Gateway Community Health, Inc.

PARTICIPANT APPLICATION

Angel House Residential Living

APPLICATION FOR Gateway's ANGEL HOUSE RESIDENTIAL LIVING

Please indicate the date you require housing.

☐ **Immediately** ☐ **Other date _____**

Part 1: CONTACT INFORMATION

Print Name: _____, _____ _____

Last First Middle

Date of Birth (__ __ /__ __ /__ __ __ __)

Telephone Number: _____

☐ Residence ☐Work ☐Message

☐ Check here if you are in a treatment or correctional facility. Have you ever used any aliases or other names? If so, please indicate below.

Personal Status (check all that apply):

☐Married

☐ Never Married

☐ Widow/er

☐ Separated

☐ Homeless

☐ Divorced

☐ Veteran

I acknowledge and understand that the Gateway Community Health/ Angel House Residential Services Program provides residential living for program participants receiving counseling services for mental health and substance use disorders. My residency is incidental to the provision of mental health and substance use counseling services. By this written agreement I acknowledge that my participation in Gateway's Program is subject to my meeting and adhering to the rules, regulations, and expectations of the program. Failure to remain in services and to comply with Gateway's Rules and Regulations will result in my immediate dismissal from the residential program. I understand that Gateway's Program is not subject to the provisions of the Virginia Landlord Tenant Act.

_____ _____

Participant Printed Name **Participant Signature**

Part 2 – Personal Information

Are you currently drinking alcohol and/or using addictive drugs?

☐YES ☐NO

If no, what is your sobriety date?

Are you a recovering drug addict? ☐YES ☐NO

Date last used:

Are you a recovering alcoholic? ☐YES ☐NO

Date of your last drink:

Part 3: Income

Are you currently employed? ☐YES ☐NO

If you answered "YES" to the above question, please answer the following:

How many hours per week do you work?

What do you expect your monthly income to be next month? $ _____

ANGEL HOUSE requires that residents are in recovery from alcohol and/or substance use. Please indicate below the type of recovery program where you are currently a participant.

☐ Detox ☐Residential Treatment ☐12- Step Program

☐ Outpatient Treatment Provider: _____

☐ Other (please describe) _____

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Part 4: DEPARTMENT OF CORRECTIONS

If you are currently under the supervision of the Department of Corrections, please answer the questions below:

DOC Number: _____ DOC Facility:_____

Case Manager Name: Email: _____

Tentative Parole Date (If applicable) / /

Will you be topping your time? ☐YES ☐NO

Part 5: ADDITIONAL QUESTIONS

Have you been convicted of drug manufacturing or distribution? ☐YES ☐NO

Are you on parole? ☐YES ☐NO If yes, whom do you report to? _____

Are you court-ordered? ☐YES ☐NO

Are you involved in drug court? ☐YES ☐NO

Are you involved in mental health court? ☐YES ☐NO

Have you been convicted of a violent crime? ☐YES ☐ NO

If yes, please explain:

_____

Are you on probation? ☐YES ☐NO

If yes, to whom do you report? _____

Are you a convicted sex offender? ☐YES ☐NO

Are you required to register? ☐YES ☐NO

Have you ever been convicted of Arson? ☐YES ☐NO

If yes, please explain and include court and date of conviction:

_____

(Attach additional sheets if needed)

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APPLICANT CERTIFICATION PLEASE INITIAL:

_____ I understand that acceptance into the program is not guaranteed, and that my participation in Gateway's Angel House Recovery Program is subject to my meeting and adhering to the rules, regulations, and expectations of the program.

_____ I agree to remain in services.

_____ I agree to remain clean and sober at all times.

_____ I agree to pay my residential living fees in advance. I understand that if I fail to pay my residential living fees, I will be expelled from ANGEL HOUSE.

_____ I agree to keep ANGEL HOUSE free form alcohol and illegal drugs at all times.

_____ I agree to enter into an Individual Behavior Contract and abide by the terms of the contract.

I certify that all the information I have provided to ANGEL HOUSE is true and correct.

I have read all the material on this application form, including the agreement terms above.

I answered each question honestly and want to achieve comfortable recovery from alcoholism and/or drug addiction with relapse.

By signing below, I acknowledge that I have read, understand, and agree to the expectations of Gateway's Angel House Residential Living Program.

SIGNATURE DATE _____

FOR OFFICE USE ONLY Date entered into database: / /

Staff Initials

Phone Interview Scheduled For: / /

Personal Interview Scheduled For: / /

Date Notice Sent: / /

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Name: _____

Last *First* *Middle*

Name at Birth (if applicable):

_____

Last *First* *Middle*

Social Security Number: _____/____/_____ Age: _____ Birthdate: _____/____/_____

Birthplace: _____

City *County* *State*

Emergency Contact Name:_____ Relationship: _____

Address: _____

Street Address *Apartment/Unit Number*

_____

City *County* *State* *Zip*

Phone Number: __(_____)_____(____)_____

Daytime *Evening*

ALTERNATIVE EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

Address: _____

Street Address *Apartment/Unit Number*

_____

City *County* *State* *Zip*

Phone Number: __(_____)_____(____)_____

Daytime *Evening*

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Number of children: _____

Age: _____ Female ☐ Male ☐

Age: _____ Female ☐ Male ☐

Age: _____ Female ☐ Male ☐

Age: _____ Female ☐ Male ☐

Who is/are the child/children's legal guardian? _____

Guardian's relationship to you: _____

If married, do you have children outside of marriage? Yes ☐ No ☐

If yes, how many? _____

Age: _____ Female ☐ Male ☐

Age: _____ Female ☐ Male ☐

Age: _____ Female ☐ Male ☐

Father's Information: (Use additional sheets if needed)

Name: _____Birthdate: ____/____/_____

_____

Street Address *Apartment/Unit Number*

_____

City *County* *State* *Zip*

Phone Number: (_____)_____(____)_____

Daytime *Evening*

Mother's Maiden Name: _____

Mother's address (if different from father's address):

Address: _____

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Street Address *Apartment/Unit Number*

_____

City *County* *State* *Zip*

Mother's full name (if remarried):_____

Health: (Use additional sheets if needed)

Have you been diagnosed with any current medical/health problems? Yes ☐ No ☐

If yes, please explain: _____

_____

_____

List any treatments and/or medications prescribed: _____

_____

Do you have any medical problems that will interfere with your ability to work? Yes ☐ No ☐

If yes, please explain: _____

_____

Are you currently taking any prescription medication? Yes ☐ No ☐

If yes, please list: _____

_____

Have you ever been recommended for mental health treatment? Yes ☐ No ☐

If yes, please explain: _____

_____

Have you been placed in a facility for treatment? Yes ☐ No ☐

If yes, please name the facility and dates confined: _____

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_____

Did you complete the treatment programs listed above? Yes ☐ No ☐

If not, please give reasons: _____

_____

Do you now or have you ever abused alcohol or drugs? Yes ☐ No ☐

If applicable, list your "drug(s) of choice", including alcohol:

_____

_____

List any treatment/counseling received: _____

_____

Did you complete the program? Yes ☐ No ☐

If not, state reason(s): _____

Who or what organization administered treatment/counseling? _____

_____

How do you plan to stay "drug free and sober"? _____

_____

High School Name: _____ Last grade completed: _____ GED:_____

Address: _____

City/County *State* *Zip*

Do you have a trade? Yes ☐ No ☐ If yes, what is it? _____

Do you have a certificate in your trade? Yes ☐ No ☐ if yes, issued by: _____

Do you have a college degree? Yes ☐ No ☐ Name of degree: _____

Military Service? Yes ☐ No ☐ If yes, Branch_____ Years of Service: _____

Combat Experience? Yes ☐ No ☐ Where? _____

Type of discharge: _____ Date: _____

Do you have a disability of any kind? Yes ☐ No ☐ If yes, please explain: _____

_____

Corrections Information:

Inmate identification number: _____

Current charge: _____

Current conviction: _____

Current sentence: _____ Plea Bargain? Yes ☐ No☐

Were you using alcohol or drugs prior to or during your offense? Yes ☐ No ☐

If yes, what were you using? _____

Did you know the victims? Yes ☐ No ☐ If yes, how? _____

Were you incarcerated on these charges? Yes ☐ No ☐ If yes, date of incarceration: _____

Parole date: _____ Expiration date:_____

Institution:_____

Was this a parole/probation violation: Yes ☐ No ☐

If yes, what were the circumstances of the violation?:_____

Who was your supervision officer?_____

How long were you in the community before the violation? _____

Will you continue to be under supervision in the community? Yes ☐ No ☐

Type of supervision: _____ Expiration: _____

Any type of conditions? Yes ☐ No ☐ If yes, specify: _____

_____

Supervision officer: _____

Past Record:

Number of adult felony convictions:_____ Number of times incarcerated:_____

List your last five (5) felony convictions:

Date Conviction City/State Sentence Prison Time Institution How much of your adult life has

been spent in prison? _____

Age of your first arrest: _____ Number of juvenile convictions: _____

Have you spent time in juvenile facilities? Yes ☐ No ☐

If yes, what were the juvenile charges? _____

_____

Use the following space to explain your interest in Gateway Community Health/Angel House Residential Living and your intentions concerning it:

By signing this application, I verify that the information I have provided is true and complete,

as I know it. I authorize Angel House or any of its representatives to make any necessary third-party verifications of anything I have written on this application or anything I said in my screening interview.

_____ _____

Signature Date

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION
(PLEASE PRINT)

Use this form to release confidential information including MH, SA, and MR clients. For SA clients referred by the Court or criminal justice/parole system for Substance Abuse Treatment/services, use "Authorization to Disclose Confidential Substance Abuse Information" SA Client Referred by Criminal Justice System for Treatment/Services (HIPAA 006).

Client's Full Name _____

Date of Birth _____

Social Security Number _____

Client's Address & Phone Number: _____

I hereby authorize: _____to release or

otherwise disclose healthcare information and records to:

Gateway Community Health, Inc.

Angel House Residential Living

to be used for the specific purpose as identified on Table A or Table B below:

Description of Information to be Used/Disclosed: (specify information from records that

can be used, released, exchanged or disclosed must be limited to "minimum necessary"

to satisfy need by checking the applicable boxes).

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TABLE A. Confidential Client Information and Records

Demographics (Name and personal identifying information) Discharge Summary

Tell of past/present participation in MH or MR Educational records/Training related records

Services to include admission and discharge dates Employment records

Assessments & evaluations (psychosocial) Disability determination records

Medical & mental health diagnosis Financial records

Medical/physical health records/medications Benefits/services needed

Psychiatric/mental health records Information to determine Title IV-E Eligibility

Psychological records/tests Re-disclose documents from another agency, hospital, or

Treatment status organization (Name of the other record)

Progress Notes

TABLE B. Confidential Substance Abuse & Sensitive Medical Information (e.g. **HIV**)

(Select only if necessary for the purpose stated above)

Tell of past/present participation in any SA services to include admission and discharge dates

Assessments/evaluations Treatment plans & review/discharge

Application for drug or alcohol (SA) services/treatment Progress notes

Referral for SA treatment Discharge summary

SA Diagnosis Urinalysis results

SA Treatment history and status Communicable disease reporting

Attendance HIV/AIDS and/or other sensitive medical conditions

SA Rehabilitation and education/training history & status Other: (describe)

Participation in SA research program

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Understanding and Instructions:

I understand that Angel House cannot condition the provision of treatment to me on my signing of this authorization.

I understand that this authorization will become effective upon the date signed below unless noted otherwise.

I understand that only the information needed to satisfy the stated purpose of this disclosure will be shared. This covers disclosure of information already on record and similar future information so long as this authorization is in effect.

I authorize all persons and organizations to accept a copy or faxed version of this form as a valid authorization to share information. If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

I understand that there is a potential for any information disclosed pursuant to this authorization to be subject to re- disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. If this information is being disclosed from records protected by the Federal substance abuse confidentiality rules (42 CFR part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by your written authorization or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have the right to know what information about me has been shared, when and with whom it was shared. If I ask each organization that has released information will show me the written accounting of recipients.

Gateway Community Health / Angel House, its agents, employees, and volunteers are hereby released from any legal responsibility or liability for disclosing information as I have authorized by completing this form, or for the use of the information by the person or organization receiving it.

EXPIRATION DATE:

This authorization expires automatically in 365 days. A new authorization form is required for any release after that. If I want this authorization to expire sooner, it will be according to the following date, event, or condition:

I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession

of my health care records. (Use "Revocation of Authorization to Disclose Confidential Information {HIPAA.008}). This authorization does not extend to information placed in my record after the date I signed this form.

NOTE: The person who receives the records to which this authorization pertains may not re-disclose them to anyone else without my new written authorization unless there is an emergency or unless the recipient makes a disclosure permitted by law.

_____ _____

Print Name of Client Print Name Authorized Signer (If applicable)

Authorized Signer: My relationship to the client is: (Check one)

□ Parent

□ Guardian

□ Spouse

□ Other relative

□ Power of Attorney

□ Other legal representative (explain):

_____ _____

Signature Date

Witnessed by:

_____

_____