



The Confederated Tribes of the Colville Reservation
San Poil Treatment Center
11614 Highway 21 South
Keller, WA 9914
Phone (509) 634-2050

SAN POIL TREATMENT CENTER CLIENT APPLICATION

Client Name: _____ Today's Date: _____

Tribal Member (Enrolled or HIS Eligible)? Yes No Tribe: _____

Insurance Information: _____ ID#: _____

Desired date to move into the San Poil Treatment Center: _____

DOB: _____ SSN: _____

Phone: _____ Email: _____

Current Physical Address: _____

Current Mailing Address: _____

Do you: Own Rent Monthly payment: _____

How long have you lived there? _____

What is your monthly gross income? _____

Are you receiving welfare or other non-job-related income? Yes No

If yes, please explain: _____

Marital Status: Single Married Separated Divorced Widowed Partnership

Level of education completed: High School College Grad School Other: _____

OTHER INFO

Veteran – If yes, what branch: _____

Pregnant – If yes, what is your due date? _____

Valid Driver's License Have a car – If yes, is it registered and insured? Yes No

Current treatment center: _____ Expected discharge date: _____

Who referred you to us? _____

SAN POIL TREATMENT CENTER AUTHORIZATION TO RELEASE INFORMATION

Name of resident:

DOB:

I hereby authorize **San Poil Treatment Center, 11614 Highway 21 South, Keller WA 99140**

To disclose or obtain information from:

Including my:

- Medical history
- Alcohol and drug abuse treatment records
- Laboratory reports
- Psychological evaluations
- Other, please list:

For the purpose of admission screening, all information I hereby authorize to be obtained from the agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

- Ninety (90) days unless an otherwise an earlier time period of:
- One (1) year
- The period necessary to complete all transactions on account-related services provided to me

I understand that unless otherwise limited by state of federal regulation, and except due to the extent that action has been taken which was based on my consent, I may withdraw this content at any time.

Signature of Resident: _____ Date: _____

Signature of Witness: _____ Date: _____

SPTC Administrator: _____ Date: _____

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To be used only if Resident withdraws consent:

Signature of Resident: _____ Date: _____

The information which is being disclosed is from records whose confidentiality is protected by federal law. Federal Regulations (42-CFR Part 2) prohibit disclosures without specific consent of the person to whom it contains. A general authorization is NOT sufficient for such release. The Federal rules restrict any use of this information from a criminal investigation or to prosecute any alcohol or drug abuse patients.



RECOVER AND SUBSTANCE ABUSE HISTORY

Do you think you have a problem with alcohol?

If yes, please explain:

Do you think you have a problem with drugs?

If yes, please explain:

Primary addiction:

Date of last use:

List the drugs/alcohol you used addictively:

1st:

Route:

Date of last use:

Age of first use:

2nd:

Route:

Date of last use:

Age of first use:

3rd:

Route:

Date of last use:

Age of first use:

EMERGENCY CONTACTS

List people not residing with you.

Name:

Relationship:

Phone:

Name:

Relationship:

Phone:

Name:

Relationship:

Phone:

OTHER INFO

Please list your hobbies and/or interests:

What would you say your best characteristics are?

Do you have a primary care physician? Yes No

If yes, who? Name:

Phone:

EMPLOYMENT INFO

Are you employed: Yes No

Current employer:

Address:

Phone:

Position:

List your last three employers, if applicable:

Company:

Supervisor Name & Phone:

Company:

Supervisor Name & Phone:

Company:

Supervisor Name & Phone:

If unemployed, what are your plans for getting a job?

Please list your vocational skills/specialized training or certificates:

LEGAL INFO

Have you been arrested in the past 30 days? Yes No

If yes, please explain:

Are you a registered sex offender? Yes No

If yes, what level?

Are you currently on parole or probation? Yes No

If yes, list probation officer name and phone:

Are you mandated? Yes No

Are you experiencing legal problems (i.e. court dates, warrants, active restraining orders, etc.)? Yes No

If yes, please explain:

MEDICAL & RECOVERY INFO

Do you take any prescription medications? Yes No

If yes, please list:

Do you have any medical allergies or other conditions: Yes No

If yes, please explain:

When did you attend your last AA/NA meeting?

How many meetings have you attended in the last 30 days?

Do you already have a sponsor or a Recovery Coach? Yes No

If yes, please list name and phone:

Do you have any other recognized addictions or disorders (i.e. eating disorder, self-harm)? Yes No

If yes, please explain:

How long have you been clean and sober?

How many previous recovery attempts/relapses have you had?

Are you on any maintenance programs, and if so, which one(s):

Are you interested in being on a maintenance program? Yes No Maybe

Have you ever lived in a home shared by other people? Yes No

Do you anticipate any problems living in a group setting? Yes No

If yes, please explain:

Please list anything else you feel is relevant to this application:

I authorize the verification of the information provided on this form.

Signature: _____ Date: _____