Crestone Residential Treatment Services

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Program Application

Health Solutions — Your Health Is Our Priority

PLEASE FILL OUT ALL AREAS COMPLETELY (Areas in RED are required)

Name:____ Date:_________________________

Maiden Name or Aliases:____

Address:____

Phone:____ Date of Birth:_________________________

SSN#:____ Gender: Male Female

Referral Source:______________________________ Phone #:_______________________________

Annual Family Income: ____________SSDI ______________SSI _______________ Other Income ____________

Insurance (Circle All That Apply): None Medicare Medicaid Self Pay Private Insurance

Name of Private Insurance Company:____

Insurance ID Number: ______________________________ Group ID Number:_______________________

Insurance Phone #:____________________________ Name of Policy Holder:_______________________

Substance Use and Mental Health Treatment History

Residential, Hospital, Outpatient. Please do not include Detox or DUI.

Name of Program	Dates Attended Tx	Type of Treatment	How Long in Tx	Length of Tx Program

Have you participated in a Health Solutions treatment program before: Yes No

When?:__________________________________ What Type of Treatment?:____________________

Have you ever been told you have a mental health condition (e.g., depression, anxiety, panic, schizophrenia, bipolar, etc.)? If so, list which condition(s):____

List all substances used including alcohol, tobacco, marijuana, illegal drugs, and prescription drugs. List with the substances you have the greatest concern with at the top:

Substance Used	Years of Use	Route (oral, nasal, IV)	Amounts Day/Week	Last Use

Legal History

List any charges/arrests/convictions received and indicate what year received:____________________________

____

____

Are you currently incarcerated? Yes No

Are you currently on:	**No**	**Yes**	**If yes, explain**
Probation			
Parole			
Hold Orders			
Duty to Warn			
Restraining Order			
Pending charges			
Will serve jail/prison time after treatment			

Probation/Parole Officer's Name:_____________________________________ **Phone #:**________________________

Are you a registered Sex Offender? Yes No If yes, you will need to provide documentation of previous sex offender treatment.

Medical Information

Do you have a Primary Care Physician? Yes No If yes, who?:____________________________________

List Past or Current Medical Conditions/Surgeries/Specialty Concerns:

Condition	Date Diagnosed	Who Diagnosed	Medications	Current: Yes or No

List any medical equipment currently being used (e.g., walker, oxygen, etc.):___________________________

____

Are you currently pregnant? Yes No If yes, when is the expected due date?_____________________

List All Current Medications (mental health and physical)	Reason for Being Taken	How Often You Take These Medications	Dosing of Medications (e.g., mg)	Who Prescribed?

Do you have any allergies?:____

____

Do you require special accommodation for physical activities? Yes No

If yes, explain:____

Please complete or attach a paper addressing the following areas in regards to your desire to be admitted into Crestone Residential Treatment Services:

1. **What is your motivation for receiving treatment at this time?**__________________________________

2. **What do you hope to gain from completing treatment at this time?**____________________________

3. **Name at least 3 difficulties you will have to address to maintain your recovery?**_________________

4. **Imagine you have sustained your recovery for 15 years. As you look back on your life, what will have taken place, what will have been your action steps to get here, and who do you see around you who will have helped support you to achieve your recovery?**______________________________

Please acknowledge the following:

- I Understand the Crestone Residential Treatment Services program is a tobacco and vape product free environment, no smoking will be allowed during the duration of the program. Nicotine replacement medications may be available for all participants.
- I agree that if I am a registered sex offender, I will need to provide documentation of treatment completion.
- In order to be considered for admission the application must be completed fully, incomplete applications may delay my consideration for the program.
- I understand that it is my responsibility to contact the admission coordinator if my contact information changes, if I fail to do so I might miss contact attempts to coordinate my admission to The Crestone Residential Treatment Services program.
- I understand that part of Crestone Residential Treatment Services programming involves mild physical activity on a daily basis and am willing to participate to the best of my ability.
- I understand that in order to be admitted to the program a full physical with lab work will be completed with Health Solutions Medical Center prior to admission on the day of my admission to medically clear me for participation in The Creston Residential Treatment Services program.
- I commit to working with the admission team to be fully detoxed from all substances prior to my admission to the Crestone Residential Treatment Services program. The admission coordination team is happy to help coordinate admission to a detox program prior to my admission to the program.
- I have reviewed The Crestone Residential Treatment Services Program Handbook, and commit to follow all the expectations for behavior and understand that failure to do so may eventually result in my discharge from the program.

Applicant's Signature　　　　Date