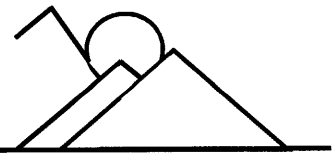

Dedicated to Promoting Individual, Family and Community Wellness - Through a Variety of Substance Abuse and Behavioral Health Services

1490 Grimes Street
Fallon, Nevada 89406
Mailing address: P.O. Box 1240 Fallon, Nevada 89407
Phone: (775) 423-1412 or 1 (800) 232-6382 Fax: (775) 423-9142

Office Use Only:
Date Application Received:_____ Admission Date: _____ Client AWARDS No. _____

All information must be completed in order for application to be processed

Application and Screening for Services

(Circle One)

Residential Outpatient Rooms for Ruth

Personal Information (please print)

_____ Date: _____
Last **First** **Middle**
Home Address: _____ City: _____ State: _____ Zip Code: _____
County: _____ Years at Address: _____
Temporary Address: _____ City: _____ State: _____ Zip Code: _____
County: _____ Years at Address: _____
Home # ( ) _____ Cell # ( ) _____ Work # ( ) _____ Message # ( ) _____
Email: _____ Social Security # _____ DOB: _____
Gender: Male ____ Female: ____ Transgender: Yes ___ No Highest Grade Completed_____

Referral Source: _____ **Contact Name:** _____ **Contact Phone #:** _____

Permanent Contact: _____ **Phone #:** _____
Relationship

Race: *Circle one* None Selected / Alaska Native (Aleut, Eskimo, Indian) / American Indian (Other than Alaskan Native) / Asian / Native Hawaiian / other Pacific Islander / Black or African/ White / Other Single Race / Two or more Races / Unknown

Ethnicity: *Circle one* Unknown / White (not of Hispanic origin) /Black (not of Hispanic origin) / American Indian / Alaskan Native / Asian or Pacific Islander / Hispanic-Cuban / Other Hispanic

Religion: *Circle one* None Protestant Catholic Jewish Islamic Other

Mother's Maiden Name: _____ **Client Birth City:** _____
Caller Identity: Self ____ Family member ____ Friend ____ Employer ____ Other _____
US Citizen: Yes _____ No _____
Veteran: (Circle one) Not a veteran / Vet w/honorable discharge / Vet w/other than honorable discharge / Active Duty / Unknown

Residential Application and Screening

Marital / Social History:

Current marital status: Married _____ Divorced _____ Separated _____ Single _____ Widowed _____
Pregnant: Yes ____ No ____ Due Date: _____ Are you receiving prenatal care? Yes ____ No ____
Number of Children: ____ Ages: _____ Are they currently in your care? Yes ____ No ____
Is CPS or DCFS involved with children: Yes ____ No ____

PLEASE LIST ALL SUBSTANCES USED (Including alcohol)

ALCOHOL & DRUGS BEING USED	AGE OF FIRST USE	# OF DAYS USED IN LAST 30 DAYS	# OF YEARS USED	DATE OF LAST USE	AMOUNT USED DAILY	METHOD OF USE	TREATED FOR PREVIOUSLY	FACILITY/ LOCATION ATTENDED

Are you an I.V. user? Yes _____ No _____ If yes, for how long? _____
Are you currently using Methadone or Suboxone? Yes _____ No _____ If yes, for how long? _____
Have you had a physical/medical exam within the last 30 days? Yes _____ No ____ By whom: _____
Have you had seizures? Yes _____ No _____ Date of last seizure: _____ Cause: _____
Do you have any current or past mental health issues? Yes _____ No _____ Diagnosis: _____
Have you ever had or are you now experiencing any suicidal or homicidal ideations? Yes _____ No _____
Explain: _____
Have you had any past suicide attempts? Yes _____ No _____ Explain: _____
Do you have any physical/mental disabilities that may interfere with treatment or for which you may need special accommodations? Yes _____ No _____ Explain: _____

PLEASE LIST ALL PRESCRIPTIONS YOU HAVE TAKEN IN THE LAST 30 DAYS

Check box if currently taking med * List additional meds on back of this sheet

MEDICATION	REASON FOR TAKING MED	PRESCRIBING DOCTOR
☐		
☐		
☐		
☐		

List all allergies (Medications, Animals, Food): _____

Indicate if you have had any of the following health problems: Please circle Yes or No

Heart Disease	Y / N	Liver Disease	Y / N	Head Trauma	Y / N
Stroke History	Y / N	Hepatitis (A, B, C)	Y / N	Anxiety	Y / N
High Blood Pressure	Y / N	Tuberculosis	Y / N	Diabetes	Y / N
Internal Bleeding	Y / N	Respiratory	Y / N	Recent Surgery	Y / N
Ulcers	Y / N	Epilepsy	Y / N	S.T.D.	Y / N

Do you have any contagious illnesses or conditions? Yes _____ No _____ Explain: _____

Any history of physical or sexual abuse? Yes _____ No _____

Residential Application and Screening

Have you ever been convicted of a sex crime? Yes _____ No _____ **if yes, complete criminal history form**
Have you ever been convicted of a violent crime? Yes _____ No _____ **if yes, complete criminal history form**
Are you currently incarcerated? Yes _____ No _____ If yes, how long? _____
Current Probation/Parole Officer: _____ Phone#: _____
Do you have any legal issues or court dates? Yes _____ No _____ Court date/County: _____
Any outstanding warrants? Yes _____ No _____ Type: _____ County: _____
Have you been ordered/referred into treatment by any of the following?

CPS _____ Social Worker _____ Counselor _____ Physician _____
Court _____ Probation/Parole _____ Other _____

Do you know anyone currently in the Residential Program? Yes _____ No _____ Who/Relationship _____
List names and dates of treatment programs that you have participated in for Residential or Outpatient for substance abuse and/or mental health in the last year:
Name: _____ Date: _____
Name: _____ Date: _____

Please list earliest date you are available to come into treatment: _____
Do you have any medical/dental or other appointments scheduled? Yes _____ No _____
Date: _____ Where: _____

What is your monthly income amount? _____ Source: _____
Please submit a copy of your proof of income along with this application.
How will you pay for treatment? Funding source (Self, Drug Ct., Insurance, IHS etc.): _____
Do you have health insurance? Yes _____ No _____
Check appropriate coverage
Medicaid _____ VA _____ Champus/Tricare (circle one) _____ Other _____
Medicare _____ HIS _____ Private Insurance _____
Name: _____ Policy #: _____ Group #: _____
Claims phone# on back of card: _____
Please submit a copy of front and back of insurance card with this application.

Smoking /Tobacco Products: Effective July 1, 2002, NFTC is a total non-smoking/tobacco free environment.

Wait List: You do have the option of being placed on the waiting list for the next available bed. New Frontier Treatment Center is required to abide by SAPTA's priority admission list to determine who receives the next available scheduling date. Admission prioritization is as follows: 1) Pregnant IV users 2) Pregnant users 3) Non-pregnant I.V. users 4) All other substance users. To be placed on the waiting list it is mandatory to have a phone number where you or a representative you designate by a signed release can be reached. Please list first and last name of the person to be contacted if someone other than you.

Contact Person: _____ Phone #: _____

Client Signature: _____ Date: _____

If you have any further questions, please do not hesitate to call New Frontier during business hours 8:00 a.m. – 5:00 p.m. Monday-Friday at (775) 423-1412. ***Mail completed application to: New Frontier @ P.O. Box 1240 Fallon, Nevada 89407 Fax completed application to: (775) 423-9142***

Residential Application and Screening

Client Name: _____ Date: _____
Last First Middle

Contact Code: In person _____ Phone call _____

Interview Setting: Circle answer
Office / Home / Outpatient clinic / Outpatient hospital / Inpatient hospital / Residential facility / Boarding home / Correctional facility / Mobile/Extended/Outreach / Hospice / Nursing home / Other

PART ONE
During the last 6 months:

1. Did you often use larger amounts of alcohol or drugs or use them for a longer time than you had planned or intended? Yes / No

2. Did you try to cut down on alcohol or drugs and were unable to do it? Yes / No

3. Did you spend a lot of time getting alcohol or drugs, using them, or recovering from their use? Yes / No

4. Did you often get so high or sick from alcohol or drugs that it—
   a. Kept you from doing work, going to school, or caring for children? Yes / No
   b. Caused an accident or became a danger to you or others? Yes / No

5. Did you often spend less time at work, school, or with friends so that you could drink or use drugs? Yes / No

6. Did your use of alcohol or drugs often cause- -
   a. Emotional or psychological problems? Yes / No
   b. Problems with family, friends, work, or police? Yes / No
   c. Physical health or medical problems? Yes / No

7. Did you increase the amount of alcohol or a drug you were taking so that you could get the same effects as before? Yes / No

8. Did you ever keep drinking or taking a drug to avoid withdrawal or keep from getting sick? Yes / No

9. Did you get sick or have withdrawal when you quit or missed drinking or taking a drug? Yes / No

10. Which drugs or alcohol caused you the MOST serious problems? See list below.

	Drug Name	**# of days used in the last 30 days**
Primary Substance:	_____	_____
Secondary Substance:	_____	_____
Tertiary Substance:	_____	_____

11. How often did you inject drugs with a needle? **Circle answer**
Never / Only a few times / 1-3 times a month / 1-5 times a week / about every day

12. How serious do you think your drug problems are?
Not at all / Slightly / Moderately / Considerably / Extremely

13. How many times before now have you ever been in an alcohol treatment program?

14. How many times before now have you ever been in a drug treatment program?
(Do not include AA/NA/CA meetings)

15. Do you think you need treatment for your drug use now?
If "Yes," answer question "a" below:
a. How important to you is it that you get into some type of treatment program now?
Not at all / Slightly / Moderately / Considerably / Extremely

16. How many times have you received psychiatric or counseling services for reasons other than alcohol or drug problems? (Include all hospitalization and outpatient visits)

17. Do you currently have a medical condition?
If "YES" Choose no more than 3 conditions below: Circle answer

Seizures	GI Bleeding	Gastritis/Ulcers	Anemia	Hepatitis	HIV
Injuries	Heart disease	Hypertension	Diabetes	Cancer	Malnutrition
Respiratory	Lung Disease	STD	TB	Other	

Other Medical Conditions? _____

18. What medications have been prescribed or have you been taking in the past 6 months for **substance abuse or mental health problems**?

_____ _____

a. If female, are you pregnant? Yes / No

GAMBLING BEHAVIORS

19. How old were you the first time you gambled (bet money or something of value on sports, a game of chance or skill, played the lottery, or bet cards or dice games?
20. In the last 30 days, have you gambled for anything of value? Yes/No
21. If you have gambled in the past 12 months, how much money did you usually bet?
22. In the past year, have you often found yourself thinking about gambling or planning to gamble? Yes/No
23. In the past year, have you ever spent more than you meant to on gambling? Yes/No
24. In the past year, has gambling lead you to lie to your family? Yes/No

25. Has the money you spent gambling led to financial problems? Yes/No
26. Has the time you spent gambling led to problems in your family, work, school, or personal life? Yes/No

Please explain criminal history in detail especially those violent or sexual in nature.

Year: _____ Conviction: _____ Time served: _____

Year: _____ Conviction: _____ Time served: _____

Year: _____ Conviction: _____ Time served: _____

Year: _____ Conviction: _____ Time served: _____

Year: _____ Conviction: _____ Time served: _____

Year: _____ Conviction: _____ Time served: _____

Year: _____ Conviction: _____ Time served: _____

Year: _____ Conviction: _____ Time served: _____

Year: _____ Conviction: _____ Time served: _____

Year: _____ Conviction: _____ Time served: _____

Year: _____ Conviction: _____ Time served: _____

Comments: _____

Please Also include any current Pending court cases.

COVID-19 Awareness Screening

Name:_____ Date:_____

Potential Contact

1. Have you traveled outside of the United States, in the past 14 days? Yes No

   If yes, list locations _____

2. Have you been in contact with anyone who has traveled outside of the United States in the past 14 days? Yes No

3. Have you been in contact with anyone who has been exposed to COVID-19? Yes No

4. Do you live in a group home setting or in custody? Yes No

Potential Symptom Check

1. Are you 65 or older? Yes No
2. Do you have a history of respiratory issues? Yes No
3. Do you suffer from any serious chronic illnesses, such as heart disease, diabetes, lung disease, etc)? If yes, please list _____ Yes No
4. Do you have a fever, cough, or shortness of breath? Yes No

OFFICE LOCATION

1490 Grimes Street
P.O. Box 1240
Fallon, NV 89407-1240
Ph: (775) 423-1412
Fax: (775) 423-4054

Important: Please Read

New Frontier Treatment Center requires **ALL** prospective clients to submit Proof of Income for the last 12 months of **EVERY** household member before assigning bed dates. It does not matter how much or how little has been earned, just that there is valid documentation to prove income levels. This can be done in the form of: an employee pay stub, tax return for the prior year and financial statements or bank account deposit records, unemployment benefits, Social Security check stub, Disability check stub, Food Stamps or TANF documentation. If you have worked for under the table wages you must provide a written and signed statement to that affect stating the last 12 months income.

These documents **MUST** be received with the application or faxed to (775) 423-9142 before you will be assigned a bed date. If you are unable to provide ANY documentation then you may write a personal income statement stating all income earned in the last 12 months along with date and signature.

If you have any questions, please contact the Intake dept. at (775) 423-1412.

Thank you,
New Frontier Intake Dept.