	ADMISSIONS & INTAKE APPLICATION	1876 S Sheridan AVE Sheridan, WY 82801	1.866.438.2862 1.307.426.4740 admissions@VOANR.org

What you need to provide to apply:

- **Photo Verification** (Examples are drivers license, passport, student ID)
- **Income Verification** (Examples are most recent tax return or 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**

Today's Date: Patient's Social Security #: Responsible Party SS#:	Si Nececitas esta forma en Español por favor avisanos. What language do you SPEAK? ☐ English ☐ Spanish ☐ Other What language do you WRITE? ☐ English ☐ Spanish ☐ Other Did someone complete this form on your behalf? ☐ Yes ☐ No				I am applying for services at (SELECT ALL THAT APPLY) ☐ VOA-Laramie ☐ VOA-Cheyenne ☐ VOA-Torrington ☐ VOA-Wheatland ☐ Center of Hope ☐ Harmony House ☐ VOA -Recovery Homes ☐ The Life House ☐ The Gathering Place
Patient's Legal Last Name:	Legal First Name and M.I.:	Patient's Birth Date:		Gender: M F	Patient's Maiden Name:
Physical Address:	City:	State:	Zip Code:		County:
Mailing Address/P.O. Box:	City:	State:	Zip Code:		County:
Home Phone:	Initial if OK to leave message: _______ Message Phone:		Is Patient a U.S. citizen? ☐ Yes ☐ No		Marital Status (check one) ☐ Divorced ☐ Legally Separated ☐ Married ☐ Minor Child ☐ Never Married ☐ Widowed
Cell Phone:	Work Phone:	Email:			
Patient's Race (check one): ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ Other/Multi-Racial ☐ White	Patient's Ethnicity (check one): ☐ Cuban ☐ Mexican ☐ Non-Hispanic ☐ Puerto Rican ☐ Other Hispanic/Latino	Patient's Housing Information (check one): ☐ Foster Home ☐ Group Home ☐ Homeless ☐ HUD/CHA ☐ Jail ☐ Own ☐ Rent Free ☐ Rent ☐ Residential Treatment ☐ Hospital			Is the Patient a veteran? ☐ No ☐ Combat ☐ Non-Combat
Tribal Affiliation:					

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

Patient's Employment Status (check one):	Patient's Employer Name:	Patient's Employer Phone Number:
□ Child (U-16) □ Disabled □ Full Time □ Homemaker □ Inmate □ Part Time □ Self Employed/Other □ Retired □ Student(16+) □ Unemployed □ Volunteer	Patient's Employer Address:	Date Hired:

Recently lost employment? □ Yes □ No	Patient's Place of Birth (city, county, state): Patient's Mother's First Name:	Highest Grade Patient Completed: □ No Schooling □ Indicate grade completed between K & 11: ____ □ High School/GED □ 1 year of College □ 2 years of College/Assc. Degree □ 3 years of College □ Bachelor's □ Master's □ Doctoral

(**For Dependents Only**) Name of Parent/Legal Guardian:	(For Dependents Only) Relationship to Patient:	Parent/Guardian Phone (if different from Patient):

Have your parental rights been suspended or terminated?	□ Yes □ No	Who has temprary parental rights?	
Do you have legal custody of your children?	□ Yes □ No	Who has legal custody?	

Describe what brings you to Volunteers of America:

Do you consider this to be an emergency? □ Yes □ No (If YES, please advise a staff person immediately.)

Have you been seen by Peak Wellness Center or Volutneers of America before? □ Yes □ No

When? If YES, under what name?

Who referred you to Volunteers of America?

Please list other agencies or providers with which you (or your child) are involved:

Are you pregnant? □ Yes □ No □ N/A	Number of dependent children:

Name: ___________________________________ **Patient HEALTH HISTORY**

Please note that if you are applying for residential treatment you will also need a signed physical from a medical provider, a medication list and a negative TB test

Height: Weight:	Name of family physician:	Have you seen your family physician in the past year? □ Yes □ No	Do you require any accomodations or have any special needs? □ Yes □ No Explain:

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:

Have you been prescribed medications for physical or mental health concerns?

Diagnosis	Date of Diagnosis	Diagnosed by Whom?	Medication Prescribed	Date Medication last

Are you allergic to any medications? □ Yes □ No
If yes, Name of medication____Reaction: ____
If yes, Name of medication____Reaction: ____

Are you allergic to any foods? □ Yes □ No If yes, a Doctor's note will be required for admission into the residential programs
If yes, Name of food____Reaction: ____
If yes, Name of food____Reaction: ____

Do you have a history of Sucidal Thoughts? Last 30 days? □ Yes □ No Lifetime? □ Yes □ No Attempts:____________

If yes, did you have a plan?____

Do you have a history of Homicidal Thoughts? Last 30 days? □ Yes □ No Lifetime? □ Yes □ No Attempts:____________

If yes, did you have a plan?____

Do you hear voices or see things that other people do not see? □ Yes □ No

If yes, please describe: ____

Have you sought help for your mental health or substance use needs in the past?		
Facility Name, City, State	**Dates of Attendance**	**Nature of Discharge**

Do you have history using substances?				
Substance(s)	**How did you take the substance?**	**How often did you take the substance?**	**Date of Last Use**	**Drug of Choice?**
	□ Oral □ Smoke □ IV □ Other:_________			
	□ Oral □ Smoke □ IV □ Other:_________			
	□ Oral □ Smoke □ IV □ Other:_________			
	□ Oral □ Smoke □ IV □ Other:_________			

Do legal problems bring you to Volunteeers of America? □ Yes □ No

If yes, please answer the questions below

Do you have an Attorney? □ Yes □ No

Name, Phone Number and Location:____

Are you currently in Drug Court? □ Yes □ No Location:____

Are you currently in Jail? □ Yes □ No Location:____

If yes, when were you incarcerated and how long will you be there?________________________________

Will you be requried to return to jail upon completion of treatment? □ Yes □ No

Are you on probation or parole? □ Yes □ No If yes, pleace check : □ Supervised □ Unsupervised □ ISP

Where are you on probation and who is your agent? ____

Are you court ordered to treatment? □ Yes □ No Which Court:____

Are you ordered to have an evaluation? □ Yes □ No If yes, pleace check : □ Mental Health □ Substsance Use □ Both

Are you awaiting sentencing? □ Yes □ No If yes, for what charges? :____

Will you be on furlough to attend treatment? □ Yes □ No If yes, what jail? :____

Do you have any outstanding warrantes that you are aware of? □ Yes □ No

If yes, out of what county and for what? ____

Please complete the following two questionnaires:

RAPS4 Rapid Alcohol Problems Screen	**Yes**	**No**
1. Have you had a feeling of guilt or remorse after drinking or using drugs?		
2. Has a friend or family member ever told you about things you said or did while you were drinking or using drugs that you could not remember?		
3. Have you failed to do what was normally expected of you because of drinking or drug use?		
4. Do you sometimes take a drink or use drugs when you first get up in the morning?		

PHQ-2 During the past 2 weeks, have you been bothered by:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, or hopeless?				

Fee Discount Application

Name: ______________________________________

Please provide copy of most recent tax return or current pay stubs, unemployment benefit letter or denial letter, worker's compensation statement:

Insurance Coverage (please provide front and back of card):	**Office Use Only**
☐ None ☐ Medicare	Household Income: _____________________based on:
☐ My Private Insurance ☐ Medicaid	☐ Tax Return ☐ Pay Stubs ☐ Other: _______________
☐ Other's Private Insurace ☐ Kid Care CHIP	Number in household: __________________
☐ Other: _____________________	Fee Level (%): ______________________________

Household - Please list all household members claimed on your tax return other than the client		
Name:	Name:	Name:
Gender: M F Birthday:	Gender: M F Birthday:	Gender: M F Birthday:
☐ Spouse ☐ Parent	☐ Spouse ☐ Parent	☐ Spouse ☐ Parent
☐ Child ☐ Step-Parent	☐ Child ☐ Step-Parent	☐ Child ☐ Step-Parent
☐ Step-Child ☐ Other:	☐ Step-Child ☐ Other:	☐ Step-Child ☐ Other:
☐ Sibling	☐ Sibling	☐ Sibling

Name:	Name:	Name:
Gender: M F Birthday:	Gender: M F Birthday:	Gender: M F Birthday:
☐ Spouse ☐ Parent	☐ Spouse ☐ Parent	☐ Spouse ☐ Parent
☐ Child ☐ Step-Parent	☐ Child ☐ Step-Parent	☐ Child ☐ Step-Parent
☐ Step-Child ☐ Other:	☐ Step-Child ☐ Other:	☐ Step-Child ☐ Other:
☐ Sibling	☐ Sibling	☐ Sibling