VOLUNTARY

APPLICATION

FOR

ADMISSION

NAME: _____

DATE: _____

PHONE:_____

E-MAIL: _____

FAX: _____

Recovery Ventures Corporation

Post Office Box 549
Black Mountain, NC 28711
Phone: (828) 686-0354
Fax: (828) 686-0359

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.

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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 **personal check, 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 al all) 1 2 3 4 5 6 7 8 9 10 (Very motivated)

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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.)_____

Marital Status: Married: _____ Divorced: _____ Single: _____ Separated: _____

If married, Spouse's Name _____

Do you have any children? _____ How Many?_____

Child's Name	**Who is the Child Staying With**	**Child's Age**

In case of Emergency, Notify: _____ Phone #: _____

Relationship to Applicant: _____Emergency Contact E-mail: _____

Parent's Name: _____ Phone #: _____

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: _____
_____

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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? _____
_____

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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: _____
_____

List any past mental health hospitalizations:
Hospital name Date(s) Reason
_____
_____
_____
_____

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

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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: _____

Drug	Age at first use	Amount used at peak	Current use	Date of last use

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)

_____

to release/exchange specified information in my client record to: _____
(Recipient Name and Address)

_____

This data shall include (Nature & Extent of Information)
Specify Time Period: _____

___Summary of Evaluation & Treatment
___ Admission Assessment/Screening
___ Alcohol or Drug History & Treatment
___ Progress Notes
___ Discharge Summary
___ Psychiatric Evaluation & History
___ Human Immunodeficiency (Virus) (History & Treatment)
___ Acquired Immunodeficiency Syndrome (Aids History & Treatment)
___ Treatment Plan & Diagnosis
___ Medication History
___ Psychological Evaluation
___ Financial Information
___ Educational Information
___ Attendance
___ Other: _____

I understand this information will be used for:

___ Evaluation & Treatment Planning
___ Case Management Services
___ Other:_____
___ Referral
___ Continuity of Care

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:_____

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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

All clothing should be Very LOOSE fitting

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** _____

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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: _____