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. Use N/A.

PLEASE PRINT

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: _____

Please identify where you have resided over the past year. This includes jail, homelessness living with friends._____
_____
_____
_____
_____

How did you hear about Bethany Hall? _____

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

Level of education: _____

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.

Name	DOB	Where do they live currently?	Do you have custody?	Visitation court ordered?
			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: _____ Name of PCP:_____

Name of Psychiatrist (if applicable): _____

Please circle your Medicaid MCO: Anthem (Healthkeepers) Virginia Premier Magellan Optima United Healthcare Aetna

Medicaid Incarcerated Medicaid FFS

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

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

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 describe of why you are requesting admittance into Bethany Hall? -

_____

_____

_____

Are there any barriers to your sobriety?

_____

_____

_____

VI. SUBSTANCE ABUSE HISTORY

Drug:	Date of first use:	Frequency of use:	Amount of use:	Date of last use:
Alcohol				
Benzodiazepines				
Opiates				

Heroin				
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?

	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:

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
Intake Specialist Brooke Benson
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:

_____

_____