Recovery Connections Community

# APPLICATION

# FOR

# ADMISSION

_____ _____

Applicant Name Date

_____ _____

Case Manager Contact Number

Recovery Connections Community

# Admission Information

***Referral Sources:***

1) Self- through the internet and word of mouth;
2) Criminal Justice System as an alternative to incarceration.
3) Treatment centers and detox facilities.

***Exclusionary Criteria***:

- Convicted of: assault with a deadly weapon, arson, murder, attempted murder conviction or convicted of a sex offense.
- Extensive history of violence.
- Unstable Psychiatric Diagnosis.

***The Primary Criteria for acceptance is the sincere desire to change your life and the willingness do whatever it takes to achieve that goal.***

***Application Process:***

1. Complete an application packet.

2. Write a 2-page autobiography - give details of your life from as far back as you can remember up to and including your decision to complete our application and seek long term recovery. This is very important information that will be reviewed and referred to many times throughout your participation in the program.

3. Complete phone interview with an intake coordinator.

   **BE SURE TO INCLUDE CURRENT CONTACT INFORMATION** so we can arrange a time to conduct an interview either by telephone or in person. Please be sure to include a working telephone number and the best time to make contact. If you are working with a referring agency, we will contact them to make arrangements for your interview.

4. Complete follow-up interview if applicable.

5. Must have a valid TB test (within 1 year of admission).

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***Upon Acceptance:***

1. Applicants are required to submit a one-time entry fee of $150 and any additional transportation fees for legal obligations. These fees are non-refundable.
2. Arrangements will be made to have you transported to **Recovery Connections Community** housing. Many agencies provide transportation to our housing. However, we may have to arrange for transportation through alternate agencies or by staff members or residents. In either case, you need to be prepared so that you may be transported immediately upon acceptance.
3. Storage space is limited in our housing; therefore we request that you only bring enough clothing to last a week. You will be provided with clothing while in our program but we must allow a few days for proper sizing. **DO NOT BRING** any clothing promoting substance use or racial overtones. Such articles are not a part of our philosophy and will not be permitted.
4. Bring a minimal supply of personal hygiene products, toothbrush, soap, deodorant, etc. You will receive additional supplies once you are settled.
5. Bring no more than three pairs of shoes: **1**-Dress, **1**-Sneakers, **1**-Work.

**DO NOT BRING:** jewelry, money, cell phones or any personal items that you consider valuable. There will be no need for these items, and we cannot be responsible for the loss of these items. **ANY ITEMS OF THE AFOREMENTIONED ITEMS BROUGHT WILL BE MAILED TO FAMILY OR DONATED TO AN OUTSIDE AGENCY.**

*Only pictures of immediate family are allowed in the initial phase of the program*

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# CLOTHING INVENTORY

Due to the overwhelming amount of clothing and gifts being sent to program residents from outside the organization, we are forced to limit what is allowed to be sent from home. Upon entering RCC, it is recommended that each person bring adequate clothing to get them through the first phase of the program. The following list must be strictly adhered to. Any items over the amount specified will be disposed of accordingly!

***The personal items should be kept to the following***:

10 pairs of pants (including 1 or 2 pair of slacks)
10 shirts (including 1 or 2 dress shirts)
10 t-shirts
2 dresses
1 suit
1 pair of pajamas or 1 nightgown/1 robe
1 pair of slippers
1 pair of flip-flops
1 purse AND wallet
1 large winter coat

1 jacket
1 AA Book / 1 NA Book
1 Bible
1 Journal
4 pictures (no significant others included)
NO more than 3 pair of shoes, 1 pair needs to be work shoes or work boots
NO more than 2 hats
ID – Social Security Card, Picture ID

***NOTE:*** *DO NOT BRING JEWELRY, WATCH, ELECTRONICS (cell phones, laptops, etc.), LETTERS, BOOKS, MAGAZINES, MONEY, CREDIT CARDS, ADDRESS BOOKS OR ANYTHING NOT LISTED IN THE ABOVE INVENTORY. Ladies clean out your purses or you will lose the contents!*

**If you do not have all of the above items, we will do our best over the following weeks to assure that you receive the clothing items you require.**

- **You** *WILL NOT* **be allowed to request any items to be sent from home until your first family visit, which is when you make lifestyle phase (approximately 6 months).** Birthday and Christmas gifts will be dealt with on a request basis. A resident must request what they would like to be sent from home as a gift on these holidays. Residents should notify family of these conditions prior to entering RCC. Failure to comply can result in accountability.

- **Recovery Connections Community will not be responsible for any personal items left behind if you leave against staff advice. You will be given one business day to make arrangements to pick up your belongings, after that they will be delivered to a local charity as a donation or disposed of in the local landfill. You are encouraged not to bring anything of sentimental value!**

**understand that if I bring items other than those specifically listed above, the items will be disposed of at the time of my entry into the program. The list above is all-inclusive; there are no exceptions.**

_____ _____

Signature Date

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# General Information

Last Name:_____ First Name:_____ Middle: _____

Sex_____

SSN: _____ DL#: _____ State: _____ Driver's License Status: _____

DOB: _____

Most Recent Address: _____

City: _____State: _____Zip: _____

Height: _____' _____" Weight: _____lbs Hair Color: _____ Eye Color:_____

Distinguishing Marks: (Tattoos, Scars, etc.)_____

Marital Status: Married: _____ Divorced: _____ Single: _____

If married, Spouse's Name _ _____

Do you have any children? _____ How Many? _____

| Child's Name | Who is the child staying with | Child's Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

In Case of Emergency, Notify: _____ Phone #: _____

Relationship to Applicant: _____

Parent's Name: _____ Phone #: _____

Address: _____

City: _____State: _____Zip: _____

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# Legal Information

Are you a convicted felon? _____

Do you have any outstanding warrants? _____

Do you have any outstanding charges? If yes, what are they? _____

When is your court date? _____

Are your represented by an attorney? _____

Attorney's Name: _____

Phone #:_____

Address: _____

City: _____ State: _____ Zip: _____

Are you on supervised probation? _____

If yes, in what county and state? _____

Probation Information: Officer's Name: _____

Address: _____

City/State/Zip: _____

Phone #:_____

Last Seen/Spoken With: _____

Is your probation officer aware that you are seeking long term help? _____

Are you obligated for child support payments? _____

Are payments current? _____ County: _____

Case worker Name: _____

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# Medical Information

Do you have any medical conditions that will limit your activities? _____

If yes, explain: _____

Are you taking any prescription medication(s)? _____

If yes, list all (and how long you have been taking them:

_____

_____

Have you ever experienced or been diagnosed as having any of the following:

_____ Seizures _____ TB _____ Diabetes _____ Hepatitis

_____ Heart Disease _____ Epilepsy _____ Cirrhosis _____ High BP

Are you currently under the care of a physician? _____

Doctor's Name: _____Phone #: _____

Reason(s) for current treatment:

_____

_____

Have you ever been hospitalized in a mental institution? _____

Hospital Name: _____ Date(s):_____ Reason:

_____

_____

Have you ever tried to commit suicide? _____ If yes explain: _____

_____

Have you been tested for HIV? _____ Date: _____ Result: _____

Are you a veteran? _____ Do you qualify for medical benefits? _____

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# Education, Employment and Use History

Did you graduate from high school? _____ Year: _____ If not, highest grade completed? _____

Did you earn a GED? _____ Year: _____

Have you had any college or vocational school training? _____

Name of College/School: _____

Location: _____

Degree/Certificate Received: _____ Year: _____

What is your primary occupation? _____ How Long? _____

Do you enjoy this type of work? _____

What type of work would you like to do?

_____

_____

Substance Use History _____

Drug(s) of Choice: _____ Date Last Used: _____

How long have you been using drugs? _____ How Often? _____

How long have you been using alcohol? _____ How Often? _____

Other drugs used or tried? _____

Have you been in recovery before? _____

Prior recovery programs tried? _____Dates: _____

_____Dates: _____

_____Dates: _____

How old were you when you first used drugs and/or alcohol? _____

Have you ever used drugs intravenously? _____

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# Consent for Release of Information

Client Name: _____

Date of Birth: _____ Social Security Number: _____

I, _____, hereby authorize _____
(Client's Name) (Facility, Physician, and address of person releasing information)

to release/exchange specified information in my client record to: _____
(Recipient Name and Address)

_____

This data shall include (Nature & Extent of Information)
Specify Time Period: _____

___Summary of Evaluation & Assessment
___ Admission Assessment/Screening
___ Alcohol or Drug History
___ Progress Notes
___ Discharge Summary
___ Psychiatric Evaluation & History
___ Human Immunodeficiency (Virus) (History & Treatment)
___ Acquired Immunodeficiency Syndrome (Aids History & Treatment)
___ Action Plan & Diagnosis
___ Medication History
___ Psychological Evaluation
___ Financial Information
___ Educational Information
___ Attendance

Other:_____

I understand this information will be used for:

___ Evaluation & Action Planning ___ Referral
___ Case Management Services ___ Continuity of Care
___ Other: _____

*I hereby request and authorize the above named agency, organization or individual which possesses information relative to the client named above to release information, as specified, to the agency, organization or individual named on the request. I understand that the information to release may include information regarding drug abuse, alcohol abuse, sickle cell anemia, or psychological or psychiatric information.*

*I certify this authorization is made freely, voluntarily and without coercion. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless otherwise provided for by state and federal law. This consent shall be valid for a period not to exceed one year. I further acknowledge that I may revoke this consent, in writing, at ANY time except to the extent that action based on this consent has been taken.*

Client: _____ Legal Representative: _____

Date: _____ Witness: _____

Person Releasing Information: _____ Date: _____

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# Excluded Medications

Recovery Connections Community doesn't allow the medications listed above and will most likely not accept any that may cause similar reactions.

| | | | |
|---|---|---|---|
| Morphine | Dilaudid | Vicodin | Lortab |
| Codeine | Buprenorphine | Demerol | Percocet |
| Oxycodone | Methadone | Darvon | Darvocet |
| Mebaral | Nembutal | Phenobarbital | Seconal |
| Valium | ProSom | Flurazepam | Triazolam |
| Klonopin | Librium | Ativan | Restoril |
| Xanax | Dexedrine | Adderall | Strattera |
| Ritalin | Cylert | Medadate | Concerta |
| Ephedrine | Seroquel | Haldol | Clozaril |
| Risperdal | Thorazine | Flexeril | Cycoflex |
| Zanaflex | Soma | Skelaxin | Elavil |
| Remeron | Tofranfl | Lithium | Trazodone |
| Pamelor | Sinequan | Hydroxyzine | Gabapentin |

We have found that certain over the counter medications have the potential for abuse. We only allow clients to take OTC's that are provided by the facility, and ordered by a doctor. Residents are not permitted to bring in or hold their own OTC medications.

Please call us if you have a question about a client's medication. Often, it is possible to replace one unacceptable medication with one that is acceptable to us and just as effective for the client's condition. If this is the case, this must take place before admission in order to ensure efficacy.

**We will accept Geodon, Abilify, Depakote, and Zyprexa**

Resident signature: _____

Date: _____