REQUEST FOR ADMISSION (RFA) – RESIDENTIAL TREATMENT

Central Intake Department – Phone: 775-461-0025 ext. 109 Fax: 775-461-0512
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 homeless? ☐ Yes ☐ No

Age: ________ DOB: ____/____/____ ☐ Female ☐ Male ☐ Other ☐ Transgender Social Security #: ____-____-____

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
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ 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:

☐ Stroke	☐ Diabetes	☐ Neurological Disorders	☐ Thyroid Disease	☐ Head Trauma
☐ Cancer	☐ Heart Disease	☐ High Blood Pressure	☐ Liver Disease	☐ Chronic Pain
☐ Epilepsy	☐ Seizures	☐ Asthma/respiratory Problems	☐ Stomach Problems	☐ HIV
☐ Migraine	☐ Immune Disorder	☐ Sexually Transmitted Disease	☐ Hormone Problems	☐ 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 Our of Pocket Expense: $
Claims Address: ____________________
Substance Abuse Benefits Available: ____________________

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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: ____________________

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VITALITY INTEGRATED PROGRAMS
COMPLETE BEHAVIORAL HEALTH

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.***

______________________________ ____________________

Signature **Date**