Tunica Biloxi Tribe
Healthy Transitions

755 Earl Barby Sr Blvd
Mansura, Louisiana 71350
Phone: 318-240-6450

YOUTH PARTICIPANT APPLICATION

Please read each question carefully before answering. Failure to complete all required Healthy Transitions forms will delay the process of your application. False or misleading information will be treated as a false statement and may lead to you being disqualified from the program.

PERSONAL INFORMATION

Name: _____ DOB: _____/_____/_____

Address: _____

Mailing Address if different: _____

Currently Living: Alone _____ Spouse/Significant Other _____ Parent(s): _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ SSN: _____/_____/_____

Emergency contact information

_____ _____ _____

Name Number Relationship

EDUCATIONAL HISTORY

Level of Education: In School___ HS Diploma __GED ___College___ Year Complete _____

Vocational Degree _____ College Degree_____

Are you currently enrolled in any educational or skill development program? Yes___ No ____

If yes, explain: _____

Have you ever been diagnosed with a learning disability? Yes____ No ____

If yes explain: _____

FINANCIAL STATUS & EMPLOYMENT HISTORY:

Do you receive any public assistance? Yes___ No____

Social Security? Yes____ No____

SSI? Yes ___ No ___

Other? _____

Are you currently employed? Yes___ No___ Full-time____ or Part-time_____

Health Insurance? Yes ____ No____

MILITARY HISTORY:

Branch of Service: _____ Highest Rank Achieved: _____

Length of Service: _____ Discharge Type: _____

FAMILY HISTORY:

Family history of mental illness or substance abuse? Yes___ No___

Current Status: Single____ Married ____ Divorce: ____ Separated: ___ Widowed: ___

Name of spouse or significant other: _____

Do you have any children? Yes ___ No___

Do they reside with you? Yes___ No____

Children's names, ages and living situation

Name: _____ Age: ____Living : _____

Name: _____ Age: ____ Living: _____

Name: _____ Age:____ Living: _____

MONTHLY EXPENSES:

Rent/mortgage_____ Utilities_____

Phone_____ Food_____ Clothing_____

Medication_____

PHYSICAL/MENTAL HEALTH:

Please list any current mental health diagnosis: _____

Treating Psychiatrist: _____ Agency: _____

Phone No: _____

Current Medications: _____

Side Effects:_____
Please list any current physical problems:_____

Have you been hospitalized in the last year? Yes___ No____ Date(s)_____

History of suicidal ideations (threats, attempts)? Yes____ No___ Year(s)_____

Please explain: _____

Is there anything you would like us to know?

_____
_____
_____
_____
_____

Thank you.