Staff use only

Date received:_____

Staff initials:_____

GENESIS RECOVERY SERVICES, INC.

Application for Services

Applicant Name: _____ Date:_____

Services Requested: ☐ Substance Use Assessment ☐ Residential Treatment

Reason why services are being requested:_____

_____

_____

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?_____

Mailing Address:_____ Phone Number: _____

_____ Msg Number: _____

_____ Other: _____

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.

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? ☐ Yes ☐ No

Probation Officer: _____ Phone Number: _____

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

_____

Medical Information

Current Physician's Name: _____

Phone Number: _____

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

Address: _____

_____

_____

Current Medical Conditions / and or Allergies: _____

_____

_____

List of Current Prescribed Medications or other medications you're taking:

Type of Medication: Reason why you take this medication: Prescribing Doctor:

_____

_____

_____

_____

_____

Do you have a disability that might affect your treatment needs? ☐ Yes ☐ No

If so, please explain: _____

_____

_____

Previous or Current Mental Health or Substance Abuse Treatment

Where: Dates:

_____ _____

_____ _____

_____ _____

Notice:
Required Release of Information to be completed for each previous/current treatment.

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
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.

All forms must be submitted via fax or in person. We do not accept documents via email.

_____ _____

Applicant Printed Name Date

_____

Applicant Signature