Family Support & Rehabilitation Services

WVFSRS ENROLLMENT REFERRAL FORM / APPLICATION

CLIENT DEMOGRAPHICS	
CLIENT NAME:	**DATE:**
DOB:	**Social Security #:**
Mailing Address:	
Physical Address *(if different from mailing address)*:	
County of Residence:	

Type of Residence:

☐ PRIVATE RESIDENCE
☐ INSTITUTION – *(select type below)*:
☐ SOBER LIVING
☐ GROUP HOME OR SHELTER
☐ DRUG/ALCOHOL REHABILITATION
☐ JAIL/PRISON
☐ PRTF
☐ HOMELESS
☐ HOSPITAL
☐ RESIDENTIAL TREATMENT FACILITY - Please indicate level: _____
☐ OTHER *(specify)*: _____

If not a private residence, please indicate the name of the company/facility:

Primary Phone #: Phone Type: ☐ Home ☐ Cell ☐ Fax ☐ Other: **Client E-Mail Address** *(if applicable):*	**Secondary Phone #** *(if applicable):* Phone Type: ☐ Home ☐ Cell ☐ Fax ☐ Other:

Does the client provide permission to leave a voicemail on identified #s? ☐ YES ☐ NO

Marital Status:
☐ SINGLE
☐ MARRIED
☐ DIVORCED
☐ SEPARATED
☐ WIDOWED
☐ DOMESTIC PARTNER

Religious Preference:
☐ CHRISTIAN – PROTESTANT
☐ CHRISTIAN – CATHOLIC
☐ JEWISH
☐ MUSLIM
☐ AGNOSTIC
☐ ATHEIST
☐ BUDDHIST
☐ HINDU
☐ GNOSTIC
☐ OTHER:
☐ PREFER NOT TO ANSWER

GENDER:
☐ MALE
☐ FEMALE
☐ TRANSGENDER IDENTIFIES AS A MALE
☐ TRANSGENDER IDENTIFIES AS A FEMALE
☐ TRANSGENDER UNKNOWN
☐ NON-BINARY
☐ OTHER:
☐ PREFER NOT TO ANSWER

ETHNICITY:
☐ PUERTO RICAN
☐ MEXICAN
☐ CUBAN
☐ OTHER SPECIFIC HISPANIC
☐ NOT OF HISPANIC ORIGIN
☐ HISPANIC-SPECIFIC ORIGIN UNKNOWN
☐ UNKNOWN
☐ OTHER:
☐ PREFER NOT TO ANSWER

RACE:
☐ ALASKA NATIVE
☐ AMERICAN INDIAN
☐ BLACK OR AFRICAN AMERICAN
☐ WHITE/CAUCASIAN
☐ ASIAN
☐ OTHER SINGLE RACE
☐ TWO OR MORE RACES
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ OTHER:
☐ PREFER NOT TO ANSWER

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# Of Minor Children: **# Of Other Dependents:**	**Are there currently any custody issues:** ☐ No ☐ Yes: Please explain:

VULNERABLE POPULATION INFORMATION

Pregnant woman who injects drugs	☐ Pregnant woman who uses substances	☐ Victim of Physical Abuse
☐ Person who injects drugs	☐ Intellectual/Developmental Disability	☐ Victim of Emotional Abuse
☐ Overdose Survivor	☐ Veteran	☐ Victim of Sexual Abuse
☐ Adolescent	☐ Victim of Domestic Violence	☐ Victim of Neglect

VETERAN STATUS

Veteran: ☐Yes ☐No

Branch: Rank:

Years Active Duty: Discharge Status/Reason:

INSURANCE INFORMATION

MEMBER NAME *(As it appears on card):*	**MEMBER ID #:**
INSURANCE COMPANY (Name):	**Customer Service #** *(located on back of card)*:

REFERRAL SOURCE INFORMATION

SERVICES REQUESTED *(i.e. sober living, residential treatment*):

REFERRAL REASON – PRESENTING PROBLEMS (i.e. diagnoses, mental health, behavioral health, grief, anger, substance abuse, etc.)

CURRENTLY ON MEDICATION-ASSISTED TREATMENT (MAT)?
IF YES, WHAT KIND?
PRESCRIBER OF ALL MEDICATIONS:
WILL RESIDENT HAVE ENOUGH MEDICATION TO LAST AT LEAST 7 DAYS?
IF NOT, ARE THERE ANY REFILLS REMAINING? WHAT MEDICATIONS, DOSAGE, AND PHARMACY?

REFERRAL SOURCE:

☐ SELF	☐ COUNTY-MH/IDD PROGRAM	☐ COUNTY DRUG/ALCOHOL COURT
☐ WVDHHR	☐ CRIMINAL JUSTICE SYSTEM *(Probation/Parole)*	☐ COMMUNITY PROVIDER
☐ DRUG/ALCOHOL PROVIDER	☐ RESIDENTIAL FACILITY/MENTAL HEALTH INPATIENT	☐ HEALTHCARE PROVIDER
☐ EMPLOYER	☐ FAMILY/FRIENDS/SIGNIFICANT OTHER	☐ HOSPITAL
☐ OTHER: _____		

REFERRING AGENCY *(Name/Address):*

REFERRED BY *(Name)*:	TITLE:	PHONE #:	E-MAIL:

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Substance Use History:

Have you completed detox? Yes / No Where? _____

Substance Use History	Date Of Last Use	Frequency Of Use	Avg. Amount Used
Alcohol: Yes / No			
Crack/Cocaine: Yes / No			
Heroin: Yes / No			
Fentanyl: Yes / No			
Other Opiates: Yes / No			
Marijuana: Yes / No			
Methamphetamine: Yes / No			
Benzodiazepines: Yes / No			
Hallucinogens: Yes / No			
Synthetic: Yes / No			
Suboxone: Yes / No			
Subutex: Yes / No			

How long have you been addicted to drugs and/or alcohol? _____

Does addiction run in you family history? Yes / No Lineage of Substance Use: _____

Type of Substance Used:_____

Medical History:

Do you have a history of seizures? Yes / No If yes, are you on medication? Yes / No

Do you have severe withdrawal symptoms? Yes / No

Are you pregnant? Yes / No If yes, how far along? _____

Do you have a family doctor? Yes / No If yes, who is your doctor? _____
Location: _____

Do you have any developmental or physical disabilities? Yes / No

If yes, please list the type of disability and the cause: _____

_____

_____

Have you ever visited a Harm Reduction Program (syringe exchange)? Yes / No

Are you an IV drug user? Yes / No If yes, have you been tested for HIV/AIDS and Hep C? Yes / No

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Have you been diagnosed with HIV/AIDS? Yes / No Hep: Yes / No Type: A / B / C

Any chronic health conditions? _____

_____

_____

Current Medications	Treatment For?	Dosage	Frequency

Where did you get your medications filled at previously?

_____

Are there any medications you're prescribed but not taking at this time? Yes / No

If yes, please list them:

_____

_____

Allergies: YES / NO If yes, please list them:

_____

Mental Health History:

Are you currently experiencing a mental health crisis? (hearing voices, thinking of hurting yourself, etc.) Yes / No

Have you been diagnosed with any mental health/emotional issues? Yes / No

If yes, what was the diagnosis?

_____

Have you been diagnosed with an intellectual or developmental disability? Yes / No

If yes, what was the diagnosis?

_____

Have you been hospitalized for psychiatric reasons in the past? Yes / No

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If yes, when and where?

_____

Do you feel you need a mental health medication provider while in our program? Yes / No

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Criminal Background:

Have you ever been convicted of a felony? Yes / No If yes, describe the charges:

_____

_____

_____

Have you ever been convicted of a misdemeanor? Yes / No If yes, describe the charges:

_____

_____

_____

Have you ever been convicted of a violent crime? Yes / No

[ ] Arson [ ] Murder/Manslaughter [ ] Domestic Assault [ ] Assault with a deadly weapon

[ ] Robbery [ ] Kidnapping [ ] Endangerment [ ] Other: _____

Are you a registered sex offender? Yes / No

If yes, please briefly describe the offense:

_____

_____

_____

Are you on Parole? Yes / No Probation? Yes / No Day Report? Yes / No

Home Confinement? Yes / No GPS Monitoring? Yes / No

Parole/Probation Officer: _____ County: _____

When is your next appointment with parole/probation?

_____

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Other Information:

Are you a domestic violence victim? Yes / No Are you currently fleeing a violent situation? Yes / No

Do you have a protective order out against anyone? Yes / No If yes, who? _____

Do you have your High School Diploma? Yes / No GED? Yes / No

If no, are you interested in obtaining your GED? Yes / No

Do you have your Driver's License? Yes / No WV State ID? Yes / No Birth Certificate? Yes / No

Social Security Card? Yes / No

Veteran's Information:

Veteran Status: None / Army / Marine / Navy / Reserves: Type: _____

If you served, what year(s) did you serve? _____ Discharge: Honorable / Dishonorable

What year(s) were you enlisted? _____ What was your rank? _____

Were you in active duty? Yes / No Where were you stationed? _____

Were you sent to war? Yes / No If yes, where? _____

Were you injured during active duty? Yes / No

If yes, please briefly explain your injuries:

_____

_____

_____

Have you ever been assessed for PTSD (Post Traumatic Stress Disorder) or TBI (Traumatic Brain Injury)? Yes / No

If yes, please provide date of your assessment/diagnosis and the doctor who diagnosed you:

_____

_____

_____

What did you enjoy most about being in the military?

_____

_____

_____

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What did you least enjoy about being in the military?

_____

_____

_____

If you didn't serve, do you have any family that served? Yes / No

Relation: _____

What year(s) did they serve? _____ Discharge: Honorable / Dishonorable

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Individual Written Contract For Admission:

I, _____, agree that if any substance use occurs, I will immediately be discharged from the program and will not be eligible for re-admittance for a term of 30-days. I also agree to adhere to all rules and regulations put into effect by the WV FSRS RAS program.

_____ _____/_____/_____

Applicant Signature Date

_____ _____/_____/_____

WV FSRS Staff Signature Date