Welcome to The MARC at Health Solutions

Hope. Health. Together

Thank you for your interest in becoming a patient at the Medication Assisted Recovery Center (MARC) at Health Solutions. Our program provides Medication-Assisted Treatment (MAT) such as Suboxone, Sublocade and Vivitrol to support you in your recovery. Our providers — Dr. Kay Hooshmand-Parsi and Sondra Ware, FNP — are here to help you meet your recovery goals. We will partner with you throughout your treatment.

BEFORE WE CAN SCHEDULE AN APPOINTMENT, WE WILL NEED:

• Photo ID • Insurance card(s) or insurance number • Completed application packet

Please submit your completed packet during Open Access hours at one of the following locations:

☐ Pueblo MARC Location
41 Montebello Rd., Suite 120, Pueblo, CO

☐ Trinidad MARC Location
910 E. Main Street, Trinidad, CO

OPEN ACCESS HOURS Monday – Friday | 8:00 AM – 11:00 AM

Open Access is first come, first served, based on provider availability. The process may take 1 to 3 hours depending on your needs — please plan ahead.

Orientation for the MARC program is required for all patients and will be completed before your appointment with the provider.

MEDICATION START REQUIREMENTS

To begin medication on the day of your History & Physical / Induction:

- Suboxone: be 24–36 hours without opiates
- Vivitrol: be 7 days without opiates
- Sublocade: available per provider recommendations

On-site Pharmacy for easy access to prescribed medications

You may be asked to return for a 2-day follow-up after starting medication to ensure everything is working well and to make any needed adjustments. If you are not yet ready for medication, we can still see you for evaluation and planning.

NEED HELP WITH YOUR APPLICATION OR HAVE ADDITIONAL QUESTIONS? Call: 719-423-1500

Or we have Support Staff available at both locations Monday – Friday, 8:00 AM – 5:00 PM (Please note: these hours may differ from actual MARC hours)

Mission: *Health Solutions exists to assist those in need of healthcare services who require expert care to support recovery and to successfully achieve their healthcare goals. Health Solutions is committed to offering exceptional quality services that set the standard for healthcare in Colorado. This care is provided through service excellence, innovation, compassion, and promotion of self-determination.*

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MARC APPLICATION

Name: _____ Date of Birth: _____

First, Middle, and Last Name

Insurance Information:

Insurance: Medicare Self Pay Medicaid Member #:_____ _

Other Insurance Information: _____

Medical History:

Who is your current Primary Care Provider? ☐ I do not currently have a Primary Care Provider

Name: _____ Phone:_____

Are you currently pregnant? Yes No

List all current Prescription Medications you presently use, the amount, and how often:

Medication Name	Amount/Dose	How Often

Please note, Benzodiazepine use is not allowed while in the MARC program.

Are you interested in Suboxone or Vivitrol treatment? Suboxone Vivitrol

Are you currently taking Suboxone? Yes No

If yes, please list the doctor currently prescribing it and how long you have been taking it:

Are you currently employed? Yes No

Who referred you to the program/How did you hear about us: _____

Substance Use History:

List all the street drugs you presently use, the amount, and how often:

Drugs	Amount	How Often

Are you currently enrolled in residential treatment? Yes No If yes where and for how long? _____

Are you currently on probation or parole? No Yes PO's Name: _____

Applicant's Signature: _____ Date:_____

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PATIENT INFORMATION

DATE: _____

HOW DID YOU HEAR ABOUT US? _____

PATIENT NAME: _____

First MI Last (If patient is under 18 years old, please see PARENT/GUARDIAN section)

PREFERRED NAME: _____

SOCIAL SECURITY #: _____ **PATIENT DOB:** _____

BIRTH SEX: ☐ FEMALE ☐ MALE ☐ UNDIFFERENTIATED

CURRENT GENDER: ☐ FEMALE ☐ MALE ☐ UNKNOWN

GENDER IDENTITY: ☐ DECLINE ☐ OTHER ☐ GENDERQUEER ☐ FEMALE ☐ FTM/Trans Male ☐ MALE ☐ MTF/Trans Female

SEXUAL ORIENTATION: ☐ DECLINE ☐ BISEXUAL ☐ GAY/LESBIAN ☐ HETEROSEXUAL ☐ OTHER

PREFERRED PRONOUN: ☐ DECLINE ☐ HE/HIM/HIS ☐ OTHER ☐ SHE/HER/HERS ☐ THEY/THEM/THEIRS ☐ ZE/HIR

MAILING ADDRESS: _____

CITY, STATE, ZIP: _____

PHYSICAL ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE #: _____

CELL PHONE #: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ DOMESTIC PARTNER

RACE: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ DECLINED ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ WHITE/CAUCASIAN

ETHNICITY: ☐ NOT HISPANIC ☐ DECLINED ☐ HISPANIC ☐ MEXICAN ☐ PUERTO RICAN ☐ CUBAN

LANGUAGE PREFERENCE: ☐ ENGLISH ☐ SPANISH ☐ OTHER

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WOULD YOU LIKE TO RECEIVE NOTIFICATIONS? ☐ VOICEMAIL ☐ SMS TEXT ☐ EMAIL ☐ OPT OUT

EMAIL ADDRESS: _____

PREFERRED CONTACT:

☐ HOME PHONE ☐ CELL PHONE ☐ SMS TEXT ☐ EMAIL ☐ PATIENT PORTAL

PRIMARY INSURANCE: _____

MEMBER ID: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____

SUBSCRIBER SOCIAL SECURITY #: _____

SECONDARY INSURANCE: _____

MEMBER ID: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____

SUBSCRIBER SOCIAL SECURITY #: _____

PARENT/GUARDIAN SECTION (If patient is under 18)

PARENT 1 NAME: _____

PARENT DOB: _____

PARENT SOCIAL SECURITY #:

_____

ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____

CELL PHONE: _____

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PARENT 2 NAME: _____

PARENT DOB: _____

PARENT SOCIAL SECURITY #: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____

CELL PHONE: _____

PATIENT PRIMARY ROLE: ☐ STUDENT ☐ MILITARY ☐ RETIRED ☐ VOLUNTEER ☐ HOMEMAKER ☐ EMPLOYED FULL TIME (35+ HOURS/WK) ☐ EMPLOYED PART TIME (UNDER 35 HOURS/WK) ☐ UNEMPLOYED

PATIENT PLACE OF RESIDENCE: ☐ INDEPENDENT LIVING ☐ ASSISTED LIVING ☐ SUPPORTIVE HOUSING ☐ BOARDING HOME/ADULT RESIDENTIAL ☐ NURSING HOME ☐ FOSTER HOME ☐ HALFWAY HOUSE ☐ HOMELESS ☐ SOBER LIVING ☐ OTHER (Please specify)

PATIENT CURRENT LIVING ARRANGEMENT: ☐ ALONE ☐ SPOUSE ☐ PARTNER/SIGNIFICANT OTHER ☐ CHILDREN ☐ FATHER ☐ MOTHER ☐ FOSTER PARENT(S) ☐ GUARDIAN ☐ RELATIVE(S) ☐ SIBLINGS ☐ UNRELATED PERSON

ARE YOU A VETERAN? ☐ YES ☐ NO

ARE YOU DISABLED? ☐ YES ☐ NO

ARE YOU PREGNANT? ☐ YES ☐ NO

DO YOU NEED TRANSPORTATION? ☐ YES ☐ NO

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____

EMERGENCY CONTACT PHONE: _____

Okay to contact in an emergency? ☐ YES ☐ NO

PREFERRED PHARMACY: _____

PHARMACY ADDRESS: _____

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