PROGRAM APPLICATION

The Empowerment Center (TEC) provides a residential program that requires a ***mandatory 5 month*** client commitment, with a 60 day blackout. During blackout you are required to remain on campus and may not possess a cell phone or other personal electronics. The program combines a strong 12-step recovery component with an Outpatient Treatment component. This program is for *women only* who are **sincerely** dedicated to achieving and maintaining a clean and sober productive lifestyle.

Your entry into TEC program indicates that you agree to:

- **Complete 5-month (150 day) program - Including Blackout & finding a job**
- **Actively participate in all treatment requirements - Groups & 1:1 counseling**
- **Actively work a 12-step recovery program - Outside meetings & finding a sponsor**
- **Provide a current TB test result**

TEC does not serve individuals who have been convicted of a sexual offense, a violent crime, a crime against minors, or a crime against seniors.

Every section of this application must be completely filled out. *Incomplete applications will not be considered.*

Please write/print legibly.

DEMOGRAPHICS

Name	Date
Current Address	NDOC#
City, State, Zip	Referral Source
Date of Birth (month/day/year)	Phone#
Social Security Number	Veteran? Yes No Status ________________
State Issued ID: Yes No If yes, ID# ____________________________	
Marital Status: Never Married Married Partnered Divorced Widowed	
Ethnicity: Hispanic / Latino Not Hispanic / Latino	
Race: American Indian / Alaskan Native Black / African American Asian Native Hawaiian Pacific Islander White	
Language: English Spanish Other ____________________________	

DEMOGRAPHICS (cont.)

Emergency Contact

Name	Phone#
Address	Relationship

Spouse

Name	Phone#
Address	

Employment

Name of last employer	Start date	End Date
Did you have insurance through your employer? Yes No		
Name of insurance company		
Address		
Primary policy holder Self Spouse Parent Partner	Group#	Policy ID#

Education

What is your highest level of education?

If you have special training, a degree or certification, what field?

Financial / Insurance / Benefits

Do you have an income? Yes No	If yes, specify monthly income

Cash Income

Unemployment SSI/SSDI TANF Child Support Retirement Spouse Support Veteran Pension

Veterans Disability Other ____

Non-Cash Benefits

TANF WIC Section 8 Rental Assistance VA Medical Support Tribal Support Medicaid Medicare

Other ____

Do you have State Issued Insurance?

Medicaid – ID#	Medicare – ID#
SilverSummit – ID#	Health Plan of Nevada – ID#
Molina Healthcare – ID#	Anthem – ID#

CRIMINAL HISTORY

Do you have a criminal history? Yes No

If yes, please provide ALL past and current criminal charges. A criminal history does NOT exclude you from entry into TEC program. Your accurate information will help us to understand your current situation and any additional services you may need.

Crime Convicted of (List current first)	Date of Conviction (Month/Year)	Sentence

Currently incarcerated Yes No Name of facility

PED MPR EXP

Currently under supervision of a Specialty Court? Yes No

If yes, Specialty Court Case Manager Phone#

Have you been convicted of a violent offense, offense against a minor/senior, or a sexual offense? Yes No

If yes, please explain in detail, use additional sheets if necessary.

If incarcerated, have you had any write-ups/disciplinary actions in the past 2 years? Yes No

If yes, what were they for? What was each infraction? Use additional sheets if necessary.

What was your role in the crime(s) for which you were convicted?

CRIMINAL HISTORY (cont.)

Do you have any other criminal issues that have not yet been resolved that may come up during your time at TEC? Yes No

MENTAL HEALTH / SUBSTANCE USE HISTORY

Your health information is confidential. It will not be released without your signed consent in accordance with federal law.
Accurate information will help us to understand your current situation and additional services you may need.

NOTE: If you have had a drug/alcohol evaluation in the past 12-months, please submit a copy with your application if available.
If you do not have a copy, please sign the release of information at the end of the application.

Mental Health History

Are you currently under the care of a Mental Health Professional? (Psychiatrist, Psychologist, Therapist or Counselor) Yes No

If yes, Agency/Provider Name

Have you every had a Mental Health or Substance Evaluation? Yes No

If yes, when? Agency/Provider Name

Have you been diagnosed with the following? (Check all that apply)

ADHD Alcohol Use Disorder Anger/Irritability Anorexia/Bulimia Anxiety Autism Bipolar Disorder

Borderline Personality Disorder Cocaine Disorder Cannabis Disorder Depression Dysgraphia Dyslexia

Insomnia Disorder Methamphetamine DO OCD Opioid Disorder PTSD Schizoaffective Schizophrenia

Other ______________________________ Other________________________________ Other _____________________________

Other ______________________________ Other________________________________ Other _____________________________

Have you ever been hospitalized for suicide attempt/suicidal ideations? Yes No If yes, How many times?

Name(s) of hospital(s)

Date(s) of hospitalization(s)

Have you ever been admitted to a hospital or psychiatric facility for a mental health crisis? Yes No

If yes, name of facilities / hospital(s)

How many times? Date(s) of admission

Have you attended or completed any substance use/mental health rehabilitation programs?
(Examples: New Frontier, Step II, Bristlecone, RBH etc.) Yes No

Program Completed Yes No Date

Program Completed Yes No Date

Program Completed Yes No Date

Program Completed Yes No Date

MENTAL HEALTH / SUBSTANCE USE HISTORY (cont.)

Substance

Please check past illicit substance use including past prescription medication used that was not prescribed to you.

Adderall Alcohol Cannabis Cocaine Ecstasy Fentanyl Heroin Kratom LSD Methamphetamine

Methadone Morphine PCP Percocet Psilocybin Suboxone Vicodin Xanax Other_______________

Other______________________________ Other________________________________ Other___________________________

What is your drug of choice?	Date of last use	Method of use	Frequency
What is your drug of choice?	Date of last use	Method of use	Frequency
What is your drug of choice?	Date of last use	Method of use	Frequency

Current Psychiatric Medication

Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber

Past Psychiatric Medication

Abilify Amitriptyline Ativan Buspirone Cymbalta Depakote Doxepin Effexor Haldol Invega

Lamictal Lexapro Methadone Mirtazapine Olanzapine Prozac Ritalin Risperdal Seroquel

Suboxone Trazodone Valium Xanex Other__________________________ Other____________________________

MEDICAL HISTORY

Your medical information is confidential. Your personal health information will not be released without your signed consent in accordance with federal law. Your medical information is not considered when determining your eligibility for TEC program. Accurate information will help us to understand your current situation and additional services you may need.

Medical Conditions

Have you been diagnosed with a medical condition? Yes No If yes, please check all that apply.

Asthma Bowel/Gastro Conditions Cancer Chronic Pain COPD Diabetes Epilepsy Heart Condition

Hepatitis HIV Hypertension Insomnia Sleep Apnea Thyroid Disorder TBI Other________________

Other______________________________ Other______________________________ Other______________________________

Please explain medical condition(s) noted above.

Are you currently under the care of a medical provider? Yes No

Physician Name Phone#

Last TB Test Are you currently pregnant?

Current Medication

Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber

Pharmacy

Pharmacy Name Phone#

Address

GENERAL

The following two questions provide important information to help us understand who you are, and why you are seeking treatment.
If necessary, use additional sheets of paper, be thorough and WRITE LEGIBLY.

In your own words, why are you seeking services at a recovery program?

What changes do you hope to make as a result of coming into The Empowerment Center?

I hereby state that ALL above information and statements contained in this application are true to the best of my knowledge.

Please return this application to:

Email **Preferred**
admission@empowermentcenternv.org

In Person or by Mail
The Empowerment Center: Admissions
7400 South Virginia St
Reno, NV 89511

Applicant Name (print)	**Date**	**Applicant Signature**	**Date**

The Empowerment Center is compassionately dedicated to helping women who suffer from substance abuse to restore their dignity and quality of life. Our nonprofit organization empowers women to build a better future through treatment and workforce development in a safe living environment. We believe in the power of recovery to change outlooks, lives and ultimately our community.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name ___________________________________ **Date of Birth** _______________ **Phone#** __________________

I Authorize	**To Release To**
Name of Agency/Person	Name of Agency/Person **The Empowerment Center**
Address	Address: **7400 S. Virgina Street**
City, State, Zip	City, State, Zip **Reno, Nevada 89511**
Phone# Fax#	Phone# **(775) 853-5441** Fax# **(775) 243-4510**

Information that may be released (Initial to authorized release)

____Mental Health Evaluation ____Substance Use Evaluation ____Psychiatric EvaluationTreatment Plans ____Progress Notes

____Medication Management Records ____Billing Records ____Other (specify)____________________________________

Purpose for which information is to be used

____Continuing Care ____School/Vocational Rehabilitation ____ Disability Benefits ____Legal

____Personal/Employment Conditions ____Other (specify)____

This consent expires one year from the date below unless otherwise specified: (not to exceed one year)

INFORMATION FOR INFORMED CONSENT

This consent expires one year from the date below unless otherwise specified: (not to exceed one year)

INFORMATION FOR INFORMED CONSENT

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including Nevada Revised Statutes. These Statutes, Rules and Regulations require that the patient give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations.

NOTICE OF REDISCLOSURE: I understand the information and records disclosed pursuant to this consent may be protected under 42 CFR Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and 45 CFR parts 160 and 164, State Confidentiality laws and regulations, and cannot be released without my consent unless otherwise provided for by the regulations. State and Federal regulations prohibit any further disclosure of such information and records without my specific written consent unless otherwise permitted by such regulation.

The information I authorize for release may include records that may indicate the presence of communicable disease, which may include, but is not limited to the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I understand that information used or released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may inspect or copy the information prior to its disclosure, and I may refuse to sign the release. I understand I have the right to withdraw this authorization in writing, at any time.

I, ____, the client, am aware of and have been advised of the existing State and Federal Statutes, Rules and Regulations and health information practices. I understand and have been explained my right to confidentiality of the information of these records. I realize this is not a required consent and I must voluntarily and knowingly sign this authorization before any records can be released.

______________________	______________	________________________	______________
Client Name (print)	**Date**	**Client Signature**	**Date**

Revocation: I hereby revoke the above authorization ________________________ Client Signature ______________ Date

THE EMPOWERMENT CENTER
Solutions for Recovery

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________________________ ________________ ________________________ ________________
Client Name (print) **Date** **Client Signature** **Date**

Revocation: I hereby revoke the above authorization ________________________ ________________
Client Signature Date

THE EMPOWERMENT CENTER (TEC) CONTRACT FOR RESIDENCY

1. Alcohol/narcotic consumption and gambling are prohibited on or off site as a resident of TEC. Noncompliance will result in immediate discharge.

2. All weapons are strictly forbidden.

3. Residents of TEC agree to random urinalysis and breathalyzer testing.

4. Staff has the right to search your possessions if alcohol, narcotics, weapons, contraband, trafficking or theft is suspected.

5. Theft is not tolerated. Residents are responsible for their own possessions. Living quarters are to be locked when not occupied. TEC is not liable or responsible for missing items.

6. Violence, including all forms of physical, mental, or emotional violence, intimidation, injury, abuse, negligent treatment, maltreatment, or exploitation, including sexual abuse, or harassment is strictly forbidden. This includes, but is not limited to verbal or physical conduct that creates an intimidating, hostile, offensive environment, or sexual in nature directed toward any resident, visitor, staff or volunteer of TEC.

7. TEC is an all-female facility. There are no intimate or sexual relationships allowed among residents, or on property in any form.

8. Smoking is not allowed on property.

9. Residents are required to use the sign in/out sheets when leaving the facility. All fields must be completely filled out, legible, include your full name and your time of departure and anticipated return.

10. All residents are expected to know what phase they are on and comply with all requirements as documented in their phase packets.

11. All residents are required to abide by a 60 day blackout. You may not possess personal electronics of any kind. You may not leave campus w/o TEC staff.

12. All visitors must be approved by TEC staff.

13. Each client is required to complete their phase book monthly as provided in their Resident Handbook. Additional recovery work assigned by their Peer Support and/or Counselor is expected to be completed in the time agreed.

14. In the instance of illness, staff MUST be immediately notified. Residents must disclose to medical personnel that they are in recovery from an addictive disorder and may not be prescribed narcotics. Residents must provide staff with copies of all prescriptions and comply with all medication management policies and safe keeping requirements.

15. Upon discharge, you must remove all your personal belongings. If your property is not removed within seven (7) days it will be considered abandoned. If you are unable to personally remove your property, you may give written authorization for a person of your choosing to retrieve your property.

VIOLATION OF THIS CONTRACT MAY RESULT IN IMMEDIATE DISMISSAL FROM THE PROGRAM.

______________________________	___________________	______________________________	___________________
Applicant Name (print)	**Date**	**Applicant Signature**	**Date**