

Treatment Application Information**Date:** _____

Application may be submitted in person on any Tuesday or Thursday at 9:00 a.m. at 1201 River Road, North Little Rock or may be faxed to (501) 372-1801 or e-mailed to rhalter@rcofa.org.

Name: (Last) _____ (First) _____ (Middle) _____

DOB _____ SS# _____ Male _____ Female _____ Age _____

Telephone: _____ Message Phone: _____ E-mail Address: _____

Client Self Evaluation

Why do you want treatment _____

Requested Treatment Modality: (Circle One) Residential Outpatient

If you are requesting residential treatment and have minor children, who will care for them while you are in treatment? _____

Referral Source

Who referred you to RCA? _____ e-mail address _____

Address and Phone # _____

Substance Use History For The Past Year

Substance Used	Frequency of use in past 30 Un-institutionalized days	Check if IDU
1.		
2.		
3.		
4.		

Do you have a history of withdrawal symptoms (hallucinations, seizures or DT's) ___yes ___no

Are you in a safe environment? ___yes ___no If no, why not? _____

Are alcohol/drugs available to you? ___yes ___no Explain _____

Previous treatment? ___yes ___no RCA self-pay balance _____

Household InformationHome Address: _____
(Street or PO Box) (City) (State) (Zip Code)

List individuals in household

Name	Relationship	Income	Source of Income
A self			
B			
C			
D			
E			

Consider: wages, social security income, child support, food stamps, housing assistance, trust funds

Total household annual income _____

Medicaid ___yes ___no Insurance Company & Policy # _____

If unemployed, how do you support yourself? _____

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Legal History (include child custody issues)

Court referred (copy of order required by RCA) <input type="checkbox"/> yes <input type="checkbox"/> no Δ Act 861 Δ 911 Court/Judge _____
Current charges _____
Upcoming court dates/location _____

Mental Health History / Level of Care

Have you ever received mental health treatment? <input type="checkbox"/> yes <input type="checkbox"/> no
Are you currently being seen at a mental health center? <input type="checkbox"/> yes <input type="checkbox"/> no (if yes, copy of mental health treatment plan required)
If yes, where _____
Have you ever been hospitalized for mental health problems? <input type="checkbox"/> yes <input type="checkbox"/> no
If currently in hospital anticipated discharge date _____
Diagnosis (if known) _____ or symptoms _____

Medical History / Abilities

Are you currently being treated for medical problems? Do you expect to need medical treatment in the next 30 days? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, what for? _____
Are you taking any medicine? <input type="checkbox"/> yes <input type="checkbox"/> no Do you have a 30 day supply of these medications? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, what and what for? _____
Do you have any accommodation or dietary needs? If so, what _____
If disabled, reason for disability: _____
Currently Pregnant <input type="checkbox"/> yes <input type="checkbox"/> no # of months: _____ Are you receiving pre-natal care: <input type="checkbox"/> yes <input type="checkbox"/> no

Emotional Risk History

Previous suicide attempts? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, when _____ Current suicidal thoughts? <input type="checkbox"/> yes <input type="checkbox"/> no
In the past six months have you assaulted anyone? <input type="checkbox"/> yes <input type="checkbox"/> no Previous homicide attempts? <input type="checkbox"/> yes <input type="checkbox"/> no
Explain: _____

Application Disposition (To Be Completed by Staff)

Tour of facility <input type="checkbox"/> yes <input type="checkbox"/> no	Person completing application _____
Patient Placement recommendations: <input type="checkbox"/> Residential <input type="checkbox"/> Outpatient	
Reimbursement	
<input type="checkbox"/> Self @ _____	<input type="checkbox"/> ADAP/Self @ _____
<input type="checkbox"/> Insurance/Self @ _____	<input type="checkbox"/> Fed or BOP _____
<input type="checkbox"/> Fed/Self @ _____	<input type="checkbox"/> Other, specify _____
<input type="checkbox"/> Approved: Intake Date _____ Time _____ Location _____ Case Manager _____	
<input type="checkbox"/> Denied, reason (provide client copy of screening if denied) _____	
<input type="checkbox"/> Application withdrawn	
<input type="checkbox"/> Applicant unwilling to comply with treatment expectations	
<input type="checkbox"/> Waiting list _____	Date Completed _____
Date _____	