Bethany Hall
FOR A NEW BEGINNING

A Program of

ARCH
ADVOCATE | REBUILD | CHANGE | HEAL

Treatment Application

DBDHS licensing form 645.B.1

All spaces must be filled or the application will be considered incomplete. Incomplete applications can delay the approval process. Use N/A for sections that do not apply to you.

I. GENERAL INFORMATION/DEMOGRAPHICS

Date: _____

Name: _____
Last First MI

Current Living Arrangements: Please check one
□ Family/Friends/Own
□ Jail Date of Incarceration: _____
□ Currently Homeless

Current Address: _____

City/State/Zip: _____

Phone: _____

Social Security #: _____ DOB: _____ Age: _____

Height:_____ Weight: _____

Sex: □ Female □ Transgender: □ M to F □ F to M

Marital Status: □ Single (Never married) □ Married □ Separated □ Divorced □ Widowed

Ethnicity: □ Hispanic or Latino □ Non-Hispanic/Non-Latino

Race:
□ American Indian/Alaskan Native
□ Native Hawaiian/Other Pacific Islander
□ American Indian/Alaskan Native
□ Black/African American
□ White
□ Asian

Are you currently pregnant?: □ Yes □ No Estimated Due Date:_____

II. FAMILY INFORMATION

Emergency Contact Name: _____ Relationship: _____

Phone: _____

Children under the age of 18: *Children older than 6 months of age will not be allowed to live on site.

Date of Birth	Who do they currently live with?	Do you have custody?	Court Ordered Visitation?
		Yes / No	Yes / No
		Yes / No	Yes / No
		Yes / No	Yes / No
		Yes / No	Yes / No

III. LEGAL ISSUES

Is Treatment Court Ordered? □ Yes □ No If yes, Court: _____

Probation Officer: _____ Phone: _____

District: _____

Attorney (if applicable): _____ Phone: _____

If currently incarcerated, where? _____ Since? _____

Release Date: _____

Have you ever been incarcerated in the past 5 years? □ Yes □ No
If yes, please give details in box below:

Charges:	Dates:	Pending? Circle one	Outcome:	Next Court Date/ Comments
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		

IV. MEDICAL INFORMATION

Name of Insurance: _____ Policy Number: _____

Effective Date: _____

Current Medical and/or Mental Health Issues (please list all).

Diagnosis/Condition:	Currently taking medication(s)?	Name of Medication(s)
	□ Yes □ No	
	□ Yes □ No	
	□ Yes □ No	
	□ Yes □ No	
	□ Yes □ No	

*Please see back page for additional space to add diagnosis and medications

Inpatient Hospitalizations

Name of Facility:	Type of Facility Circle One	Reason for Admittance?	Admittance date:	Discharge Date:
	Medical / Psychiatric			
	Medical / Psychiatric			
	Medical / Psychiatric			
	Medical / Psychiatric			

Have you ever thought about, planned, or attempted suicide? □ Yes □ No

If yes, please describe: _____

Have you ever cut, burned, or otherwise injured yourself? □ Yes □ No

If yes, please describe: _____

Have you ever heard voices or had visual hallucinations when NOT using drugs/alcohol? □ Yes □ No

If yes, please describe: _____

Have you ever had an eating disorder? □ Yes □ No

Do you currently have an eating disorder? □ Yes □ No

If yes, please describe: _____

V. CASE MANAGEMENT NEEDS

Do you currently have: □ State Issued ID □ Original Birth Certificate □ Social Security Card

Please provide a brief description of why you are requesting admittance into Bethany Hall?

_____

_____

_____

Are there any barriers to your sobriety? What is preventing you from maintaining sobriety?

_____

_____

_____

VI. SUBSTANCE ABUSE HISTORY

Drug:	**Frequency of Use:** **(Daily, Weekly, etc.)**	**Amount Used:**	**Date of Last Use:**
Alcohol			
Benzodiazepines			
Opiates			
Heroin			
Subxone/Subutex/Methadone (non-prescribed)			
Marijuana			
Cocaine/Crack			
Methamphetamines			
Inhalants			
Bath salts			
Synthetic marijuana			
Nicotine			
Other: Please List			

VII. ADDITIONAL QUESTIONS:

1. Have you participated in any of the following substance use treatment programs in the past year? If NOT, please explain below.

_____

_____

_____

	Dates:	**Location:**	**Outcome:**
IOP (Intensive Outpatient)			
Inpatient/Residential Tx (to include detox services)			
12 Step Meetings (to include NA and AA)			
Celebrate Recovery			
Other			

2. Please describe your support system. This could include family, friends, spouses, community members, or any services currently in place (such as counseling).

_____

_____

_____

3. Does anyone in your social circle uses drugs and/or alcohol? Please explain:

_____

_____

_____

4. Describe your living situation. If you are incarcerated, what was your living situation like prior to incarceration and what will it be upon your release?

_____

_____

_____

ADDITIONAL COMMENTS/ADDITIONAL MEDICATION INFORMATION (THIS SECTION CAN BE USED TO PROVIDE ADDITIONAL INFORMATION THAT YOU FIND HELPFUL IN THE APPLICATION PROCESS)

_____

_____

_____

_____

_____

_____

_____

_____

_____

VIII. PREGNANT/POSTPARTUM ADDENDUM TO APPLICATION (complete only if you are pregnant)

If not incarcerated, you must provide medical clearance verifying it is safe for you to enter a drug free program.

While participating in Bethany Hall's residential substance abuse treatment program for pregnant and postpartum women, I voluntarily agree to:

- Participate in development of my treatment plan
- Comply with the treatment program
- Participate, support and implement the plan of care
- Utilize appropriate measures to negotiate changes in the treatment plan
- Participate fully in treatment
- Comply with program rules and procedures
- Complete the treatment plan
- I acknowledge that I am pregnant and intend to complete the pregnancy and (**initial one**)
  - _____ I am under the active care of a physician who is an approved Virginia Medicaid Provider and who has obstetrical privileges at a hospital that is an approved Virginia Medicaid Provider

    OR
  - _____ Upon admission to Bethany Hall, I will immediately make an appointment for medical care by a physician who is an approved Virginia Medicaid Provider and who has obstetrical privileges at a hospital that is an approved Virginia Medicaid Provider

- I agree to reveal to my obstetrician my participation in substance abuse treatment and my substance abuse history
- I agree to allow collaboration between my physician, the obstetrical unit of the hospital where I plan to deliver and the treatment program staff
- I am aware that I have the freedom of choice of providers and I am choosing Bethany Hall as a program of ARCH to provide me services.

_____ _____

Client Signature Date

VII. CLIENT CONSENT FOR SERVICES

By signing this application, I state that everything is correct to the best of my knowledge and ability. I state that everything I have presented on my background information in this application is true and accurate. I agree to follow all the rules and policies of Bethany Hall.

Client Signature _____ Date _____

Please submit this application by fax to (540) 343-1275 or by mail to:

Bethany Hall
Attn: Tia Graham, Program Coordinator
1109 Franklin Road SW
Roanoke, VA 24016

FOR INTERNAL USE ONLY

IX. STAFF VERIFICATION (COMPLETED BY STAFF ONLY)

I have explained and/or read this Consent for Services to the client. See supporting documentation for eligibility criteria: ASAM

Staff Signature _____ Date _____

To be completed by Nurse Case Manager: Certification of Medical Need for Level 111.5
I certify that I have reviewed the application/intake assessment and the applicant meet the criteria and medical need for Level 111.5 treatment based on the information provided by the client.

Nurse Case Manager Signature _____ Date _____

Staff Use Only: TB Test _____ Funding _____ Verification of Pregnancy _____

APPROVAL:
□ Accepted □ Denied
Letter mailed on: _____

ADDITIONAL QUESTIONS/COMMENTS: