Volunteers of America®

THE LIFE HOUSE
3322 Strahan PKWY
Sheridan, WY 82801

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:

Primary Residential Treatment	***Transitional Residential Treatment***
The Gathering Place – Women - Sheridan	Recovery Homes – Men & Women – Sheridan
The Life House – Men – Sheridan	Harmony House – Men – Cheyenne
Harmony House - Cheyenne	Center of Hope – Men & Women - Riverton

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:

Phone: 866.843.0351 option 1 or 307.672.2044 option 1
Email: admissions@voanr.org
Fax: 307.426.4740

Once we receive the requested information in the checklist, we will be in contact regarding your status with VOA. Our wait times vary from an average of 3-4 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.*

Volunteers of America®
NORTHERN ROCKIES

Admissions Application

1876 S Sheridan Avenue, Sheridan WY 82801 1.866.438.2862(p) 1.307.426.4740(f)

- **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**

Is this considered to be an emergency: ☐ Yes ☐ No (homicidal/suicidal or hospital release)	Tribal Affiliation:	Today's Date:
Legal Last Name:	Legal First Name & M.I.:	Maiden Name:
Received services at Volunteers of America before? ☐ Yes ☐ No If YES, under what name?		Mother's First Name:

Gender:
☐ Male
☐ Female

Sexual Orientation:
☐ Straight or Heterosexual
☐ Lesbian, Gay or Homosexual
☐ Bisexual
☐ Transgender
☐ Queer
☐ Intersex
☐ Other
☐ Chose Not to Disclose
☐ Does Not Know / Unknown

Birth Date:	Social Security #:	Responsible Party SSN #:

Physical Address:	City:	State:	Zip Code:	County:
Mailing Address/P.O. Box:	City:	State:	Zip Code:	County:

Type of Residence (check one):
☐ Boarding/Foster Home
☐ Group Home
☐ Hospital
☐ Jail/Correctional Facility
☐ Lacks a fixed, regular, night-time residence
☐ Other Residential Setting
☐ Private Residence/Household
☐ Residential Treatment Center
☐ Unknown

City of Birth:	State of Birth:	Country of Birth:

Ethnicity (check one):
☐ Not of Hispanic Origin
☐ Cuban
☐ Mexican
☐ Other Hispanic
☐ Puerto Rican
☐ Unknown

Race (check one):
☐ White
☐ Asian
☐ Black
☐ More Than One Race
☐ Native American/Alaskan
☐ Other/Unknown

Veteran:
☐ Not a Veteran
☐ Unknown
☐ Combat
☐ Non-Combat

Marital Status (check one):
☐ Divorced
☐ Legally or Otherwise Absent
☐ Minor Child
☐ Never Married
☐ Married
☐ Unknown
☐ Widowed

Day Phone:	Evening Phone:	Mobile Phone:

Number Type: ☐ Primary ☐ Emergency ☐ Work	OK to Leave Message: ☐ Yes ☐ No	Number Type: ☐ Primary ☐ Emergency ☐ Work	OK to Leave Message: ☐ Yes ☐ No	Number Type: ☐ Primary ☐ Emergency ☐ Work	OK to Leave Message: ☐ Yes ☐ No OK to Text: ☐ Yes ☐ No

Email:	OK to Send Email: ☐ Yes ☐ No

Service type desired, mark all that apply:

Outpatient Clinics:

- ☐ VOA-Buffalo
- ☐ VOA-Cheyenne
- ☐ VOA-Gillette
- ☐ VOA-Laramie
- ☐ VOA-Newcastle
- ☐ VOA-Sheridan
- ☐ VOA-Sundance
- ☐ VOA-Torrington
- ☐ VOA-Wheatland

Residential:

- ☐ Harmony House/The Life House (Men's)
- ☐ The Gathering Place (Women's)
- ☐ VOA-Recovery Homes (Sheridan)
- ☐ Center of Hope (Riverton)

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:

Emergency Contact Name:	Emergency Contact Phone Number:	Emergency Contact Relationship to Patient:

Employment Status (check one):

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

PRESENTING PROBLEMS AND CONCERNS

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
- ☐ Compulsive behavior
- ☐ 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
- ☐ Health
- ☐ Hygiene
- ☐ Finances

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? If yes, please describe: ☐ Yes ☐ No

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)? If yes, please describe: ☐ Yes ☐ No

PREVIOUS MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT

Yes	No	Type of Treatment:	Date/s:	Provider/Program:	Reason for Treatment and/or Diagnoses:
☐	☐	Outpatient Counseling			
☐	☐	Psychiatric Hospitalization			
☐	☐	Drug/Alcohol Treatment			
☐	☐	Self-help/Support Groups			

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

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

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

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

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

Check all strengths that apply:

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

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:

In the past 30 days, how many times have you or the patient been arrested?			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

Date of last physical exam:	Primary medical provider:

Check all medical conditions experienced a in their lifetime:

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

List current health concerns (including dental):	Please list any disabilities, disorders, or medical conditions:

Current prescription medications: ☐ None

Medication:	Dosage:	Prescriber:	How effective is medication for patient?

Past psychotropic prescription medications: ☐ None

Medication:	Dosage:	Prescriber:	How effective is medication for patient?

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	☐ Hearing Problems	☐ Sleep Disorder
☐ Alzheimer's/Dementia	☐ Heart Disease	☐ Stroke
☐ Arthritis	☐ High Blood Pressure	☐ Thyroid Problems
☐ Blood Disorder	☐ HIV/AIDS	☐ Tobacco Use
☐ Breathing Problems	☐ Liver Problems/Hepatitis	☐ Tuberculosis
☐ Cancer	☐ Mental Illness	☐ Urinary/Kidney Problems
☐ Diabetes	☐ Pain	☐ Vision Problems
☐ Gastro-Intestinal Problems	☐ Seizures/Neurological	☐ Weight Problems
☐ Other:		

SUBSTANCE USE HISTORY

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

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

Were there any medical problems during the pregnancy or birth of patient? ☐ Yes ☐ No
If yes, please describe:

Any post-partum depression or anxiety? ☐ Yes ☐ No
If yes, please describe:

Did the biological mother use any substances while pregnant with patient? ☐ Yes ☐ No
If yes, please describe substances used, quantity, and frequency:

Did patient have any developmental delays in early childhood (crawling, walking, talking)? ☐ Yes ☐ No
If yes, please describe:

As a baby, how did patient behave with other people?

☐ More sociable than average ☐ Average sociability ☐ Less sociable than average

SCHOOL INFORMATION

Current grade:	School:	Does patient see the school counselor? ☐ Yes ☐ No

This year's school grades: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Past school grades: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
This year's school behavior: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Past school behavior: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does patient have an after-school provider or after-school program or activities? ☐Yes ☐No
If so, which one(s)?

Any of the following difficulties at school?

☐ Suspension ☐ Learning Problems
☐ Poor grades ☐ Speech Problems
☐ Incomplete homework ☐ Referrals or detentions
☐ Teased or picked on ☐ Attendance problems

Ever repeated or skipped a grade?
☐ Yes ☐ No
If yes, which one(s)?

Currently on or has been on an Individual Educational Plan (IEP) or 504 plan? ☐ Yes ☐ No
If yes, please describe:

Are there concerns with ability to learn? ☐ Yes ☐ No
If yes, please describe:

Is there a need for assistive technology in the provision of services? ☐ Yes ☐ No
If yes, please describe:

What does teacher(s) say about him/her?

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Additional information needed for the Residential Treatment Application:

Insurance Coverage	
☐ None ☐ Private/Commercial Insurance ☐ Medicare	☐ Medicaid o Montana o Nebraska o Wyoming Medicaid # ____________________ Please provide a copy of your card

Please provide information on substances used:

Substances(s) used:		**Date of Last Use?**	**Drug of choice?**
			Y / N
How did you take? ☐ Oral ☐ Smoke	☐ IV ☐ Other:	**How Often did you take?**	
Substances(s) used:		**Date of Last Use?**	**Drug of choice?**
			Y / N
How did you take? ☐ Oral ☐ Smoke	☐ IV ☐ Other:	**How Often did you take?**	
Substances(s) used:		**Date of Last Use?**	**Drug of choice?**
			Y / N
How did you take? ☐ Oral ☐ Smoke	☐ IV ☐ Other:	**How Often did you take?**	
Substances(s) used:		**Date of Last Use?**	**Drug of choice?**
			Y / N
How did you take? ☐ Oral ☐ Smoke	☐ IV ☐ Other:	**How Often did you take?**	
Substances(s) used:		**Date of Last Use?**	**Drug of choice?**
			Y / N
How did you take? ☐ Oral ☐ Smoke	☐ IV ☐ Other:	**How Often did you take?**	