VOLUNTARY APPLICATION FOR ADMISSION

NAME: ____________________________________________________________

DATE: ____________________________________________________________

PHONE: __________________________________________________________

E-MAIL: __________________________________________________________

FAX: _____________________________________________________________
Program Overview

Recovery Ventures Corporation is a drug and alcohol rehabilitation center in Western North Carolina that offers long-term residential substance abuse treatment and aftercare programs in a Therapeutic Community setting. Our nonprofit organization offers a low cost option for treatment, with unique programs that give hope to individuals and families.

Program Highlights

1. Milieu Therapy:
   “The community is the agent of change” Recovery Ventures is a peer-based program where associates learn to take responsibility for themselves and others within the community.

2. Self-Sustaining Operation:
   Recovery Ventures is fully self-supporting through all the work associates do – we accept no funding from any outside sources. The associates are responsible for all functions of the treatment community.

3. Accountability:
   Teaches associates that their actions always affect others and have consequences.

4. Job Training:
   By working to support their own recovery, all associates receive extensive job training from several of the employers in the surrounding community.

5. Life Skills:
   A strong emphasis is placed on developing the basic skills needed to live an independent and healthy life in recovery after the program.

6. Orientation Program:
   All new associates attend a 5 day orientation program that helps with the transition into long-term residential treatment. The program focuses on some basic psycho-education groups on addiction and recovery, as well as the structure, rules and expectations of the program.

7. Individual and Group Counseling:
   Therapeutic groups are held 5 days a week that all associates attend. Individual counseling is available from any of our certified clinical staff upon request.

8. Family Education:
   A 2 day program is offered to the family members of any associate. The program consists of substance abuse education followed by a multi-family process group.

9. Aftercare Services:
   A continuum of care is provided to all graduates of the program, including supportive housing, group and individual counseling.

10. Horticulture Therapy:
    Under the supervision of a certified horticultural therapist, associates have the opportunity to receive hands-on experience in the hydroponic greenhouse and hothouse.
Application Procedures and Admission Process

The “PRIMARY QUALIFICATION” for acceptance is the sincere desire to remain in recovery and to make a lifelong commitment to help others recover.

Exclusionary Criteria:

1. Applicants whose criminal history includes convictions for arson or sexual misconduct.
2. Applicants with long histories of violence.
3. Applicants who have exhibited exaggerated psychotic symptoms or suicidal/homicidal ideations within the past 90 days.

TO APPLY:

- Complete all application paperwork
- Submit an autobiography
  - Minimum 3-6 pages
  - Give details of your life from as far back as you can remember, up to and including your personal decision to complete our application
- Obtain a criminal background check from any state that you resided in as an adult (if you need assistance discuss this with our admissions coordinator)
- Complete a telephone interview with an admissions coordinator. Admissions office hours are Monday – Friday: 8 AM – 5 PM

UPON ACCEPTANCE:

- Transportation arrangements need to be discussed with admissions coordinator.
- An entry date will be scheduled by the admissions coordinator. Failure to report on your scheduled entry date can result in loss of bed space. Do not show up without a scheduled entry date.
- **Entry fee of $300** must be paid at time of arrival and is NON-REFUNDABLE. Recovery Ventures only accepts payment in the form of cash, cashier’s check or money order.
- Associates that have previously left or been terminated from Recovery Ventures are required to pay a **$400 RE-ENTRY** fee.
- DO NOT bring anything that is not on the approved clothing inventory list. Items brought that are not on this list will be taken and disposed of accordingly.

On a scale of 1 to 10, how serious a problem do you think you have with drugs or alcohol?
(No Problem) 1 2 3 4 5 6 7 8 9 10 (Very Serious Problem)

On a scale of 1 to 10, how motivated are you to make changes in your life at this time?
(Not at all) 1 2 3 4 5 6 7 8 9 10 (Very motivated)
Voluntary Application for Admission

Date: ___________________________________

Name: ____________________________
Last: ___________________ First: _____________________ Middle: ________ Sex: _______ Race: _____________

SSN: ____________________ DL#: __________________ State: _______ License Status: _________ DOB: _______________

Permanent Address:__________________________________________________________________ _______________________

City: _____________________________State: _______________________ County:__________________ Zip: ____________

Height: __________’ __________’ ” Weight: _____________ lbs Hair Color: ___________ Eye Color: ____________

Distinguishing Marks: (Tattoos, Scars, etc.)_______________________________________________________________________


If married, Spouse’s Name ____________________________________________________________________________________

Do you have any children? ___________ How Many?_________

<table>
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<tr>
<th>Child’s Name</th>
<th>Who is the Child Staying With</th>
<th>Child’s Age</th>
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In case of Emergency, Notify: __________________________________ Phone #: ______________________________

Relationship to Applicant: __________________________ Emergency Contact E-mail: __________________________

Parent’s Name: ____________________________________________________________________________________

Address: ________________________________________________________________________________________

City: ________________________________________ State: _____________________ Zip: _____________________

Have you ever resided in any state other than North Carolina? Y__ N___.
If Yes, where? ___________________________________________

First time applying to RVC? Y__ N__ Have you previously been a resident in RVC? Y__ N__ Did you complete? Y__ N__
Circumstances around discharge: ___________________________________________
Voluntary Application for Admission

Criminal Justice Information

Applications may be submitted and a determination to accept or reject the applicant will be made prior to the scheduled court date. Failure to disclose pending legal action(s) may be grounds for immediate dismissal from the program.

Do you have any outstanding warrants? _____ If Yes, please describe: ____________________________________________

Do you have any outstanding charges? _____ If Yes, please describe: ____________________________________________

When is your court date? ______________________ State and county: ____________________________

Are your represented by an attorney? ____________

Attorney’s Name: ______________________________________ Phone #:_________________________

Address: _____________________________________ City: ____________________ State: _______ Zip: ________

*Must provide legal documents pertaining to any and all court cases/judgments/release orders.

Are you on supervised probation? ____________ If Yes, what are the charges? ____________________________

If yes, in what county and state? ____________________________

Probation Information: Officer’s Name: _______________________________________________________________________

Address: __________________________________________________________________________________________

City/State/Zip: ______________________________________________________________________________________

Phone #: __________________________________________________________________________________________

Last Seen/Spoken With: ______________________________________________________________________________

Is your probation officer aware that you are seeking long term treatment? ________________________________

County: ____________________________ Case worker Name: ________________________________

Financial Information

Are you obligated to pay child support? ________________ Are payments current? _________________________

County: ____________________________ Case worker name: ________________________________

Are you obligated to pay probation restitution? ____________ If yes, explain: ______________________________

Do you receive any ongoing financial reimbursement for any reason (disability, trust fund, etc.)? ____________

If yes explain? ______________________________________________________________________________________
Voluntary Application for Admission

Medical History Information

Do you have any medical conditions that will limit your activities? __________________________________________________________

If yes, explain: ________________________________________________________________________________________________

Are you taking any prescription medication(s)? _________

If yes, list all and how long have you been taking this medication(s)? ____________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

Have you ever experienced or been diagnosed as having any of the following:

_____ Seizures  _____ TB  _____ Diabetes  _____ Hepatitis

_____ Heart Disease  _____ Epilepsy  _____ Cirrhosis  _____ High BP

Are you currently under the care of a physician? _____________

Doctor’s Name: __________________________ Phone #: ____________________________

Reason(s) for current treatment: ____________________________
______________________________________________________________________________________________________________
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List any past mental health hospitalizations:

<table>
<thead>
<tr>
<th>Hospital name</th>
<th>Date(s)</th>
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Any diagnosis of schizophrenia or other psychotic disorders? ______ If yes explain: _______________________________________

Any history of suicide attempts, suicidal ideations, or other self-harm? ______ If yes explain: __________________________

Are you currently experiencing any of the above? _____ If so, do you have a plan? ____________________________

If so, please explain________________________________________

Are you having homicidal thoughts? _____ If so, Please explain _____________________________________________

Are you a veteran? ______ Do you qualify for medical benefits? _________________

Do you have health insurance? ____________________________

Do you have or maintain a primary residence at this time? ____ Yes ____ No

If No, where have you been staying/sleeping? _____ Relative _____ Friends _____ Shelter _____ On Street

How long have you been in this situation? _____ Years _____ Months _____ Days
Voluntary
Application for Admission

Educational Information

Did you graduate from high school? ______ Year: ______
If not, highest grade completed? ______
Did you earn a GED? ______ Year: ______
Have you had any college or vocational school training? Y ____ N _____
Name of College/School: ________________________________________________
Location: _____________________________________________________________
Degree/Certificate Received: ___________________________ Year: _________________

Employment Information

Are you currently employed? Y__ N__ If yes, where. ________________________________
How Long? ______ Do you enjoy this type of work? _________________________________
What type of work would you like to do? _________________________________________
How long has it been since you last worked? Where? ________________________________

Substance Use History

Drug(s) of Addiction: _________________________________________________________

<table>
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<tr>
<th>Drug</th>
<th>Age at first use</th>
<th>Amount used at peak</th>
<th>Current use</th>
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Have you ever experienced treatment for substance use? Y __ N __. If yes, please describe. (Name, dates, type of treatment, did you complete?, etc.) ____________________________________________________________
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RELEASE OF INFORMATION
AUTHORIZATION

Client Name: ________________________________________________________________

Date of Birth: ___________________ Social Security Number: ______________________________

I, _______________________________________, hereby authorize ______________________________________________________
(Client’s Name)                                               (Facility, Physician, and address of person releasing information)

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I hereby request and authorize the above named agency, organization or individual who possesses information relative to the client
named above to release information, as specified, to the agency, organization or individual named on the request. I understand that
the information to release may include information regarding drug abuse, alcohol abuse, sickle cell anemia, or psychological or
psychiatric information.

I certify this authorization is made freely, voluntarily and without coercion. I understand that the information to be released is
protected under state and federal laws and cannot be re-disclosed without my further written consent unless otherwise provided for by
state and federal law. This consent shall be valid for a period not to exceed one year. I further acknowledge that I may revoke this
consent, in writing, at ANY time except to the extent that action based on this consent has been taken.

Client: ______________________________ Legal Representative: ______________________________

Date: ______________________________ Witness: ______________________________

Person Releasing Information: ______________________________ Date: ______________________________
CLOTHING INVENTORY

The following list must be strictly adhered to. **Any items over the amount specified will be disposed of accordingly and will not be returned at a later time!** The personal items should be kept at or below the following:

### Men
- 10 pants (1 or 2 pair of slacks, black/khaki)
- 10 shirts (1 or 2 dress shirts, black/white)
- 10 t-shirts 5 undershirts
- 5 shorts
- 1 suit
- 3 pair of pajamas
- 1 pair of slippers
- 1 pair of flip-flops
- Necessary toiletries/hygiene items (NO alcohol/aerosol)
- 10 pair of underwear, 10 pair of socks
- 1 winter coat
- 1 jacket
- 1 Bible, 1 AA/NA Book, 1 Journal
- 4 pictures (no significant others/spouses, immediate family only)
- 3 pair of shoes TOTAL, 1 dress/work shoes (black non-slip), 1 work boots, 1 sneakers
- 2 hats
- 1 Wallet with Social Security Card, Picture ID-ONLY
- 1 alarm clock
- 1 sunglasses
- 3 cartons of tobacco products
- 1 pillow with pillowcase
- 1 twin sheet set
- 2 towels, 2 washcloths
- 1 twin comforter

### Women
- 10 pants (1 or 2 pair of slacks, black khaki)
- 10 shirts (1 or 2 dress shirts, black/white)
- 10 t-shirts (NO white), 5 undershirts/camisoles
- 5 shorts (at least knee length)
- 3 pair of pajamas, robe
- 1 pair of slippers
- 1 pair of flip-flops
- Necessary toiletries/hygiene items (NO alcohol/aerosol)
- 10 pair of underwear (NO thongs), 10 pair of socks, 5 bras
- 1 winter coat
- 1 jacket
- 1 Bible, 1 AA/NA Book, 1 Journal
- 4 pictures (no significant others/spouses, immediate family only)
- 3 pair of shoes TOTAL, 2 pair sneakers, 1 pair work shoes (black non-slip)
- 2 hats (winter)
- 1 Wallet with Social Security Card, Picture ID-ONLY
- 1 alarm clock
- 1 sunglasses
- 3 cartons of tobacco products
- 1 pillow with pillowcase
- 1 twin sheet set
- 2 towels, 2 washcloths
- 1 twin comforter

**NOTE:** Do not bring jewelry, watch, perfume, cologne, body spray, scented lotion, make-up, cell phone, music devices, hair clippers/electric shavers, stuffed animals, letters, books, magazines, money, credit cards, address books, or anything not listed above.

If you do not have all of the above items, we will do our best over the following weeks to assure that you receive the clothing items you require.

You **WILL NOT** be allowed to request any items to be sent from home until your first family visit, which is when you make Leadership phase (approximately 6 months). *Birthday and Christmas gifts will be dealt with on an individual basis.*

Recovery Ventures Corporation will not be responsible for any personal items left behind if you leave against clinical advice. You will be given one business day to make arrangements to pick up your belongings, after that they will be disposed of or delivered to a local charity as a donation. You are encouraged during your stay to not bring anything of sentimental value!!

I understand that if I bring items other than those specifically listed above, the items will be disposed of at the time of my entry into the program and this may result in accountability. The list above is all-inclusive; there are no exceptions.

---

**Print Name**  
**(Signature)**  
**Date**
Responsible Party Payment Contract

I fully understand that Recovery Ventures Corporation is not a medical facility and is not responsible for any medical bills or the cost of medication for associates in residence at Recovery Ventures.

I, ______________________(i.e. parent, guardian, payer, etc.), accept full responsibility for any and all medical bills and cost of medications for ______________________ (program associate) while they are a participant in the Recovery Ventures program. I am aware that the cost of the medication, although predetermined, may be subject to change during the course of the program.

I am also aware that the cost for three (3) months of medication is to be paid at the time of intake, in addition to the entry fee. Once this money runs out, payment will then be due before additional refills can be obtained. I understand that it is not Recovery Ventures responsibility to bill me or remind me of payment. I also understand that any breach of this contract will result in evaluation of the associates stay at Recovery Ventures.

By signing this I acknowledge that I understand all conditions and agree to abide by them. I take full responsibility of all payments and conditions. I also understand that in the case that the associate leaves the program or gets terminated from the program all funds remaining will be returned to the responsible party, not the associate. Please contact our office to make these arrangements.

I give Recovery Ventures permission to send any bills pertaining to the noted associate to me for payment. I also give them permission to contact me concerning any medical issues that might arise during this associates stay at Recovery Ventures.

Contact Information:

Responsible party print name_____________________________________________

Mailing Address: ________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

Email Address: __________________________________________________________

Home Phone: ___________________________________________________________

Responsible party signature ______________________________   Date: ___________