**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/Driver’s License: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug of choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been treated at Carter Hope before?** Yes \_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Status: Voluntary \_\_\_\_ Mandated \_\_\_\_\_ Charges Pending \_\_\_\_\_ Court Date \_\_\_\_\_\_\_

Probation \_\_\_\_\_ Parole \_\_\_\_\_\_ DFCS \_\_\_\_\_\_\_

How many people are in your household including yourself? \_\_\_\_\_\_\_\_\_\_

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?** \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am a substance abuser seeking treatment services \_\_\_\_\_\_ (Yes) \_\_\_\_\_\_\_\_ (No) I understand I am required to pay a nonrefundable admission fee of $1,000.

\_\_\_\_\_\_ (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. You must be seven days with no drugs or alcohol in your system to admit into the program.

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

**Probation:**

Probation Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Officer Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Officer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parole:**

Parole Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Officer Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Officer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can Applicant Read & Write? \_\_\_\_\_\_\_ Highest 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 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. Admission fee is nonrefundable.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Signature Date Referring Therapist