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Carter Hope Center Recovery Residence

506 East Hawthorne Street
Dalton, GA 30721
706-226-7044 Office
706-226-6216 Fax

Application for Service

Name:_____ DOB:_____ SSN: _____

Address:_____
Street City County Zip

Phone:(_____)_____-_____ Race: _____ Sex: _____ Marital Status: _____ # children _____

State ID/Drivers License: _____ Employer:_____

Drugs of Choice: _____ Last Use: _____

_____ Last Use: _____

_____ Last Use: _____

Previous applicant or resident at Carter Hope (out-patient or in-patient)? _____ When? _____

I am requesting _____ Inpatient Services ____Outpatient Services _____Outpatient until inpatient bed is available

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

Probation ☐ Parole ☐ DFCS ☐ **(** Are you currently a registered sex offender? **)** _____

Physical & Emotional (Include attitude, motivation, stability, allergies, emotional or physical limitations)_____

Current Medications ? _____

Can Applicant Read & Write ? _____ Grade Completed _____ Spiritual Preference _____

Referral Source: _____ Phone: (_____)_____-_____

In case of emergency contact _____
Name Relationship Phone

Consent for Services

I present myself for services at Carter Hope Center Recovery Residence(CHCRR). I understand that this application and consent ends with my discharge as a client of CHCRR. I understand that generally information regarding my treatment is confidential and may be privileged, with some exceptions. I have been informed that information about child abuse and elder abuse are not confidential and all child abuse and elder abuse will be will be reported as directed by law. Also, I am aware that any threat I make to harm anyone will be promptly reported. The information I give will be submitted to a court of law only if the court issues a legitimate subpoena. I permit a copy of this authorization to be used in place of the original. This consent is valid for the period of time necessary to complete all transactions related to my services.

I will cooperate in achieving all goals and objectives outlined in my individual treatment plan. I agree to participate in all scheduled activities and assume responsibility for all treatment costs. I understand that I must be alcohol and drug free for a minimum of one week prior to admission and must remain abstinent from all mood altering chemical during my course of treatment. I further understand that I must have at least one form of identification upon admission.

_____ _____ _____
Applicant's Signature Date Referring Therapist