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 $630. The $30.00 must be in cash _____ (Yes) _____ (No)

Are you currently involved in a relationship? _____ Who With? _____
Are you married? _____ Are you divorced? _____ Are You Separated? _____
How Long? _____ Is there a no contact order in place? _____
How Many Children? _____
Emergency contact: _____ Phone# _____
Relationship: _____

Please note: NO NEW RELATIONSHIPS CAN BE STARTED WHILE AT CARTER HOPE CENTER. ALL MEDICATIONS MUST BE APPROVED BY STAFF PRIOR TO BRINGING ON PREMISES AND BEFORE TAKING UNLESS IT IS A LIFE THREATENING EMERGENCY

Are You Mandated to treatment? _____ Complete this portion regardless if you are mandated or voluntary.

Probation:

Probation Office: _____ Office Number: _____
Office Fax: _____ Officer's Name: _____

Parole

Parole Office: _____ Office Number: _____
Office Fax: _____ Officer's Name: _____

Can Applicant Read & Write ? _____ Grade Completed _____

Spiritual Preference _____

Referral Source: _____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