Staff use only
Date received:_____
Staff initials:_____

GENESIS RECOVERY SERVICES, INC.

Application for Services

Please do not leave any question blank. If a question does not apply to you please indicate by N/A.

Applicant Name: _____ Date:_____

Services Requested: ☐ Substance Use Assessment ☐ Residential Treatment

Reason why services are being requested:_____

_____

_____

Who referred you to this program:_____

Have you had a Substance Use Assessment within the last 90 days? ☐ Yes ☐ No

If so, where did you have this Assessment completed?_____

And what were its recommendations:_____

***If you are requesting this Assessment to be used to support your need for treatment, we must have a copy of the Assessment and a signed Release of Information allowing us to contact the agency who did the Assessment.

Ethnicity / Gender Status information is optional:

Race/Ethnicity:_____ Gender: _____

Date of Birth:_____ Social Security Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children: ☐ Yes ☐ No If so, how many?_____

Childrens place of birth: _____

Where do they currently reside?: _____

Have you ever had any Office of Children Services (OCS) involvement?: ☐ Yes ☐ No

If so, please explain: _____

_____

_____

Your Mailing Address:_____ Phone Number: _____

_____ Msg Number: _____

_____ Other: _____

Your place of birth: _____

GENESIS RECOVERY SERVICES, INC.

Application for Services

Please do not leave any question blank. If a question does not apply to you please indicate by N/A.

Applicant Name: _____ Date:_____

Educational Information

Highest Grade Completed: _____ ☐ Diploma ☐ GED ☐ College

Vocational School or Training: _____

_____

Employment Information

Most Recent Employer: _____ ☐ Quit ☐ Fired ☐ Retired

Roughly Last Date Employed / Additional Informaion: _____

_____

Legal Information

Name of Attorney: _____

Phone Number: _____

Notice:
We will need you to complete an ROI for your attorney. See "Forms" section in back.

Are you currently on Probation or Parole? ☐ Yes ☐ No

Probation /Parole Officer: _____ Phone Number: _____

If you have any current charges, please list them here: _____

_____

_____

_____

_____

Past Criminal Charges, if so, please list them and the outcome: _____

_____

_____

_____

_____

_____

_____

GENESIS RECOVERY SERVICES, INC.

Application for Services

Please do not leave any question blank. If a question does not apply to you please indicate by N/A.

Applicant Name: _____ Date:_____

Medical Information:

Current Physician's Name / Clinic: _____

Address: _____Phone:_____

Current Medical Conditions and/or allergies:_____

_____

_____

_____

_____

List of Currently Prescribed Medications: Reason you take this med:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any medical conditions that may interfere with your treatment? ☐ YES ☐ NO

If so, please explain: _____

_____

_____

_____

_____

GENESIS RECOVERY SERVICES, INC.

Application for Services

Please do not leave any question blank. If a question does not apply to you please indicate by N/A.

Applicant Name: _____ Date:_____

Substance Use History Do you now, or have you ever used/tried any of the following substances

SUBSTANCE	AGE OF FIRST USE	AGE OF LAST USE	HOW OFTEN USED	HOW MUCH USED	DATE LAST USED	HOW USED (ORAL, IV SMOKE, SNORT, ETC):
AMPHETAMINE						
SPEED, UPPERS						
AMYL NITRATE						
BARBITURATES						
BENZODIAZEPINE						
COCAINE/CRACK						
CODEINE						
HEROIN						
INHALANTS						
LSD(ACID)						
MARIJUANA						
OPIUM						
PCP/ANGEL DUST						
PERCODAN						
PEYOTE						
QUAALUDES						
SPICE						
SUBOXONE						
OTHER STIMULATES						
TOBACCO						
ALCOHOL						

Have you experienced any blackouts or overdosing or negative conditions from using?: ☐ YES ☐ NO

If so, please explain: _____

_____

_____

GENESIS RECOVERY SERVICES, INC.

Application for Services

Please do not leave any question blank. If a question does not apply to you please indicate by N/A.

Applicant Name: _____ Date:_____

Financial Information: Payment is required at the time of appointment

How will you be paying for your services: ☐ Cash ☐ Medicaid

Medicaid Number: _____

Additional information you would like to include in this application:

_____

_____

_____

Forms:

To assist with the application process, you may need to submit with this applicantion Releases of Information for the following:

Public Defender Agency,
Office of Public Advocacy
Divion of Public Assistance
Department of Corrections
Office of Childrens Services
Doctors who prescribe current medications
Previous or current mental health or substance abuse treatment centers
If you have a private attorney, we may also need an ROI for them.

Please submit forms via fax , mail, or in person. Thank you :)

_____ _____

Applicant Printed Name Date

_____

Applicant Signature