

REQUEST FOR ADMISSION (RFA) – RESIDENTIAL TREATMENT

Central Intake Department – Phone: 775-461-0999 Fax: 775-562-4754

email: intake@vitalityunlimited.org

DETOX INPATIENT Referred By: _____ Date: _____ Time: _____

Applicant Name: _____ Person Calling: _____ Relationship: _____

()- _____ ()- _____ ()- _____ ()- _____

Applicant's Home Number Applicant's Cell Number Caller's Phone Number Emergency Number

Email address: _____

Address: _____

P.O. Box or Street City State Zip

How long have you been at this address? (months/years) Are you Yes No

homeless?

Female Male Social Security

Age: _____ DOB: ____/____/____ Other Transgender #: _____ - _____ - _____

Marital Status: Single Married Widowed Divorced Separated Veteran Status? Yes No

Do you know anyone who is *currently* in treatment at one of our facilities? Yes No

Date of last use: _____ Are you an IV drug user? Yes No

PLEASE LIST ALL SUBSTANCE OF ABUSE: (INCLUDING ALCOHOL AND PRESCRIPTION DRUGS)

ALCOHOL AND DRUGS BEING USED / HAVE ABUSED INCLUDING PRESCRIPTION OR "LEGAL" SUBSTANCES	AGE OF FIRST USE	NUMBER OF YEARS USED	DAILY CONSUMPTION AMOUNT	METHOD OF USE	TREATED FOR PREVIOUSLY
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you abuse more than one drug at a time? Yes No Do you use daily or binge? Yes No

How many days per week do you drink alcohol or use drugs in a week? _____

Have you ever found yourself unable to stop drinking once you have started? _____

What is the maximum number of drinks you had on any given day in the past month? _____

If you have previously been treated, please list where and when: _____

Are you currently experiencing any withdrawal symptoms? Yes No

If so, please list symptoms: _____

IS THE APPLICANT CURRENTLY USING METHADONE OR SUBOXONE? YES NO DOSE:

Have you ever used Methadone? Legally Illegally Never Liquid Tablet Dose: _____ Date taken: _____

Have you ever used Suboxone? Legally Illegally Never Dose: _____ Date Taken: _____

Do you (check appropriate box): Smoke Chew Vape None of these

Please list **ALL** Medical Conditions: _____

Do you have any disabilities that require reasonable accommodations? Yes No

Check boxes if you have/had a history of the following:

- | | | | | |
|-----------------------------------|--|---|---|---------------------------------------|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Head Trauma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma/respiratory Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Immune Disorder | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Hormone Problems | <input type="checkbox"/> Other |

If you have had seizures: Date of last seizure: _____ Cause: _____

Are you currently pregnant? Yes No If yes how many weeks along: _____

Do you have: Incontinence On-going scheduled health appointments? Current Dental Emergencies

List ALL allergies (medications, animals and foods.) _____

* Please note that Vitality Unlimited does promote the use of therapy animals in its facilities.

Please list ALL Mental Health Concerns:

Have you ever been diagnosed with a Behavioral Health Issue Yes No If yes please explain: _____

Have you ever had outpatient treatment for Mental Health Concerns? Yes No
If yes, please describe when, by whom, and nature of treatment.

Reason: _____

Dates Treated: _____

By Whom: _____

Have you ever been hospitalized for psychiatric reasons? Yes No

Reason: _____

Dates Treated: _____

By Whom: _____

Have you had any past suicide attempts: (please explain) _____

Are you having any suicidal or homicidal ideations? Yes No (if yes, please explain) _____

Has anyone in your family been diagnosed with or treated for: Bipolar Disorder Depression Anxiety
 Anger Suicide Schizophrenia PTSD Alcohol Abuse Other Substance Abuse Violence

Do you have a history of being abused emotionally, sexually, physically or by neglect? Yes No

If yes please describe when, where and by whom: _____

MEDICATIONS-PLEASE INCLUDE ALL PRESCRIPTION, OVER THE COUNTER AND HOMEOPATHIC REMEDIES

Medication	Reason	Dosage	Dates		

Have you ever been arrested? Yes No If yes please explain (dates, charges,) _____

Have you ever been charged with or convicted of a sexual crime? Yes No

Have you ever been charged with or convicted of a violent crime? Yes No

If yes please explain (dates, charges) _____

Do you currently have any legal involvement? Yes No If yes please explain _____

Are you currently on/involved with Parole Probation Drug Court Mandatory SUD treatment order

Current legal proceedings where you are required to appear in court. DUI CPS

Please provide additional details that you feel are important regarding your request to seek treatment: _____

SPECIAL CONCERNS

Religious / Cultural Needs: Yes No Please Explain: _____

Special Learning Needs: Yes No Please Explain: _____

Hearing Difficulty: Yes No Speaking / Communication Difficulty: Yes No

Are you able to sit / stand for long periods of time? Yes No

Limited Mobility: Yes No - Wheelchair Walker Cane Need to get up from class style setting and walk frequently. (Please explain) _____

Please Sign and Date: _____

Date: _____ / _____ / _____

STAFF USE ONLY – DO NOT WRITE WITHIN BOXED AREA

Date received: _____

Intake Review date: _____

Reviewed by the following: _____

Insurance Verification Completed on/by: _____ Pre-Auth Completed by/on: _____

Notes: _____



INSURANCE INFORMATION

A COPY OF THE INSURANCE CARD AND INSURED'S DRIVER'S LICENSE MUST ACCOMPANY THIS APPLICATION

Insurance Carrier: _____
Member ID #: _____ Group #: _____
Medicaid ID #: _____
Prior Authorization / Pre-Certification Phone #: _____

Card copied for file and attached? _____

Driver's license copied for file and attached? _____

INSURED'S INFORMATION

Insured's Name: _____ Relationship to client: _____
Insured's SSN: _____ - _____ - _____ Insured's Birth Date: _____
Insured's Address: _____
City: _____ State: _____ Zip: _____
Insured's Telephone Number(s): _____
Insured's Employer: _____

ADDITIONAL PAYMENT INFORMATION

Name of a family member who can help pay for medications if needed: _____
Address: _____
Phone number(s): Home: _____ Cell: _____

FOR BILLING STAFF USE ONLY

Pre-Authorization: Detox Residential

Date Called: _____ Name of Representative: _____ Ref #: _____
IN Network Provider: _____ Deductible Amount: _____
Premiums Paid Through: _____ Cobra Available Yes No
Co-Pay Required: Yes No Expected Patient Out of Pocket Expense: \$ _____
Claims Address: _____
Substance Abuse Benefits Available: _____

Immediate Clinical & Initial approval

Client's Arrival Date: _____ Time: _____ Admitted to: DETOX RESIDENTIAL
Assessment Completed: _____
Insurance Contacted: _____ Representative: _____
Approval Received Through: _____
Written Confirmation Received: _____
Date of next review: _____
Notes: _____

RESIDENTIAL TREATMENT PACKING LIST

VITALITY CENTER AND VITALITY CARSON CITY ARE TOBACCO FREE FACILITIES

CLIENTS MUST HAVE:

- A schedule FREE of obligations; Legal, Medical, Dental etc. You must take care of your obligations PRIOR to entering treatment.
- Two forms of identification such as driver's license, photo ID, social security card or birth certificate.
- Proof of uninsured client's household income for the past calendar year. Paycheck stubs, W2's, Tax Returns or a notarized letter from an acceptable agency.
- A FULL 30-DAY SUPPLY OF ALL APPROVED MEDICATIONS. Clients must disclose all medications to the intake coordinator during the application process for approval. All unauthorized meds will be destroyed and can result in immediate discharge from the program.
- HPN does not contract with Elko County pharmacies regardless of their other affiliation e.g. Raley's, KMART, Wal Mart etc. HPN clients must be prepared to pay for their medications.
- All clients regardless of their payor source e.g. Private or Public health insurance will be charged for Blister Packs- a required method used to package your medication.
- All clients will be charged \$50.00 per trip for medical transport.
- Enough appropriate clothing and undergarments e.g. socks, underwear, panties, bras for seven (7) days. Please don't overdo it, we have laundry facilities.
- Pants: NO holes or rips. Jeans must fit properly!!! NO skintight or sagging jeans will be allowed.
- Clothing that is considered provocative and gang related will need to be approved by the Rehabilitation Technician III upon your arrival. Certain clothing may or may not be suitable. NO white T-shirts will be allowed.
- Hooded shirts or sweatshirts are not acceptable attire for indoor wear and are only allowed to be worn outside.
- It is mandatory for clients to sleep in p.j.s or sweatpants and t-shirts. Clients need slippers and a robe are suggested.
- Please be mindful of the time of year and bring items that are appropriate for the season. Keep in mind that it can be very cool in the evenings and hot during the days. Heavy coat or jacket, boots or heavy shoes, heavy socks and gloves may be necessary in winter.
- Hygiene products; soap, toothbrush and toothpaste, deodorant, sunscreen, shampoo and conditioner etc. Please make sure to read all product labels, there must be no alcohol in the first 5 ingredients in all toiletry products.
- Clients must purchase any Tobacco replacement products from the client store.
Please be aware that anything containing alcohol will be sent home or destroyed. Read all labels carefully before bringing products 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.

PLEASE NOTE: Communication with family and friends will be restricted to written form for the first half of the treatment stay. For example: 30 day = 15 day black out.

VITALITY UNLIMITED will not and CAN NOT mail prescription to the clients. All clients must be responsible for signing out their medication upon discharge. Any medication left behind will be destroyed.

SUGGESTED ITEMS CLIENTS SHOULD BRING:

- Telephone Card. All outbound calls will require a calling card.
- Non-wire bound notepads for writing letters along with stamps and envelopes.
- Hair dryer, curling iron etc.

PLEASE LIMIT THE AMOUNT OF LUGGAGE YOU BRING TO TREATMENT. VALUABLES SHOULD BE LEFT AT HOME AS

VITALITY WILL NOT BE LIABLE FOR LOST OR STOLEN ITEMS.

THINGS YOU MUST NOT BRING INTO TREATMENT:

- Any sort of Alcohol, Illegal Drugs, or un-authorized prescriptions, herbs, vitamins or supplements.
- Tobacco replacement products must NOT be brought into treatment, include Commit lozenges and nicotine patches.
- No food or beverages of any kind including; candy, gum and cough drops.
- Nothing with alcohol, please read the labels on your toiletries.
- Nothing in an aerosol can such as hair spray, foot spray, deodorants.
- Electric toothbrushes, electric razors, perfume or colognes, nail polish, polish remover or mouthwash.
- Bed linen, blankets, throws, pillows, plush toys, or towels, etc. These items will be provided for you.
- Ball point or ink pens, mechanical pencils, markers, highlighters, or wire bound notebooks.
- Magazines or books. Exceptions will be made for approved school or recovery books.
- Bicycles or skateboards.
- Weapons of ANY kind this includes sharp tools and scissors.
- Tattoo guns or drug paraphernalia.
- Condoms.
- Latex or rubber gloves.
- Electronic games, radios, TV's or cameras.
- Cell phones, beepers, iPods, MP3 players, CD players, DVD players, or laptops.
- Tight, revealing clothing or pants that hang on the hips or at the crotch. No gang affiliated or racist logos or clothing.

*****Please be aware that if any of the above-mentioned items are brought in, they will be removed immediately and/or may be destroyed.***