**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: \_\_\_\_\_\_\_\_\_\_\_

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

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Mental Health Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications (please include all medications including OTC meds)

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

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Are you fully vaccinated from Covid 19? \_\_\_\_\_\_ (Yes) \_\_\_\_\_\_\_\_ (No)

\*If not vaccinated, you must agree to be vaccinated for Covid 19 within two weeks of admission. \_\_\_\_\_\_ (Yes) \_\_\_\_\_\_\_\_ (No)

(**This also applies to outpatient services as well.**)

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 $1,200.

\_\_\_\_\_\_ (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.

ALL Patients must be fully vaccinated or agree to be vaccinated or agree to be vaccinated from Covid 19 within two weeks of admission to 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 The 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