VITALITY UNLIMITED
VITALITY INTEGRATED PROGRAMS
COMPLETE BEHAVIORAL HEALTH

www.vitalityunlimited.org

REQUEST FOR ADMISSION (RFA)

Admission Department ~ Cell: 775-934-8537 | Fax: 775-461-0062 | Phone: 775-461-0999
email: intake@vitalityunlimited.org

Date: ______________________

Applicant Name: ______________________ Phone Number: ______________________

Caller Name: ______________________ Phone Number: ______________________

Referral Source: ______________________

Covid-19 Vaccination No Yes Willing to get vaccinated? No Yes

Do you think you need substance abuse treatment? No Yes Why/why not? ______________________

APPLICANT INFORMATION

Address: ______________________
PO Box or Street City State Zip

Email address: ______________________

DOB: ______________________

Gender: ☐Male ☐Female Identifies As: __________ Pronouns: __________

Race: __________ Ethnicity: __________

Veteran:No Yes Are you homeless? No Yes How long? __________

Currently Incarcerated:No Yes List facility: ______________________

Emergency Contact: ______________________ Phone: ______________________

Relationship: ______________________

MEDICAL PAST AND PRESENT

Height: __________ Weight: __________ Last medical exam/Dr.'s appointment: __________

Currently Pregnant: No Yes Unknown Due Date: __________

Are you currently receiving prenatal care? No Yes

Do you have or have you had any of the following? (Please check all that apply.)

Allergies	No	Yes	Heart Condition	No	Yes	Neurological Disorder	No	Yes
Asthma	No	Yes	Hernia	No	Yes	Open Sores/Wounds	No	Yes
Cancer	No	Yes	Hepatitis A B or C	No	Yes	Seizures	No	Yes
COPD	No	Yes	High Blood Pressure	No	Yes	STD	No	Yes
Diabetes	No	Yes	Immune Disorder	No	Yes	Surgery	No	Yes
Epilepsy	No	Yes	Liver Disease	No	Yes	Thyroid Disorder	No	Yes
Head Injury	No	Yes	Loss of Consciousness	No	Yes	Tuberculosis	No	Yes

MEDICATION

Are you currently taking pain medication? No Yes Explain:

Please list *ALL* prescriptions, over the counter, and homeopathic remedies

____

____

Are you capable of administering your own medication? No Yes

SPECIAL NEEDS

Do you have any disabilities? No Yes Explain: ____________________

Do you require reading glasses? No Yes Type: ____________________

Do you have ambulatory issues? No Yes Explain: ____________________

Do you require any of the following? (Check all that apply) Wheelchair Walker Cane

Do you have any special learning needs? No Yes Explain: ____________________

Do you have hearing difficulty? No Yes Do you have a hearing aid? No Yes

Do you have speaking/communication difficulty? No Yes Explain: ____________________

Do you have reading difficulty? No Yes Explain:

LEGAL

Are you involved with the judicial/legal system now? No Yes Explain:

Are you on probation, or parole? No Yes Is treatment court ordered? No Yes

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

Explain: ____

Have you ever been charged with, arrested for, or convicted of a sex crime? No Yes

Explain: ____

EMOTIONAL

Do you think that you need mental health treatment? No Yes Explain: ____________________

Have you ever harmed yourself intentionally? No Yes Explain: ____________________

Have you ever thought of ending your life? No Yes Explain: ____________________

Have you made suicide attempts? No Yes Explain: ____________________

SUBSTANCE USE PAST AND PRESENT

Have you ever taken Methadone or Suboxone? No Yes Legally or illegally? ____________

In what form? ____________________ When was your last Methadone use? ____________

When was your last Suboxone use? ____________

OTHER SUBSTANCE USE – PLEASE LIST ALL

In the "Method of use Column," ***PLEASE*** *use the following numbers that apply to how you ingested the drugs. Example; alcohol as a drink is 1. Oral (by mouth) because you drink it.* ***ORAL=1, SMOKING=2, INHALATION=3, INJECTION/IV=4, OTHER=5***

SUBSTANCE	DATE OF LAST USE	AGE AT FIRST USE	# OF YEARS USED	AMOUNT	FREQUENCY	METHOD OF USE (1,2,3,4,5)
Alcohol						
Methamphetamines						
Cocaine						
Heroin/Opiates						
Marijuana						
Club Drugs (Ecstasy, Molly, GHB, Ketamine, Roofies, LSD, Acid)						
Sedatives/Tranquilizers						
Prescription Medication						
Inhalants						
Tobacco						
Synthetic Drugs						

What does drugs/drinking do for you? ____________________

Have you ever had DTs, hallucinations, or severe withdrawal? No Yes

Have you experienced seizures during withdrawal? No Yes

What is the longest period you have ever gone without using/drinking? ____________

Signing this document indicates that the information you provided was true, and correct, to the best of your knowledge. Dishonesty on this Request for Admission could be grounds for your immediate dismissal from the program.

____
Applicant Signature

Date ____________

Applicant's Name: ____________________

INSURANCE / FINANCIAL

Primary

Name of Policy Holder: ______________________ SSN: ______________ DOB: ____________

Group Number: ____________________ Subscriber Number: ____________________________

Secondary

Name of Policy Holder: ______________________ SSN: ______________ DOB: ____________

Group Number: ____________________ Subscriber Number: __________________

Name of Employer: ______________________ Phone Number: ______________________

Employer Address: ____

Name of nearest relative not living with you: ______________________________

Primary Phone: ______________________ Cell Phone: ______________________

Address: ____

I, the undersigned, give permission to release information to third party carrier(s) and all insurance benefits for treatment are to be paid directly to VITALITY UNLIMITED and request that this assignment remain on file with my insurance carrier. I certify that this assignment shall be as valid as the original.

I, the undersigned, recognize that the provider cannot accept responsibility for collecting insurance claims or negotiating any settlement on a disputed claim. I also agree that in the event of a default in the payment of any amount due, or if this account is placed with an agency or attorney for collection or legal action, to pay any additional charge(s) i.e., the cost of collection including agency and attorney fees, and court costs incurred by laws governing these transactions.

______________________________________ ____________________

Applicant Signature Date

PLANNING FOR TREATMENT AT VITALITY

PLEASE LIMIT THE AMOUNT OF LUGGAGE YOU BRING TO TREATMENT

1. FREE your schedule of all obligations and appointments: Legal, Medical, Dental, CPS, Court, etc. You must take care of your pending issues PRIOR to entering treatment.

2. You will need two (2) forms of identification such as a driver's license, photo ID, Social Security card, or birth certificate.

3. If uninsured, you must have proof of household income for the past calendar year. Paycheck stubs, W2s, tax returns or a notarized letter from an acceptable agency.

4. **MEDICATION:** If you are taking prescribed medication, it is your responsibility to provide them.
   - **BRING A FULL 30-DAY SUPPLY OF ALL APPROVED MEDICATIONS.**
   - Admissions Coordinator must approve all medication during the application process.
   - If you have unauthorized medication in your possession upon admission, it will be destroyed.
   - HPN does not contract with pharmacies regardless of its other affiliation, e.g. Raley's, Walmart, etc.
   - HPN Consumers must be prepared to pay for their medications.
   - All Consumers 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.

5. **CLOTHING:** Vitality Unlimited's dress code is strictly enforced. Staff will confiscate any clothing deemed inappropriate. The confiscated clothing will be returned at the time of discharge. Bring enough clothing and undergarments (socks, underwear, bras) for seven (7) days. Please do not over pack. We have laundry facilities.
   - Pants must fit properly and shouldn't have holes or rips. You will not be allowed to wear skin-tight or sagging pants.
   - Clothing that is considered provocative, gang related, drug and alcohol related, or otherwise overtly controversial are not allowed.
   - Certain clothing may not be suitable. Hooded shirts or sweatshirts are only allowed to be worn outside.
   - It is mandatory for Consumers to sleep in pajamas or sweatpants and T-shirts.
   - Slippers are needed and a robe is suggested.
   - No open-toed shoes.
   - Please be mindful of the time of year and bring seasonally appropriate items.

6. **HYGIENE PRODUCTS:** Read all product labels.
   - Products containing alcohol are not allowed.
   - Aerosols of any type (hairspray, foot spray, deodorants) are not allowed.
   - You should bring your personal toiletries, e.g. soap, toothbrush, toothpaste, deodorant, sunscreen, body lotion, shampoo, conditioner, hair dryer, curling iron, etc.

7. For journaling or writing letters bring non-spiral-bound notebooks/pads, stamps, and envelopes.

8. All consumers will be charged $50.00 per trip for medical transport. Medicaid clients are excluded.

9. Consumers must purchase any vaping products from Vitality. Outside products are not allowed. $25.00 for vape base and starter tip, $23.00 for every two vape tips after that. Underage youth will not be allowed to purchase or use vaping products.

10. The Elko facility has a service dog, please advise us of any allergies, or issues you may have with this.

DO NOT BRING ITEMS OF VALUE. VITALITY UNLIMITED WILL NOT BE LIABLE FOR LOST OR STOLEN ITEMS. PLEASE LEAVE VALUABLES AT HOME.

PLEASE NOTE: Communication with family and friends will be restricted to written form for the first ten (10) days of treatment.

DO NOT BRING THE FOLLOWING ITEMS TO TREATMENT AT VITALITY

Three-ring binders
Alcohol
Ballpoint pens
Bed linens or sheets
Beverages
Bicycles
Blankets or throws
Camera
Candy
CD/DVD players
Cell phones
Cigarettes
Colognes
Commit lozenges
Condoms
Cough drops
E-cigarettes
Electric razors
Electric toothbrushes
Electronic games
Food
Gum
Guns
Herbs
Highlighters
Illegal drugs
Ink/Gel pens
iPods
Knives
Latex/Nitril rubber gloves
Markers
Mechanical pencils
Mouthwash
Nail polish or remover
Nicotine patches
Perfume
Radio
Scissors
Sharp objects
Spiral notebooks
Tattoo guns or paraphernalia
Television
Tobacco replacement products
Tools
Towels
Un-authorized prescriptions
Vape juice
Vapes
Vitamins
Weapons

Be aware if any of the above-mentioned items are brought to Vitality, they will be removed immediately and/or may be destroyed.

Applicant's Name: ______________________________