, explain:

____

____

____

If you have been or are currently in a correctional center what are the charges for which you have been detained?

____

____

Please list any upcoming court dates:

____

____

____

PHYSICAL HEALTH:

Doctor's name:		Doctor's phone number:	
Please tick any health issues that apply to you:	☐Visual Impairment ☐Hearing impairment	☐Pregnant ☐Communicable diseases: (e.g. HIV, Hepatitis)	☐Acquired Brain Injury ☐Mobility concerns
Describe any physical health concerns:	List any allergies:	Please indicate the number of **overnight** hospital visits in the **last 12 months** for **physical problems:**	Please indicate the number of **Emergency Department** visits in the **last 12 months** for any issue:

MENTAL HEALTH:

Have you been diagnosed with a mental health problem by a qualified mental health professional…	within the last 12 months? within your lifetime?	☐Yes ☐ Yes	☐No ☐ No
Have you been hospitalized for mental health concerns…	within the last 12 months? within your lifetime? currently?	☐Yes ☐ Yes ☐ Yes	☐No ☐ No ☐ No
Have you received treatment for a mental health, emotional, behavioral or psychological concern from a professional…	within the last 12 months? within your lifetime?	☐ Yes ☐ Yes	☐ No ☐ No
Name of service provider:			
Contact information for service provider:			
Are you prescribed medication for mental health concerns?		☐ Yes	☐ No
Do you engage in self-harm behaviours? (e.g. cutting)	☐ Yes ☐ No	If yes, what?	
Have you ever attempted suicide?	☐ Yes ☐ No	If yes, when?	
Have you ever overdosed?	☐ Yes ☐ No	If yes, when?	

MEDICATIONS:

Please indicate any current medication/s	Please indicate your current dosage/s
1.	
2.	
3.	
4.	
5.	
6.	

SUBSTANCE USE HISTORY:

Please indicate any substances used in the past 12 months (select all that apply)

Substance	Date used	Method of use
Alcohol		☐Smoked ☐Snorted ☐Injected ☐ Swallowed

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Amphetamines and other stimulants		☐Smoke ☐Injected	☐Snorted ☐ Swallowed
Barbiturates		☐Smoked ☐Injected	☐Snorted ☐ Swallowed
Cannabis		☐Smoked ☐Injected	☐Snorted ☐ Swallowed
Cocaine		☐Smoked ☐Injected	☐Snorted ☐ Swallowed
Ecstasy/MDMA		☐Smoked ☐Injected	☐Snorted ☐ Swallowed
Heroin		☐Smoked ☐Injected	☐Snorted ☐ Swallowed
Methamphetamines (e.g. crystal meth)		☐Smoked ☐Injected	☐Snorted ☐ Swallowed
Other psycho-active substances		☐Smoked ☐Injected	☐Snorted ☐ Swallowed
Over the counter codeine		☐Smoked ☐Injected	☐Snorted ☐ Swallowed
Prescription opioids		☐Smoked ☐Injected	☐Snorted ☐ Swallowed
Tobacco		☐Smoked ☐Injected	☐Snorted ☐ Swallowed
Other		☐Smoked ☐Injected	☐Snorted ☐ Swallowed

How old were you when you first tried any drug or alcohol? ___________________________

How old were you when you first tried your current drug of choice? _____________________

Thank you for completing the Farm Application Form

For Office Use Only:	Has the assessment been completed? ☐ Yes ☐ No
	On what date was the assessment completed?
	If no assessment was completed please indicate why:
Admissions Staff Name:	
Admissions Staff Signature:	