**Rural Nevada Counseling – Supportive Housing**
**Confidential Client Intake Form**

**Phone – (775) 575-6191**
**Fax – (775) 980-8042**
**www.ruralnevadacounseling.org**

***General Information***

Name_____Date_____
County of Residence_____
Address_____
City_____State_____Zip_____
Years at Address_____
Phone #'s: Home_____Work_____Cell _____
Please **DO NOT** contact me at: Home Work Cell
E-mail_____
Sex: M * F * Trans Date of Birth_____Age_____
SSN#_____Race_____Ethnicity_____
Mother's Maiden Name_____
Birth City_____US Citizen_____
Veteran_____
Referred By_____
How did you hear about our services?_____

Emergency Contact_____Phone # _____
Have you been in a controlled environment in the past 30 days? Y / N
If so, where? _____ How many days?_____
Do you have an ID card? Y/N
Do you have a Social Security card? Y/N
Do you have your Birth Certificate? Y/N

**Medical**

How many times have you been hospitalized?_____In the past 12 months?_____
Health Insurance? Y/N Name of Provider_____Card #_____
Do you have any chronic Medical Problems? Y / N Doctor_____
If so, please list:

_____
_____

Date of last physical exam
_____
Date of last TB Test _____
Results _____

*If accepted, it is your responsibility to provide a copy of current TB results prior to arrival into RNC supportive housing unit. Rural Nevada Counseling is prohibited, by law, to accept you into our supportive housing program without this documentation.

*Supportive housing program lasts approximately 3-6 months followed by Outpatient Treatment. Although each person is unique to their own treatment planning needs, we ask that you commit 12-18 months towards your full continuum of care.

_____

_____

Medications Currently Taking (This information is mandatory to enter treatment)

_____

_____

Are you on Disability: Y / N Are you able to return to work: Y/N

Medicare: Y / N

If yes to disability, for what?_____

If female, are you pregnant? Y / N / NA

Medical problems in the last 30 days? Y / N If so, how many days?_____

*On a scale from 1-10, with 1 being not a problem, how do you rate the following?

How troubled are you about medical problems?_____

How important is treatment for your medical problems? _____

**Education**

Grades completed _____Technical Training?_____months

Medicaid: Y / N Card #_____

Driver's License or ID #_____Applied for Medicaid: Y / N

Over the past three years have you been more employed or unemployed?_____

Days worked in the past 30?_____Dependents _____

*On a scale from 1-10, with 1 being not a problem, how do you rate the following?

How troubled or bothered have you been by employment problems in the past 30 days? _____

How important to you now is treatment for these employment problems? _____

**SUBSTANCE USE**

| Drug Use and Patterns | Use Past 12 months | Use Past 30 days | Highest use Frequency and Amount | Age First use | Date of Last Use | Route | 1st, 2nd, 3rd choice |
|---|---|---|---|---|---|---|---|
| Alcohol | | | | | | | |
| Heroin<br>Street Methadone | | | | | | | |
| Barbiturates<br><br>(Opium/Demerol/ Morphine/Talwin) | | | | | | | |
| Benzodiazepines (Hypnotics/Sedatives /Anxiolytics | | | | | | | |
| Cocaine/Crack | | | | | | | |
| Methamphetamines or other Amphetamines (Speed/Ice/other uppers) (exclude MDMA | | | | | | | |
| Cannabis (Marijuana/Hashish | | | | | | | |
| Hallucinogens/ Psychedelics (LSD/PCP/ Mushrooms/Peyote) | | | | | | | |
| Inhalants | | | | | | | |
| Other Opiates/Analgesics | | | | | | | |
| Spice | | | | | | | |
| Over the counter | | | | | | | |

Do you, or have you, ever used intravenous drugs? Y / N
Have you taken the substance in larger amounts or over a longer period than was intended? Y / N
Is there a persistent desire or unsuccessful efforts to cut down or control substance use? Y / N
Did you spend a great deal of time in activities necessary to obtain substances? Y / N
Do or did you have a craving, strong desire or urge to use substance? Y / N
Did you use substance recurrently and the results were a failure to fulfill major role obligations at work, school or home? Y / N
Have you ever been engaged in treatment before? Y / N
If yes, how many times in your life have you been treated for substance use? _____
For what?_____ Facility_____Date_____
Did you successfully complete this treatment? Y / N
Have you ever had DT? Y / N Have you ever attended Detox? Y / N
In the past 30 days did you spend money on drugs and or alcohol? Y / N
If yes, how much?_____
Did others give you drugs or give you money? Y / N How much? _____
What is your longest period going without the use of alcohol and/or other drugs:
_____
Have you been bothered by substance use issues in the past 30 days? Y / N
If yes, how many days? _____

*On a scale from 1-10, with 1 being not a problem, how do you rate the following?
How important is treatment to you at this time? _____
How serious do you feel your drug and/or alcohol problems are? _____
Have you been involved in prior treatment including residential care? Y/N
If so, where and when and did you successfully complete:
_____
_____
_____

**Legal**

Was this visit prompted by the criminal justice system? Y / N
If so, which one? _____
Are you on Probation or Parole? Y / N Officer? _____
Are you under court supervision? Y / N Which one? _____

Projected date of expiration of court or criminal justice supervision? _____
Have you ever been convicted of a violent offense? Y/N
If yes, explain

Have you ever been convicted of a sexual offense? Y/N
If yes, explain
_____
Past charges?

Current charges?_____

# of DUI's? _____
How many months have you been incarcerated in your life? _____

*On a scale from 1-10, with 1 being not a problem, how do you rate the following?
How serious do you feel your legal problems are? _____
How important do you feel treatment is for these issues? _____

**Relational Information**
Marital Status _____
Children? Y / N
If yes, ages and location: _____
Are any of your children living with someone else due to a protective order? Y / N
How many children do you have?_____Do you owe child support? Y / N
Did you live with someone who drinks or uses substances? Y / N Who? _____
Have you had problems getting along with anyone in the past 30 days? _____
Lifetime? _____
Have you ever been sexually, physically, or psychologically abused? Y / N
If so, please explain

_____
_____
If so, how old were you? _____

If so, how old were you and who abused you?

_____
_____

*On a scale from 1-10, with 1 being not a problem, how do you rate the following?
How troubled have you been by social or family issues in the past 30 days?

_____
How important to you is treatment or counseling for these issues?

_____

**Mental/Emotional Health**
How many times have you been treated for a psychological or emotional problem?

_____
In hospital?_____Outpatient?_____
Do you have a psychiatric disability? _____

| Have you experienced: | Past 30 days | In lifetime |
|---|---|---|
| -Serious Depression | Y / N | Y / N |
| -Anxiety or Tension | Y / N | Y / N |
| -Hallucinations | Y / N | Y / N |
| -Trouble Controlling Violence | Y / N | Y / N |
| -Behavior | Y / N | Y / N |
| -Thoughts of Suicide | Y / N | Y / N |
| -Attempted Suicide | Y / N | Y / N |

Been Prescribed Medications for Mental Health Reasons? Y / N
If so, please list: _____

_____

In the last 30 days have you experienced psychological issues? Y / N
How many days? _____

*On a scale from 1-10, with 1 being not a problem, how do you rate the following?
How troubled have you been in the past 30 days by psychological issues?
_____
How important now is treatment for these psychological problems?
_____

**Personal Scales**
On a scale from 1-10, 1 being poor and 10 being high, how would you rate the following?

Your self-esteem? _____
Your support system? _____
Your family stability? _____
Employment Skills? _____
Academic Stability? _____
Motivation to change? _____
Self-Care? _____
Self-Control? _____

Have you recently lost somebody close to you? Y / N

Please list any other information you would like us to know?

_____

# RNC Supportive Housing Rules

As a functional and balanced household, it is important that you treat each other with respect and care regardless of personality or belief. Making this house a HOME will depend on cooperation from everyone. We are not here to govern or rule, we are here to support you in your personal growth and recovery. By applying to Rural Nevada Counseling's supportive housing program, you are agreeing to a minimum of a 6-month process of alcohol and drug treatment, life skills training, medical and mental health, educational and job skills development and various other interventions before we begin the process of assisting you in finding full-time sustainable employment and long-term housing. All services are provided at one of our offices and we will assist you with transportation to and from your appointments. However, in order to maintain our environment for everyone, some ground rules are listed here. Some of these are State Health and Fire Code Requirements and others are to maintain an environment focused on recovery living. The following supportive housing agreement has been set forth to assure safety for you and your roommates.

1. Alcohol, gambling or the use of any mind or mood altering chemicals (legal or not) is forbidden at any time during residency, on or off the premises.
2. Violence, including verbal abuse will not be tolerated and you may be asked to leave the house should this occur.
3. Weekly and daily chores list will be assigned by House Dad/Mom. Chores will be done on a daily basis.
4. Sign-out sheets will be signed each time you leave and return to the house. We need to know where you are and when you are plan on returning at all times.
5. When it is determined by your Case Manager/Counselor you are ready to seek employment, you will be up and ready for job searching by 8am Monday through Friday.
6. Wake up time is 6am for those who are not involved in job searching Monday through Friday.
7. Beds must be made, Rooms neat and orderly, and clothes put away by 7am Monday through Friday.
8. It is unacceptable to quit your job without advising your Case Manager/Counselor first who can assist you with various issues that may surround this choice.
9. Dinner is a community meal and requires all house members (who are not employed or who do not have work schedules which could prevent them) to eat together as house mates. Dinner is prepared by all house members depending on your assigned day of the week.
10. Attendance at all groups and individual counseling sessions is mandatory to maintain residency in our supportive housing unit. Additionally, your Case Manager/Counselor may require your attendance at other meetings including; self-help support, educational, and other sessions depending on your individualized treatment plan. If required, your attendance becomes mandatory and failure to follow through may result in termination from RNC Supportive Housing Program.
11. Helping to give back in the community through weekly Community Service is a requirement for all house mates who are not engaged in full-time employment.
12. Fees will be incurred based on the following general schedule:
    a) Counseling fees may be charged beginning on the day you arrive
    b) Room/Board fees may be charged on the day you arrive
    c) Speak with your Case Manager/Counselor regarding your fees, as it is not our goal to set you up to fail based on fees. Generally speaking, we start charging fees only after you have

acquired employment and we will never 'discharge' you for not paying your fees as a single issue.

13. Visitors/Passes are allowed only when house dad/mom is present and upon prior approval from your treatment team and not to be scheduled during appointment/treatment times.
14. Curfew times are 5pm Monday through Sunday unless engaged in verifiable employment or prior approval by your treatment team.
15. House phone is provided for your convenience. No cell phones unless approved by your treatment team.
16. Smoking is allowed only in approved area and no less than 500 ft from the house. This is a privilege not a right and can be taken away at any time it is abused.
17. There is no dating or sexual intimacy between clients of the agency regardless of which program location they attend/reside. Pornography is forbidden.
18. TV hours are determined by treatment team and house dad. Mon-Fri – no later than 10pm on non-holidays.
19. All residents are subject to random drug screens.
20. Food Stamps are overseen by your house dad/mom and are released to you when you leave your stay.
21. Food supplies are managed by your house dad/mom and are prepared in accordance with the posted 4-week menu.

This is now your home temporarily and we make every attempt to make it comfortable and for your time here to be positive. It is our goal to help you find the path to a healthy and fulfilling lifestyle.

By signing below, I acknowledge that I have been oriented to my house's general rules and I agree to abide by the above guidelines. In so doing, I am making a commitment to recovery and a new life.

_____ _____

Client Signature Date Signed

# Visitor's Rules

All visitors must agree to adhere to the following rules:

1. All visitors must read and sign the confidentiality form when visiting. No visitor may disclose any information regarding a client's attendance or any other information that will identify a client as a house member in one of Rural Nevada Counseling's supportive housing units.
2. A staff member must be present whenever guests are in the house. Clients must arrange for visits in advance.
3. All visits must take place in the common areas. There are the living, dining and kitchen areas. No visitors are allowed in the bedrooms at any time.
4. Visitors should dress appropriately. Please avoid provocative clothing or any logos that would promote the use of alcohol, drugs, or a lifestyle incongruent with the agency's mission.
5. Please avoid excessive 'public display of affection.'
6. This is a non-smoking facility. Please do not smoke on the property.
7. Anyone entering onto a Rural Nevada Counseling property in possession of, or under the influence of an intoxicating substance will be asked to leave immediately.
8. Children must be supervised at all times.
9. Please respect all Rural Nevada Counseling properties. If you need something, please ask a staff member.
10. Rural Nevada Counseling staff reserves the right to ask guests to leave at any time for any behavior they deem inappropriate.

_____ _____

Guest Signature Date Signed

# Request for RNC Supportive Housing

I,_____, hereby request residency at one of Rural Nevada Counseling Supportive Housing Units for as long as clinically beneficial to me as deemed necessary by my treatment team. I have read the rules and procedures pertaining to supportive housing requirements, and give my word to abide by them and to participate fully in my recovery process and my individualized service plan. I agree to work with my Counselor to develop a personal plan for my growth and to continue to review and develop that plan on a regular basis as I meet the goals I set for myself. I realize that failure to work within the guidelines set forth by RNC's Supportive Housing Unit(s) could result in my dismissal from the house, which will be reported to any entity requiring said notifications. I also understand that if I reported to Rural Nevada Counseling admission staff any information that was falsified in order to gain admission, and said admission was dependent on that self-report, that I may be transferred to a more appropriate level of care or discharged. I understand that if I require a more intensive level of care such as residential treatment due to increase of symptoms, I will work with RNC staff in whatever way is required of me.

_____ _____

Client Signature Date Signed

# Rural Nevada Counseling

720 South Main Street, Suite C
Yerington, NV 89447
1-866-831-2774
Phone: 775-463-6597
Fax: 775-463-6598

Dayton
775-246-6214
Fernley
775-575-6191
Silver Springs
775-577-4633
Virginia City
775-847-9311


## CONSENT TO TREATMENT

**As a client of the Rural Nevada Counseling I understand that:**

1. I am entitled to treatment and rehabilitation care to include referral to appropriate medical, psychological and training services as part of my treatment plan.
2. I have the right to refuse any or all parts of the treatment plan, with the exception of emergency medical treatment.
3. Consent to any or all parts of the treatment plan may be withdrawn at any time.
4. I will be informed of the nature, consequences and purposes of the treatment plan, and any alternative plans and resources available.
5. Participation in an AA or NA is encouraged. I will respect member's right to confidentiality, and authorize AA or NA involvement in my treatment.

**Treatment conditions and program expectations:**

1. To achieve/ maintain abstinence from all mood altering chemicals
2. To learn about the disease concept of addiction
3. To improve self-esteem
4. To reduce defense mechanism
5. To accept responsibility and develop a plan for recovery
6. To achieve/ maintain economic self sufficiency

**I have been fully informed of the above, understand the process, and agree to accept such treatment and to cooperate in its implementation.**

_____ _____
Client signature Date

_____ _____
Witness Date

_____ _____
Signature of parent, guardian or authorized representative Date


Supported by: State of Nevada Mental Health & Developmental Service, Substance Abuse Prevention & Treatment Agency/ Lyon County/City of Fernley/City of Yerington/Healthy Communities Coalition of Lyon & Storey Counties/Yerington Youth Task Force
*OFFICES IN:* Yerington – Fernley – Silver Springs – Dayton – Virginia City

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## CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize

**Rural Nevada Counseling**
(Name or general designation of program making disclosure)

to disclose to: _____
(Name of person, treating provider, entity or organization to which disclosure is to be made)

the following information:
(Select the nature of the information that you want released to this party)

| | | |
|---|---|---|
| ___ Drug & Alcohol Assessment report<br>___ Comprehensive Evaluation<br>___ Diagnosis | ___ Progress Notes<br>___ Treatment Plans<br>___ Discharge Summary | ___ All of my substance use disorder records<br>___ General Summary Letter only |
| | ___ Other (Specify):_____ | |
| The purpose of the disclosure authorized herein is to: | | |
| | | |

(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Date: _____ _____
Client Signature

Date: _____ _____
Signature of parent, guardian or authorized representative if needed

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Supported by: BHPT - Behavioral Health Prevention & Treatment
Lyon County/City of Fernley/City of Yerington

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