We applaud your first step by beginning your admissions process to be a part of our VOA family.

Volunteers of America Northern Rockies Treatment Services is a residential treatment setting providing comprehensive individualized substance abuse services for men and women. Our program is designed to incorporate the 12-Step model with common cognitive behavioral therapies. A Christian based 12-Step treatment approach and a Native American Cultural 12-step treatment approach (Sheridan only) are available and encouraged to those who request it. While we are a faith-based organization, we respect the values and beliefs of all of our clients.

Locations include the following:

<table>
<thead>
<tr>
<th>Primary Residential Treatment</th>
<th>Transitional Residential Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Gathering Place – Women - Sheridan</td>
<td>Recovery Homes – Men &amp; Women – Sheridan</td>
</tr>
<tr>
<td>The Life House – Men – Sheridan</td>
<td>Harmony House – Men – Cheyenne</td>
</tr>
<tr>
<td>Harmony House - Cheyenne</td>
<td>Center of Hope – Men &amp; Women - Riverton</td>
</tr>
</tbody>
</table>

Enclosed is our Admissions Packet for the above-listed residential services.
If you have any questions or concerns throughout this process, please feel free to contact our Admissions team by contacting our team at:

800.843.0351 option 1 or 307.672.2044 option 1
admissions@voanr.org

<table>
<thead>
<tr>
<th>Admissions Contacts</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Erin Peterson</td>
<td><a href="mailto:erin.peterson@voanr.org">erin.peterson@voanr.org</a></td>
</tr>
<tr>
<td>Brielle Prehemo</td>
<td><a href="mailto:brielle.prehemo@voanr.org">brielle.prehemo@voanr.org</a></td>
</tr>
</tbody>
</table>

Once we receive the requested information in the checklist, we will be in contact regarding your status with VOA. Our current wait times vary from an average of 4 weeks to as long as 3 months if an individual is incarcerated.

- Completed VOANR Application.
- Current ASI & Clinical Assessment (ASAM).
- Current Physical (within past 30 days) that addresses and/all medical concerns including chronic conditions such as seizures, diabetes, chronic pain and associated treatments. Applicants must be medically stable.
- Current Medication List (within past 30 days).
- Current TB Record (within past 6 months) If an applicant has a positive TB test, chest x-ray is required along with documentation from the Department of Health regarding TB treatment/medication regimen.
- Release of Information for Probation & Parole (if applicable).
- ALL Current Court documents, specifically any court orders.

*Applicants may be asked to provide additional information related to medical and/or mental health evaluations prior to being accepted for treatment.*
Received services at Volunteers of America before? □ Yes □ No

If YES, under what name?

- Photo Verification (driver’s license, passport, government ID, Resident ID and student ID)
- Income Verification (tax return, 3 current pay stubs, unemployment benefit letter or denial letter, worker’s compensation statement)
- Private Insurance Coverage Card(s) (Medicare Card, Medicaid Card, or Equality Care Card)
- Additional documents are required for minor children, DUI Evaluations, DV Assessments, and Residential Treatment

<table>
<thead>
<tr>
<th>Type of Residence (check one):</th>
<th>Tribal Affiliation:</th>
<th>Today’s Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Boarding/Foster Home</td>
<td>□ Not a Veteran</td>
<td></td>
</tr>
<tr>
<td>□ Group Home</td>
<td>□ Unknown</td>
<td></td>
</tr>
<tr>
<td>□ Hospital</td>
<td>□ Combat</td>
<td></td>
</tr>
<tr>
<td>□ Jail/Correctional Facility</td>
<td>□ Non-Combat</td>
<td></td>
</tr>
<tr>
<td>□ Lacks a fixed, regular, night-time residence</td>
<td>□ Private Residence/Household Residential Treatment Center Unknown</td>
<td></td>
</tr>
<tr>
<td>□ Other Residential Setting</td>
<td>□ Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity (check one):</th>
<th>Race (check one):</th>
<th>Veteran:</th>
<th>Marital Status (check one):</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Not of Hispanic Origin</td>
<td>□ White</td>
<td>□ Not a Veteran</td>
<td>□ Divorced</td>
</tr>
<tr>
<td>□ Cuban</td>
<td>□ Asian</td>
<td>□ Unknown</td>
<td>□ Legally or Otherwise Absent</td>
</tr>
<tr>
<td>□ Mexican</td>
<td>□ Black</td>
<td>□ Combat</td>
<td>□ Minor Child</td>
</tr>
<tr>
<td>□ Other Hispanic</td>
<td>□ More Than One Race</td>
<td>□ Non-Combat</td>
<td>□ Never Married</td>
</tr>
<tr>
<td>□ Puerto Rican</td>
<td>□ Native American/Alaskan</td>
<td></td>
<td>□ Married</td>
</tr>
<tr>
<td>□ Unknown</td>
<td>□ Other/Unknown</td>
<td></td>
<td>□ Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Widowed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number Type:</th>
<th>OK to Leave Message:</th>
<th>Number Type:</th>
<th>OK to Leave Message:</th>
<th>Number Type:</th>
<th>OK to Leave Message:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Primary</td>
<td>□ Yes</td>
<td>□ Primary</td>
<td>□ Yes</td>
<td>□ Primary</td>
<td>□ Yes</td>
</tr>
<tr>
<td>□ Emergency</td>
<td>□ No</td>
<td>□ Emergency</td>
<td>□ No</td>
<td>□ Emergency</td>
<td>□ No</td>
</tr>
<tr>
<td>□ Work</td>
<td></td>
<td>□ Work</td>
<td></td>
<td>□ Work</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OK to Text:</th>
<th>OK to Send Email:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>□ Yes</td>
</tr>
<tr>
<td>□ No</td>
<td>□ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OK to Text:</th>
<th>OK to Send Email:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>□ Yes</td>
</tr>
<tr>
<td>□ No</td>
<td>□ No</td>
</tr>
</tbody>
</table>
### Service type desired, mark all that apply:

<table>
<thead>
<tr>
<th>Outpatient Clinics:</th>
<th>Residential:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ VOA-Buffalo</td>
<td>□ Harmony House/The Life House (Men’s)</td>
</tr>
<tr>
<td>□ VOA-Cheyenne</td>
<td>□ The Gathering Place (Women’s)</td>
</tr>
<tr>
<td>□ VOA-Gillette</td>
<td>□ VOA-Recovery Homes (Sheridan)</td>
</tr>
<tr>
<td>□ VOA-Laramie</td>
<td>□ Center of Hope (Riverton)</td>
</tr>
<tr>
<td>□ VOA-Newcastle</td>
<td></td>
</tr>
<tr>
<td>□ VOA-Torrington</td>
<td></td>
</tr>
<tr>
<td>□ VOA-Sundance</td>
<td></td>
</tr>
<tr>
<td>□ VOA-Wheatland</td>
<td></td>
</tr>
</tbody>
</table>

Who was the referral source for services?

Primary reason/s for referral:

- Adult Probation and Parole
- Attorney
- Clergy
- Community Mental Health Center
- Court (Not Title 25)
- Court Ordered (Title 25 Inpatient)
- DD - Developmental Disabilities
- Department of Corrections
- DFS (Department of Family Services)
- Drug Court
- Drug/Alcohol Abuse Treatment Center
- DVR (Division of Vocational Rehabilitation)
- Early Childhood Setting
- Employer
- Family/Friends
- Juvenile Probation (DFS)
- Medical Hospital
- Nursing Home
- Other
- Other Inpatient Psychiatric Service
- Other Physician
- Other Private Mental Health Practitioner
- Police/Law Enforcement
- Private Psychiatrist
- Schools
- Self
- Shelter
- Social Security/Disability
- Unknown
- Veterans Affairs
- WLRC (Wyoming Life Resource Center)
- Wyoming State Hospital

Describe what brings you to Volunteers of America:

<table>
<thead>
<tr>
<th>Emergency Contact Name:</th>
<th>Emergency Contact Phone Number:</th>
<th>Emergency Contact Relationship to Patient:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Employment Status (check one):**

- □ Child (U-16)
- □ Homemaker
- □ Self Employed/Other
- □ Unemployed
- □ Disabled
- □ Inmate
- □ Retired
- □ Full Time
- □ Part Time
- □ Volunteer
- □ Student (16+)

Patient’s Employer Name:

Patient’s Employer Phone Number:

**Annual Household Income:**

**Number of Individuals on Income:**

Have your parental rights been suspended or terminated? □ Yes □ No

If yes, who has temporary parental rights?

Do you have legal custody of your children? □ Yes □ No

If not, who has legal custody?

**Household Income Source:**

- □ DFS (Department of Family Services/Welfare)
- □ Family (Parent/Guardian)
- □ Other Disability
- □ Other/Unemployment
- □ Retirement
- □ Employment
- □ SSDI (Social Security Disability Income)
- □ SSI (Social Security Income)
- □ Unknown

**Highest Grade Completed:**

- □ No Schooling
- □ Indicate last grade completed for K-11: ____
- □ High School/GED
- □ 1 year of College
- □ 2 years of College/Assc. Degree
- □ 3 years of College
- □ Bachelor’s
- □ Master’s
- □ Doctoral
Please check all of the behaviors and symptoms that seem to be problematic:

- □ Distractibility
- □ Hyperactivity
- □ Impulsivity
- □ Boredom
- □ Poor memory/confusion
- □ Seasonal mood changes
- □ Sadness/depression
- □ Loss of pleasure/interest
- □ Hopelessness
- □ Thoughts of death
- □ Self-harm behaviors
- □ Crying spells
- □ Loneliness
- □ Low self-worth
- □ Guilt/shame
- □ Fatigue
- □ Other:

- □ Change in appetite
- □ Lack of motivation
- □ Withdrawal from people
- □ Anxiety/worry
- □ Panic attacks
- □ Fear away from home
- □ Social discomfort
- □ Obsessive thoughts
- □ Aggression/fights
- □ Frequent arguments
- □ Irritability/anger
- □ Homicidal thoughts
- □ Flashbacks
- □ Hearing voices
- □ Visual hallucinations
- □ Suspicion/paranoia
- □ Racing thoughts
- □ Excessive energy
- □ Wide mood swings
- □ Sleep problems
- □ Nightmares
- □ Eating problems
- □ Gambling problems
- □ Computer addiction
- □ Problems with pornography
- □ Parenting problems
- □ Sexual problems
- □ Relationship problems
- □ Work/school problems
- □ Alcohol/drug use
- □ Recurring, disturbing memories

Are problems affecting any of the following?

- □ Handling everyday tasks
- □ Work/School
- □ Recreational activities
- □ Self-esteem
- □ Housing
- □ Sexual activity
- □ Relationships
- □ Legal matters
- □ Hygiene
- □ Finances
- □ Health

In the past 30 days, have you or the patient had thoughts, made statements, or attempted to hurt self?  □ Yes  □ No
If yes, please describe:

In the past 30 days, have you or the patient had thoughts, made statements, or attempted to hurt someone else?  □ Yes  □ No
If yes, please describe:

In the past 30 days, have you or the patient been physically hurt or threatened by someone else?  □ Yes  □ No
If yes, please describe:

Have you or the patient engaged in high-risk behaviors of concern (e.g., unprotected sex, needle sharing, drinking and driving)?  □ Yes  □ No
If yes, please describe:

### PREVIOUS MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Type of Treatment:</th>
<th>Date/s:</th>
<th>Provider/Program:</th>
<th>Reason for Treatment and/or Diagnoses:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Outpatient Counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychiatric Hospitalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drug/Alcohol Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-help/Support Groups</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please check the following types of traumas or loss that have been experienced:

- [ ] Emotional abuse
- [ ] Sexual abuse
- [ ] Physical abuse/assault
- [ ] Parent substance abuse
- [ ] Teen pregnancy
- [ ] Neglect
- [ ] Combat Veteran
- [ ] Crime victim
- [ ] Loss of loved one
- [ ] Sexual assault
- [ ] Lived in a foster home
- [ ] Natural disaster
- [ ] Homelessness
- [ ] Significant parent illness
- [ ] Placed child for adoption
- [ ] Violence in the home
- [ ] Terrorism
- [ ] Multiple family moves

Please check the following if you have committed or participated in any of these acts of abuse or violence:

- [ ] Emotional abuse
- [ ] Sexual abuse
- [ ] Physical abuse/assault
- [ ] Parent substance abuse
- [ ] Teen pregnancy
- [ ] Neglect
- [ ] Combat Veteran
- [ ] Crime victim
- [ ] Loss of loved one
- [ ] Sexual assault
- [ ] Lived in a foster home
- [ ] Natural disaster
- [ ] Homelessness
- [ ] Significant parent illness
- [ ] Placed child for adoption
- [ ] Violence in the home
- [ ] Terrorism
- [ ] Multiple family moves

Check all strengths that apply:

- [ ] Family
- [ ] Friends
- [ ] Co-workers
- [ ] Neighbors
- [ ] Community Group
- [ ] Support/Self-Help Group
- [ ] Community Resources
- [ ] Religious/Spiritual
- [ ] Clubs

Describe strengths:

Check all skills and abilities that apply:

- [ ] Motivated
- [ ] Hopeful
- [ ] Care for Self
- [ ] Work or Attend School

Describe skills and abilities:

Check all needs that apply:

- [ ] Social Supports
- [ ] Community Resources
- [ ] Education
- [ ] Employment
- [ ] Housing

Describe needs:

How important are spiritual beliefs?  
- [ ] Not at all
- [ ] Little
- [ ] Somewhat
- [ ] Very much

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):

LEGAL INFORMATION

Do legal problems bring you to Volunteers of America?  
- [ ] Yes
- [ ] No

If yes, please answer the questions below:

Do you have an Attorney?  
- [ ] Yes
- [ ] No

Attorney’s Name:

Attorney’s Phone Number:

Attorney’s Address:

Are you currently in Drug Court?  
- [ ] Yes
- [ ] No

Location:

Are you currently in Jail?  
- [ ] Yes
- [ ] No

Location:

Date Incarcerated:

Expected Length:

Required to return to jail upon completion of treatment?  
- [ ] Yes
- [ ] No

Are you on probation or parole?  
- [ ] Yes
- [ ] No

Location of Probation:

Probation Agent:

- [ ] Supervised
- [ ] Unsupervised
- [ ] ISP

Are you court ordered to treatment?  
- [ ] Yes
- [ ] No

Which Court:

Ordered to have an evaluation?  
- [ ] Yes
- [ ] No

Evaluation Type:

- [ ] Mental Health
- [ ] Substance Use
- [ ] Both

Awaiting Sentencing?  
- [ ] Yes
- [ ] No

What charges?

Will you be on furlough to attend treatment?  
- [ ] Yes
- [ ] No

What jail?

Any outstanding warrants that you are aware of?  
- [ ] Yes
- [ ] No

What county and for what?
**MEDICAL INFORMATION**

<table>
<thead>
<tr>
<th>Date of last physical exam:</th>
<th>Primary medical provider:</th>
</tr>
</thead>
</table>

**Check all medical conditions experienced a in their lifetime:**

- Allergies
- Chronic Pain
- Dizziness/Fainting
- High Fevers
- Sexually Transmitted Disease
- Asthma
- Surgery
- Meningitis
- Diabetes
- Abortion
- Headaches
- Serious Accident
- Seizures
- Hearing Problems
- Sleep Disorder
- Stomach Aches
- Head Injury
- Vision Problems
- Miscarriage
- Other: ________

**List current health concerns (including dental):**

**Please list any disabilities, disorders, or medical conditions:**

**Current prescription medications:**

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Dosage:</th>
<th>Prescriber:</th>
<th>How effective is medication for patient?</th>
</tr>
</thead>
</table>

**Past psychotropic prescription medications:**

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Dosage:</th>
<th>Prescriber:</th>
<th>How effective is medication for patient?</th>
</tr>
</thead>
</table>

**Allergies and/or adverse reactions to medications:**

- Yes
- No

**Allergies and/or adverse reactions to food:**

- Yes
- No

**If yes, please list:**

**Current over the counter or complementary health approaches (vitamins, acupuncture, massage, homeopathy, etc.):**

**Are you pregnant?**

- NA
- Yes
- No

**If yes, are you receiving pre-natal care?**

- Yes
- No

**Check all that apply to your current health status:**

- Alcohol/Drug Problems
- Alzheimer's/Dementia
- Arthritis
- Blood Disorder
- Breathing Problems
- Cancer
- Diabetes
- Gastro-Intestinal Problems
- Other:

- Hearing Problems
- Heart Disease
- High Blood Pressure
- HIV/AIDS
- Liver Problems/Hepatitis
- Mental Illness
- Pain
- Seizures/Neurological
- Sleep Disorder
- Stroke
- Thyroid Problems
- Tobacco Use
- Tuberculosis
- Urinary/Kidney Problems
- Vision Problems
- Weight Problems
SUBSTANCE USE HISTORY

<table>
<thead>
<tr>
<th>Substance Type</th>
<th>Current (last 6 months):</th>
<th>Past Use:</th>
<th>Age of First Use:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Frequency</td>
</tr>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caffeine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine/crack</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecstasy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin or Opioids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methamphetamine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain Killers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP/LSD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steroids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tranquilizers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gambling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you or the patient had withdrawal symptoms when trying to stop using any substances? □ Yes □ No
If yes, please describe:

Have you or the patient had problems with work, relationships, health, law, etc. due to substance use or gambling? If yes, please describe: □ Yes □ No

Do you or the patient have a family history of substance abuse? □ Yes □ No
If yes, please describe:

Has gambling ever caused any financial problems for you or the patient? □ Yes □ No
If yes, please describe:

Have you or the patient used IV drugs? □ Yes □ No
If yes, last date of injection:
CHILDREN/MINOR INFORMATION ONLY

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were there any medical problems during the pregnancy or birth of patient?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, please describe:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any post-partum depression or anxiety?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, please describe:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the biological mother use any substances while pregnant with patient?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, please describe substances used, quantity, and frequency:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did patient have any developmental delays in early childhood (crawling, walking, talking)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, please describe:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As a baby, how did patient behave with other people?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ More sociable than average □ Average sociability □ Less sociable than average</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SCHOOL INFORMATION**

<table>
<thead>
<tr>
<th>Current grade:</th>
<th>School:</th>
<th>Does patient see the school counselor?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>This year’s school grades:</td>
<td>□ Excellent □ Good □ Fair □ Poor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past school grades:</td>
<td>□ Excellent □ Good □ Fair □ Poor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This year’s school behavior:</td>
<td>□ Excellent □ Good □ Fair □ Poor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past school behavior:</td>
<td>□ Excellent □ Good □ Fair □ Poor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does patient have an after-school provider or after-school program or activities?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If so, which one(s)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any of the following difficulties at school?</td>
<td>□ Suspension □ Poor grades □ Incomplete homework □ Teased or picked on □ Learning Problems □ Speech Problems □ Referrals or detentions □ Attendance problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever repeated or skipped a grade?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, which one(s)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently on or has been on an Individual Educational Plan (IEP) or 504 plan?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, please describe:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there concerns with ability to learn?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
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<td>If yes, please describe:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a need for assistive technology in the provision of services?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
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<td>If yes, please describe:</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>What does teacher(s) say about him/her?</td>
<td></td>
<td></td>
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</tr>
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</table>
### Additional information needed for the Residential Treatment Application:

#### Insurance Coverage
- None
- My Private Insurance
- Other’s Private Insurance
- Other:
- Medicare
- Medicaid

Please provide front and back of card with your application.

#### Please provide information on substances used:

<table>
<thead>
<tr>
<th>Substances(s) used:</th>
<th>Date of Last Use?</th>
<th>Drug of choice?</th>
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How did you take?
- □ IV
- □ Oral
- □ Smoke
- □ Other:

How Often did you take?

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