



RESIDENTIAL TREATMENT APPLICATION

Intake Fax No.: (775) 738-2625

Intake Fax No.: (530) 541-0456

Please circle your facility preference and fax application to the respective Intake department.

Date Application Completed: _____ Referral Source? _____

How did you find out about our program(s)? _____

Applicant Name: _____

Mailing Address: _____
P. O. Box or Street City State Zip Code

Physical Address: _____
Street Address City State Zip Code

How long at this address? (months/years) _____ Are you homeless? _____ For how long? _____

() _____ () _____ () _____
Home Phone Cell Phone Message Phone

Age: ____ Sex: ____ Transgender: M to F or F to M (circle one) Date of Birth: _____

Social Security #: _____ - _____ - _____ Birth City: _____

Your Race: _____ Your Ethnicity: (Circle One) Hispanic or Not of Hispanic Origin

Your Mother's First Name: _____ Religious Preference: _____

CHILDREN:

How many children do you have? _____ What are their ages? _____

Is there an open Child Protective Services (CPS) case? Yes: _____ No: _____

Are they in foster care? Yes: _____ No: _____ Who will care for your children during your treatment?

ALCOHOL AND DRUG HISTORY:

Last Date of Use? _____ Are you an IV drug user? Yes: ____ No: ____

List all substances used in the past 12 months:

ALCOHOL/DRUGS USED	AGE OF FIRST USE	PAST 30 DAY USE	HOW MANY YEARS HAVE YOU USED?	FREQUENCY AND AMOUNT	METHOD OF USE

Have you experienced withdrawal symptoms? Yes: ____ No: ____ Please list symptoms below:



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Have you used methadone? Legally? Yes: _____ No: _____ Illegally? Yes: _____ No: _____
 Form: Liquid or Tablet? _____ Dose? _____ Date Taken? _____
 Have you used Suboxone? Legally? Yes: _____ No: _____ Illegally? Yes: _____ No: _____
 Form: Tablet? _____ Dose? _____ Date Taken? _____
 Do you smoke or chew tobacco? Yes: _____ No: _____ How much/How often? _____

TREATMENT HISTORY:

Have you been in residential treatment before? Yes: _____ No: _____
 What Program(s) did you attend? Please give the approximate dates of attendance? _____

Did you complete? Yes: _____ No: _____ How long did you remain abstinent after discharge? _____
 Have you attended Outpatient services? Yes: _____ No: _____
 Name of Organization and approximate dates of attendance: _____

Did you complete? Yes: _____ No: _____ How long did you remain abstinent after discharge? _____
 Have you ever been in a medical or social detox? Yes: _____ No: _____ How many times? _____
 Name of facility and approximate dates of attendance? _____
 What withdrawal symptoms did you experience? _____

MEDICAL HISTORY:

Have you experienced seizures? Yes: _____ No: _____ Mild _____ Moderate _____ Severe _____
 Date of last Seizure: _____ Frequency of Seizures: _____
 What is/was cause of your seizures? _____

List all medical issues: _____

PLEASE BE ADVISED OF THE FOLLOWING STATED IN OUR MEDICATION POLICY:

- YOU MUST BRING ENOUGH PERScription MEDICATION FOR AT LEAST 30 DAYS WITH AVAILABLE REFILLS AND THE FINANCIAL MEANS TO OBTAIN THE REFILLS IF NECESSARY.
- SOME MEDICATIONS SUCH AS NARCOTICS AND BENZODIAZEPINES WILL NOT BE AUTHORIZED DURING TREATMENT.
- DO NOT BRING ANY MEDICATION, HERBS OR SUPPLEMENTS THAT HAVE NOT BEEN PRE-AUTHORIZED BY THE MEDICAL STAFF OF VITALITY CENTER AND ACTIONS PROGRAMS.
- ANY UNAUTHORIZED MEDICATIONS, HERBS, SUPPLEMENTS, INCLUDING VITAMINS, BROUGHT TO VITALITY CENTER **WILL BE DESTROYED.**

NOTE: PLEASE READ AND COMPLETE THE MEDICAL RESPONSIBILITY FORM ON PAGE 5 AND READ THE FULL MEDICATIONS POLICY ON PAGE 10 BEFORE YOUR INTERVIEW.

PLEASE LIST ALL MEDICATIONS:

Medication	Reason	Prescribing Doctor

What medications are you allergic to? _____ Symptoms? _____

Are you NOT taking a medication that you should be taking? Yes: _____ No: _____ What? _____



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Have you recently stopped taking a medication? Yes: ____ No: ____ What? _____

Do you have difficulty with your vision or hearing? _____ Physical disability? Yes: ____ No: ____

Do you have any other allergies? Yes: ____ No: ____ What? _____

Please list any other allergies, special needs or disabilities: _____

Pregnant? Yes: ____ No: ____ Due date: _____ Prenatal Care? Yes: ____ No: ____

Have you had any problems during pregnancy? Yes: ____ No: ____ If yes, please explain: _____

MENTAL HEALTH:

Have you ever had a mental health diagnosis? Yes: ____ No: ____ Diagnosis: _____

Who confirmed the diagnosis? _____ Where? _____

Please explain your symptoms? _____

Have you attempt suicide as an adolescent? Yes: ____ No: ____ As an adult? Yes: ____ No: ____

How many times have you attempted suicide? _____ Did you have a plan? Yes: ____ No: ____

Please explain what happened: _____

Do you feel suicidal now? Yes: ____ No: ____ When did you last feel suicidal? _____

LEGAL STATUS:

How many times have you been arrested? _____ How many convictions? _____

List and describe your convictions and the outcome of sentencing:

1. _____ Approximate Date: _____

Circumstances: _____ Disposition Complete? Yes: ____ No: ____

2. _____ Approximate Date: _____

Circumstances: _____ Disposition Complete? Yes: ____ No: ____

3. _____ Approximate Date: _____

Circumstances: _____ Disposition Complete? Yes: ____ No: ____

Have you been ordered here by: CPS: ____ Probation: ____ Parole: ____ Court: ____ Other: ____

Name of Social Worker; Probation/Parole Officer; Judge; etc.: _____

Has there ever been a Restraining Order against you? Yes: ____ No: ____ Current? Yes: ____ No: ____

To your knowledge, do you currently have any outstanding warrants? Yes: ____ No: ____

Have you ever been charged with a sex offense? Yes: ____ No: ____

Have you ever been involved in sexual misconduct? Yes: ____ No: ____

Have you ever been convicted of or arrested for a violent incident? Yes: ____ No: ____

Do you have any upcoming court dates? Yes: ____ No: ____

Please explain any "Yes" answers. Be specific, give dates and circumstances; were you under the influence?



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Marital Status:

Married _____ Widowed _____ Divorced _____ Separated _____ Single/Never Married _____
Living Together _____ Domestic Partnership _____ Common Law Marriage _____

Does anyone in your household drink or use drugs? Yes: _____ No: _____

If "Yes", who and how do you deal with their use? _____

FAMILY AND SOCIAL RELATIONSHIPS:

Is there anyone in your family of origin (mom, dad, grandparents, etc.) that either have a problem with addiction or have had a problem with addiction? Yes: _____ No: _____

Do you have any family members or friends in "recovery"? Yes: _____ No: _____

Has your substance use created problems within your family? Yes: _____ No: _____

Please explain any "yes" answers: _____

Have you ever been involved in a physically or sexually abusive relationship? Yes: _____ No: _____

Have you ever been a victim of a violent crime? Yes: _____ No: _____

Have you served in the military? Yes: _____ No: _____ During wartime? _____ During Peacetime? _____

Please explain any "yes" answers: _____

Do you have any gang affiliation or socially offensive tattoos? Yes: _____ No: _____

IF you answer "YES" to this question, what are they and where are they located? _____

FINANCIAL:

Are you employed? Yes: _____ No: _____ Do you have Health Insurance? Yes: _____ No: _____

What is your monthly income? _____ Source of Income? _____

How do you plan to pay for your treatment? _____

If you answered "YES" to Health Insurance, please FULLY complete the last page of this application and submit immediately. If you do not complete the insurance information, we will be unable to acquire pre-authorization and therefore, unable to bill your insurance. You would then be solely responsible for payment of your treatment bill. Please have your insurance card at the time of admission. Pre-Authorization must be confirmed for you to be admitted into treatment. Also, please know that pre-authorization by insurance is not a guarantee of payment.



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Do you have Medicaid? Yes: ____ No: ____ Medicaid #: _____

If you answered "YES" to Medicaid, please bring your Medicaid card with you for admission. Please be aware that not all Medicaid plans pay for substance abuse treatment. An FH-11 has to be completed and submitted and approval confirmed, prior to admission into treatment.

Medical Responsibility

I, _____, affirm (1) that I will have sufficient

Printed Name of Responsible Party

funds available to pay any and all necessary expenses in the event that medical necessity and or medications/refills are needed for _____, during

Printed Name of Patient

that period of time in which she/he is receiving residential treatment services through Vitality Center, and (2) barring unforeseeable circumstances, will be able to pay for travel to and from their home at the time they discharge from the program.

Date: _____

Responsible Party Signature

Debit and Credit Card Payments:

By your signature below, you or the debit/credit cardholder hereby authorizes the charges detailed above for the duration of your treatment and/or Detoxification Services to the debit/credit card listed below:

Visa MC Card No.: _____ Expiration Date: _____ Amount: _____

Patient or Cardholder's signature: _____ Date: _____

Please use the space below to describe why you want or feel that you need to be in Residential Treatment at this time and to clarify or add any information you feel is relevant to your admission:

This is to verify that all the above information is true and accurate to the best of my knowledge. I further understand that to misrepresent or withhold any relevant information could result in my application being withdrawn.

Signed: _____

Applicant Signature

Date: _____

HEALTH DIVISION PLACEMENT CRITERIA WORKSHEET

Client Name: _____

Date: _____

#	Question	YES	NO
1a.	Have you ever had life threatening symptoms during withdrawal?		
1b.	Are you currently having similar withdrawal symptoms?		
2.	Do you have any current, severe and untreated physical health problems?		
3.	Do you feel that you are in danger of harming yourself or someone else?		
4a.	Do you feel that you have an immediate need for alcohol and or drug treatment?		
4b.	Are you being required to enter treatment by any of the following: Criminal Justice System; Social Services; Employer; School; Family Member(s)?		
5a.	Are you currently under the influence of alcohol or drugs?		
5b.	Are you likely to continue using or relapse in an imminently dangerous manner?		
6.	Are there any dangerous family members, significant other, living situations, work situations, or school situations which threaten your immediate safety and or your sobriety?		

DO NOT WRITE BELOW THIS LINE

FOR STAFF USE ONLY

Dimension #	Dimension	High	Med.	Low
1.	Acute Intoxication and or Withdrawal Potential.			
2.	Biomedical Conditions and Complications.			
3.	Emotional, Behavioral or Cognitive Conditions and Complications.			
4.	Readiness to Change.			
5.	Relapse, Continued Use or Continued Problem Potential.			
6.	Recovery and Living Environment. (Legal, Homelessness, Friends, Family)			

Preliminary Assessment/Recommendation: _____

Determination: APPROVED: Yes: ____ No: ____

DENIED: Yes: ____ No: ____

Reviewed by: _____
Clinical Supervisor/Clinical Staff Signature

HDPC LOC Placement: _____
Date: _____



Medication Policy

VITALITY CENTER supports the use of prescription medication for co-occurring disorders. Our staff works closely with primary physicians and care givers to ensure your stay with us is productive. When you apply for admission to **VITALITY CENTER**, you must list **ALL** medications, herbs, vitamins, and supplements you are currently taking. All medications, herbs, vitamins, and supplements must be pre-authorized by the medical and clinical staff prior to your admission. If you present with non-authorized medications, herbs, vitamins, or supplements, please know that these items will be destroyed immediately upon admission. Here are some of the things you need to know before you make a decision to enter our program.

- 1. Do not bring any medication, herbs or supplements that have not been pre-authorized by the medical staff of VITALITY CENTER and ACTIONS Programs. Some medications such as narcotics and Benzodiazepine will not be authorized, under any circumstances, at any time while you are participating in our programs. Any Unauthorized Medications, herbs, supplements, including vitamins, brought into VITALITY CENTER will be Destroyed.**
- 2. If you either stop taking medication or begin a new medication within 30 days of admission, please make sure you inform the Intake Coordinator. Once you have entered treatment you may only stop medication with a physicians documented consent.**
- 3. You are responsible for bringing enough medication to last throughout your entire stay or you must have the financial ability to pay for refills. VITALITY CENTER will not pay for your medication while you are here. If your prescription changes it will again be your responsibility to pay for the new medication. Part of treatment compliance is taking your medication as prescribed.**
- 4. Some medications are not appropriate for treatment. If you are taking medication that makes you drowsy or lethargic during the day, you may want to talk to your primary physician before entering treatment.**
- 5. VITALITY CENTER requires that all clients bring \$40.00 to be placed on their books for the purpose of paying for medications. This Meds Incidental Fee will be returned to the client at time of discharge, if not used.**
- 6. If you have any medication questions please ask our Intake Coordinator before entering treatment and she will get back to you with answers. All unauthorized medications will be destroyed upon admission.**

Please list the name, phone number and address of three (3) people (spouse, parents, and/or friends) to be contacted in case of an emergency:

By signing this form, I acknowledge my understanding of the VITALITY CENTER Medication Policy and agree to abide by the standards set forth. I am also aware that by not following the policy I can be discharged from treatment for being non-complaint.

Client Signature

Date: _____



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Financial Affidavit

Date: _____

First Name	Last Name	Home Phone	Social Security Number	County (Required)
Physical Street Address		City	State	Zip
Mailing Address		City	State	Zip

I certify through signature that the information given below is true and correct to the best of my knowledge and belief:

Name of current or recent employer	Phone	Gross Income	Contact Person
Address	City	State/Zip	Date Terminated
Other income (SSI, Welfare, Unemployment, Disability)	Amount	State	Position

Other Parties that are providing for your household support

First Name	Last Name	Home Phone	Relationship	County (Required)
Physical Street Address		City	State	Zip
Household Income	Number in Household			

Note: Clients with insurance coverage fully understand that just because pre-authorization is given by their insurance company, **THIS DOES NOT GUARANTEE PAYMENT** for services received. In that event, client agrees to pay for their own treatment and seek reimbursement on their own from their insurance company.

As a client of a treatment program receiving funds administered by SAPTA, you have the right to a determination of fees according to a sliding schedule that takes into account household income and family size. Reduction of fees according to this sliding schedule of fees is contingent upon your providing verifying information. Such documentation (pay stubs, income tax forms, award letters from Social Services or Social Security, bank statements, benefit notice forms, EDD, etc.) must be provided at the Fee and Financial Appointment to determine your co-pay.

You will need to bring with you the following financial information:

- 1) Picture ID
- 2) Proof of income (Check stub, Unemployment award letter, SSI statement, bank statements or Notarized statement by other parties providing your support.
- 3) Insurance Card(s) or proof of insurance or other medical benefits

Any person who signs this statement and willfully states as true any material matter which he/she knows to be false is subject to the penalties prescribed for perjury in the Penal Code by the State of Nevada.

_____	_____	_____
Client Signature	Print Name	Date

_____	_____	_____
Witnessed & Verified	Title	Date

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CLIENTS MUST HAVE:

- Enough appropriate clothing and underwear for seven (7) days. Please don't overdo it, we have laundry facilities. (Keep in mind that it can be very cool in the evenings and hot during the days.)
- Appropriately fitted and decent jeans (dark blue or light blue only; they should be free of holes, with no patches or rips; they must fit properly without being skin tight or sagging).
- PLAIN T-Shirts with absolutely no logos (can not be red or white) must be worn. All clients must have at least three (3) T-Shirts. If you do not have the appropriate shirts, you must bring \$15.00 to purchase the shirts from our store. For cooler weather sweatshirts may also be purchased for \$7.00 each.
- Pajamas are mandatory. You must sleep in p.j.'s or sweat pants and t-shirts. You will also need slippers and a robe is suggested. You will be staying in a communal environment and must always be appropriately clothed.
- Please be mindful of the time of year and bring items that are appropriate for the season. (i.e.: Heavy coat or jacket, boots or heavy shoes, heavy socks and gloves.)
- Hygiene products (soap, toothbrush and paste, deodorant, shampoo and conditioner . . .) Please make sure all products you bring are alcohol free or at the very least, there must be no alcohol in the first 5 ingredients.
- A schedule free of obligations (i.e.: Legal, Medical, Dental . . .) Take care of these obligations PRIOR to entering treatment.

Please be aware that anything containing alcohol will be destroyed, so read all labels before bringing products in with you. The dress code is strictly enforced and anyone determined to be wearing inappropriate clothing will be asked to turn the items into staff and will not be allowed to wear them again.

SUGGESTED ITEMS TO BRING:

- Telephone Card
- Pencils (not mechanical pencils), non-wire bound notepads
- Stamps and envelopes
- Sunscreen
- Hair dryer, curling iron

THINGS YOU MUST NOT BRING INTO TREATMENT:

- No jewelry or other valuables. Vitality Center is not responsible for any lost or stolen items.
- Any sort of Alcohol, Illegal Drugs, or non-authorized prescriptions, herbs, vitamins or supplements.
- No food or beverages of any kind including, candy, gum and cough drops.
- Nothing with alcohol, please read the labels on your shampoo, conditioner and other toiletries.
- Nothing in an aerosol can such as hair spray, foot spray, deodorants. ect. . . .
- Electric toothbrushes, electric razors, perfume or colognes, nail polish, polish remover, mouthwash, . . .
- No bed linens, blankets, throws, pillows, plush toys, or towels, etc. These items will be provided for you.
- No ball point or ink pens, mechanical pencils, markers, highlighters, or wire bound notebooks.
- No magazines or books (exceptions: approved school or recovery books).
- Bicycles, skateboards, . . .
- Weapons of ANY kind (this includes sharp tools, scissors, . . .)
- No tattoo guns or paraphernalia
- No condoms
- No latex or rubber gloves
- Electronic games, radios, TV's, cameras . . .
- Cell phones, beepers, iPods, MP3 players, CD players, DVD players, or lap top's . . .
- Tight, revealing clothing or pants that hang on the hips or at the crotch. No gang affiliated or racist logos or clothing. (Please review dress code)

Please be aware that if any of the above mentioned items are brought in, they will be removed immediately and/or may be destroyed. VITALITY CENTER accepts no responsibility for the violation of rules or client's bad decisions.



CONSENT FOR RELEASE OF CRIMINAL JUSTICE INFORMATION

I, _____, hereby consent to communication between (please circle one of the following) Vitality Center, Elko / Vitality Lake Tahoe and _____

(Print Name of court, probation, parole, and/or other legal referring agency)

Contact Name: _____ Relationship to Client: _____

Phone No.: _____ Fax No.: _____

Address: _____

The purpose of and need for such a disclosure is to inform the Criminal Justice agency (listed above) of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance, or lack of attendance, enrollment in, participation in, completion of or termination, exit or discharge of my treatment program, and the following: _____

I understand that this consent will remain in effect and cannot be revoked by me until:

_____ there has been a formal and effective termination or revocation of my probation, parole, conditional release, or other proceeding under which I was mandated into treatment.

_____ one year after completion or termination of this treatment program.

_____ please specify other expiration of consent _____.

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties.

Signature of defendant/client

Date Signed

Signature of Parent, Guardian, or authorized representative

Date Signed

Signature of Witness

Date Signed

Witness Phone #: _____



CONSENT FOR RELEASE OF CLIENT INFORMATION

I, _____, hereby consent to communication between (please circle one of the following) Vitality Center, Elko / Vitality Lake Tahoe and _____

(Print Name of Individual or Referring Agency)

My relationship with this individual or agency is: _____

Contact Address: _____

Contact No.: _____ Fax No.: _____

Cell Phone: _____

The purpose and need for disclosure is to inform the individual or agency listed above of the following:

I understand that this consent will remain in effect until revoked by the client or one year after completion or termination of treatment.

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of substance abuse client records and those recipients of this information may re-disclose it only in connection with their official duties.

Signature of defendant/client

Date Signed

Signature of Parent, Guardian, or authorized representative

Date Signed

Signature of Witness

Date Signed

Witness Phone #: _____