**Nile-Addiction Recovery Treatment**
**Application for Admission/Prior Authorization**

Nile-ART staff is unable to help you if we are not aware of your circumstances. Therefore we must proceed with the truth as faulty information yields faulty results. Therefore we need you to agree and sign the following;

I understand that if I have failed to answer these questions truthfully or withheld any information, this constitutes grounds for immediate dismissal from the program. I understand that being uncooperative, disruptive, demonstrating difficult attitudes or being argumentative are each, independently of another, grounds for dismissal from Nile-ART program. I also understand that dismissal can occur with one infraction of any written or spoken rule. I understand that multiple warnings are not a requirement for dismissal.

I understand that Nile-ART is a Christ centered program and teaches Christ alone and no other gods or spirituality.
**I agree to participate in Church attendance and other church related activities that occur weekly and are a requirement of Nile-ART program.**

I understand that I will receive no visitations, phone calls, or mail during my first 30 days. When I receive a phone call from anyone except a doctor, lawyer, or DCBS worker a message will be taken for me. I understand I must give permission before any family members are allowed to call and check on me.

The Nile Ministries DBA: Nile-ART provides care regardless of race, color, economic status, legal residence, sexual orientation or religious affiliation.

Date of Application: _____ Date of Potential/Desired Bed Date: _____

Name: _____ Name you go by: _____

Date of Birth: _____ Age: _____ Race: _____ Social Security Number: _____-____-_____

Driver's License Number/ID: _____ State: _____ Exp: _____

Which do you have? Driver's License ☐ Picture ID ☐ Neither ☐

Present Address (City, State & Zip):
_____

Whose address is this? _____ Do you intend to return to this location? Yes or No (Circle)

Is this a safe and sober environment? Yes or No

Telephone: Home _____Cell _____ Work _____

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

Significant Other contact information _____ Are they currently using? Yes No

Emergency Contact (Name/Relationship) _____

Emergency Contact Phone #: _____

Address (City, State, & Zip): _____

Who referred you to our program? _____ Telephone # (  ) _____

**INSURANCE**

Do you have insurance? Yes No Have you applied for Medicaid? Yes No

Who is your insurance carrier? _____ Are you on another policy: Yes No

Medicaid ID #_____ Policy ID #_____

Do you have: Insurance Card Yes No / Food Stamp Card Yes No / Social Security Card Yes No

**CHILDREN**

Do you have any children? Yes No If yes, how many? _____ Are you allowed visitation? Yes No

Who has custody of your children? _____Phone number? _____

Is there an open CPS case with any of your kids? Yes No Is treatment a requirement of a CPS case? Yes No

Names and ages of your minor children: _____

What arrangements will be made for your children while you are at Nile-ART? _____

**MEDICAL**

List medical conditions/physical limitations (including chronic conditions or illnesses):
_____

_____

_____ Diabetic _____ Thyroid issues _____ Cancer _____ Blood Pressure _____ STD's

_____ HIV+ _____ AIDS _____ Hepatitis A B or C Other: _____

Will any of these effect your participation in treatment? Yes No Do you smoke? Yes No
If yes, how will it effect your participation? _____

Are any special accommodations needed? _____
Have you had multiple partners or unprotected sex? Yes N o
Do you have persistent severe dental pain? Yes No Have you shared straws or needles? Yes No
Can you navigate stairs? Yes No Can you do chores? Yes No
Daily living activities? Yes No Keep up with/take your own prescriptions? Yes No
List any allergies (food, environment, medical)? _____
Are you on a special diet? Yes No If yes, was this diet prescribed by a doctor? Yes ____ No ____
Explain: _____

Who is your Doctor? _____ Location of Doctor? _____

Do you have a scheduled appointment? Yes No Date _____

Nile-ART only transports to doctors in the Versailles, Lexington, and Frankfort area.

Would you be willing, if necessary, to change your doctor to one of these locations? Yes No

Are you pregnant? Yes No Post-delivery plans? Parenting _____ Adoption _____ Undecided _____

Has a doctor confirmed your pregnancy? Yes No Approximate Due Date: _____

Have you been receiving pre-natal care? Yes No Pre-natal vitamins? Yes No

**If you become a client of Nile-ART, and you have begun treatment for any diagnosis, we will need a statement from your doctor explaining your needs and treatment required.**

**MENTAL HEALTH**

Have you ever been diagnosed with any of the following;

_____ Anxiety _____ Depression _____ ADHD _____ Bi-polar disorder/Manic-depression
_____ Schizophrenia _____ Eating Challenges _____ OCD _____ Borderline Personality Disorder
_____ PTSD _____ Hallucinations Other: _____

Have you been in therapy before (where & when)? Yes No
_____

Ever been hospitalized for mental health treatment? Yes No _____

Are you current on your medications? Yes No Do you take them as prescribed? Yes No

List any and all medications that you are currently taking:

| Medication | Dosage | Reason | How Long |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever tried to commit suicide? Yes No When: Date/s: _____

What were the circumstances? _____

What method did you use? _____

Were you hospitalized? Yes No _____ Any current suicidal thoughts/ideations? Yes No

If yes, how would you do it? _____ Do you intend to follow through? Yes No

Any current or past self-harm behaviors (cutting, etc): Yes No _____

Any significant trauma history: Physical Yes No / Emotional Yes No / Sexual Yes No

_____

_____

_____

_____

**EDUCATION & FINANCES: As a resident you would not be permitted to be employed during your stay.**

Highest grade completed _____ GED? Yes No Diploma? Yes No

Learning Disabilities? Yes No If yes, what are they? _____

Are you currently employed? Yes No Do you have income? _____

Employer Information_____

**DRUG HISTORY**

What are your drug/s of choice? (Includes alcohol) _____

Age you began using? _____ What day did you last use? _____

What was it/how much?

_____

_____

Currently Intoxicated: Yes No

Do you need to detox? Yes No If yes, from which substance? _____

Detox is required before admittance for certain drugs. What are your plans for detox?(if applicable):

_____

What drugs have you done in the past two weeks? How Much? How often?

_____

_____

Explain your drug history (including the reason you started using):

_____

_____

_____

History of overdose, blackouts, or seizures (when & were they drug related or diagnosed, if diagnosed are you medicated for them)? _____

Have you had any clean time in the past? Yes No How long? _____

Previous Treatment? Yes No (List name of facility and dates you were there)
Hospital Inpatient: _____
Residential: _____
IOP: _____
OP/Outpatient: _____

Was it successful? Yes No Why/Why not? _____

How have you supported your drug habit? _____

Performed illegal acts? Yes No Sexual acts? Yes No

Why are you seeking treatment this time?

_____

_____

What are your current stressors: _____

What is your highest priority at this time: _____

Do you have a Support system (family, friends, sponsor, church, etc): Yes No

Explain: _____

**LEGAL ISSUES**

Court Ordered to Treatment? Yes No Number of days? _____

Have you ever been arrested? Yes No How many times? _____

Dates/charges: _____

_____

Are you currently in jail? Yes No If yes, date of incarceration/expected discharge. _____

Are your charges drug related: Yes No Have you ever been charged with a violent or sexual crime? Yes No
Explain: _____

Do you have any outstanding warrants? Yes No County and State of warrant: _____

Explain: _____

Any pending court dates? Yes No Date/Time/Location: _____

Name of Attorney or Legal Representative: _____Telephone: ( ) _____

If anyone besides applicant needs to discuss Intake/Application details; the back two pages of application will need to be completed by the client as a HIPAA requirement.

By signing below I affirm the information I have given is accurate, I have read (or someone has read it to me) and I agree to all statements on this application as true and accurate.

**Signature of Applicant _____ Print Name _____ Date _____**

**Signature of Witness _____ Print Name _____ Date _____**

**Signature of Witness _____ Print Name _____ Date _____**

My Exit Plan when I leave the Nile: _____

**Transporter:**

I agree to arrive at Nile-ART and transport (Applicant's Name) _____ when she is being released, willingly or against the advisement of Nile-ART staff. My signature is my affirmation that I will participate as her transporter.

Signature of Transporter: _____ Print Name _____Date: _____

Contact information: _____

Signature of Witness: _____ Print Name _____ Date _____

**SIGNATURE OF STAFF TAKING APPLICATION: _____**

OFFICE USE ONLY

O UNABLE TO CONTACT FOR FOLLOW UP DATE: _____

O ACCEPTED DATE: _____

O DECLINED DATE: _____ REASON: _____

_____

_____

OTHER RESOURCES GIVEN TO APPLICANT: _____

_____

_____

**OFFICE USE ONLY**

**Nile-Addiction Recovery Treatment**
**Prior Authorization – Follow up**

Date of application: _____ Insurance validated date: _____ Anticipated bed date:_____

Follow up questions needed by clinicians/nurse:

1:

2:

3:

4:

Information update:

Date: _____ Result: _____ Call made by whom? _____

Date: _____ Result: _____ Call made by whom? _____

Signature and date of approval for intake: Clinician: _____ Date: _____
RN: _____ Date: _____

Weekly contact must be made with potential intakes. If message is left, then 3 attempts are to be made weekly:

Date: Result: Call made by whom?

Date: Result: Call made by whom?

Date: Result: Call made by whom?

Date: Result: Call made by whom?

Date: Result: Call made by whom?

Date: Result: Call made by whom?

Date: Result: Call made by whom?

Date: Result: Call made by whom?

Prior Authorization interview with client completed: _____ Approval date/Rejection date: _____

Date client called with results: _____ Call made by whom? _____

Scheduled intake date/time: _____

Notes/Comments of communication:

**HIPAA - Privacy Authorization Application Form**

**Authorization for Use or Disclosure of Application Information**

I _____ authorize Nile-Addiction Recovery Treatment to

(the individual applying)

use and disclose my application information to the individuals listed below.

Authorized individuals:

☐ Parole Officer: _____

☐ Social Worker: _____

☐ Counselor/Therapist: _____

☐ Judge/Court Representative: _____

☐ Lawyer: _____

☐ Hospital Representative: _____

☐ Referring Business: _____

☐ Family Member: _____

☐ Other: _____

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____ _____

Applicant Signature Print Name Date

_____ _____ _____

Representative's Signature Print Name Date

Representative's Relationship to Applicant: _____

Witness signature is required if signed by representative of applicant.

_____ _____ _____

Witness Signature Print Name Date

Required by Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164