

Carter Hope Center Recovery Residence

506 East Hawthorne Street

Dalton, GA 30721

706-226-7044 Office

706-529-5225 Fax

Application for Service/Screening Sheet

Name: _____ DOB: _____ SSN: _____

Address: _____

Street City State County Zip
Phone: (____) _____ - _____ Race: _____ Sex: _____ Marital Status: _____

State ID/Drivers License: _____ Employer: _____

Email Address: _____

Drug of choice: _____ Last Use: _____
_____ Last Use: _____
_____ Last Use: _____

Have you ever been treated at Carter Hope before? _____ Date: _____

I am requesting: Residential Services _____ Outpatient Services _____ Outpatient until residential bed is available _____

Status: Voluntary _____ Mandated _____ Charges Pending _____ Court Date _____

Probation _____ Parole _____ DFCS _____ Highest grade completed _____

Do you currently have a family member or acquaintance at Carter Hope Center? _____
Please explain:

Do you have any physical or emotional disabilities? _____ Please explain: _____

Mental Health Diagnosis: _____

Current Medications (please include all medications including OTC meds)

Are you physically able to work: _____ If not, do you currently receive disability? _____

Are you a sex offender? _____ If yes, what are your restrictions: _____

I am a substance abuser seeking treatment services _____ (Yes) _____ (No)

I understand I am required to pay admission fee of \$600. _____ (Yes) _____ (No)

