FIRST at Blue Ridge, Inc.

Application for Admission

FIRST at Blue Ridge, Inc.
32 Knox Road
Ridgecrest, NC 28770
Firstinc.org

Important

For this application to be considered, all forms must be filled out COMPLETELY, including appropriate signatures (personal, witness, and physician signatures).

Any questions, comments, concerns?

Please call (828)-669-0011 Ext. 1106 or 1111
for questions concerning the Application.

APPLICATION FOR ADMISSION

Name _____ Age _____ Today's Date _____

Program Applying to:

Short-term (7 to 90 days) ◯ If Short-term, how many days? _____

Long-term (1-Year) ◯ Veteran Program (2-Years) ◯

Current Address:

Street _____

City _____ State _____ Zip Code _____ Phone _____

Social Security # _____ Gender _____

DOB _____ Birthplace _____ County _____

Height _____ Weight _____ Hair Color _____ Eye Color _____ Race _____

Distinguishing Marks (tattoos, scars) _____

_____

Marital Status: Married/Cohabitating ◯ Divorced ◯ Single/Never Married ◯

If married/cohabitating: Spouse's/Significant other's name _____

If divorced: Date(s) _____ County _____ State _____

Do you maintain a primary residence? Yes ◯ No ◯ Are you homeless? Yes ◯ No ◯

If yes, how long have you been homeless? _____

Are you pregnant? Yes ◯ No ◯ Not Applicable ◯

Do you have children? Yes ◯ No ◯ If so, how many? _____

Fathers' Name _____

Address _____

City _____ State _____ County _____

Mothers' Name _____

Address _____

City _____ State _____ County _____

In case of emergency, notify _____

Telephone _____ Relationship _____

Referred by:

Name _____

Street Address _____

City _____ State _____ Zip Code _____ Phone _____

Have you ever applied to FIRST, Inc. before? Yes ◯ No ◯

If yes, please list the date(s) and the year(s) you resided there _____

_____

Do you have a current valid Driver's License? Yes ◯ No ◯

_____

If yes, Driver's License number and issuing state: _____

If no, please list any outstanding tickets or fines, with the county and state where the infractions took place _____

_____

Military Service (If Applicable)

Branch _____ Service Number _____

Type of Discharge _____ Year _____ Eligible for benefits? Yes ◯ No ◯

Number of Grant Per-diems previously used: _____

Criminal Justice Information

Are you currently incarcerated? Yes ◯ No ◯

If yes, which facility: _____ City _____ State _____

Expected release date: _____

Are you on probation? Yes ◯ No ◯ If yes:

County _____ State _____

*** WHAT IS YOUR PROBATION/PAROLE OFFICER'S NAME? _____

Address _____

Telephone # _____ Fax # _____

Do you have pending legal actions or outstanding warrants? Yes ◯ No ◯

If yes, please list them by name and date: _____

_____

If the case(s) have not been disposed of, please list all upcoming court dates:

Date _____ City _____ State _____ County _____

Date _____ City _____ State _____ County _____

*** ATTORNEY'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE # _____ FAX # _____

LIST ALL PRIOR CONVICTIONS

Offense	Disposition	Date of Disposition
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever committed/been charged with child abuse/neglect? Yes ◯ No ◯

If yes, explain: _____

_____

Have you ever committed/been charged with arson? Yes ◯ No ◯

If yes, explain: _____

_____

Have you ever committed/been charged with a sexual offense? Yes ◯ No ◯

If yes, explain: _____

_____

Have you ever committed/been charged with an assault or domestic violence? Yes ◯ No ◯

If yes, explain: _____

_____

EMPLOYMENT INFORMATION

Currently Employed? Yes ◯ No ◯ Employer's Name: _____

Previous Employer's Name/Dates Employed:_____

Reason for leaving: _____

_____

FINANCIAL INFORMATION

Outstanding debts (child support, installment loans, IRS, etc.) _____

_____

_____

Arrangement for Payments: _____

_____

Are you ordered to pay child support? Yes ◯ No ◯

Are you behind? Yes ◯ No ◯ By how much? _____

Are you currently applying for disability (SSI, SSDI) or do you receive any ongoing financial reimbursement for any reason? (Such as disability, trust fund, etc.)? Yes ◯ No ◯

If yes, explain: _____

_____

SUBSTANCE ABUSE INFORMATION

(This information is confidential and will not affect your acceptance into the program)

List in order of preference all drugs used or tried; past or present (**This MUST be complete**)

Drug	**Age at first use**	**Amount used at peak**	**Date of last use**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prior drug program(s) and dates completed: _____

_____

_____

Do you have knowledge of the 12 Steps? Yes ◯ No ◯

Have you ever participated in 12 Step Fellowships? Yes ◯ No ◯

EDUCATION INFORMATION

High school graduate/GED? Yes ◯ No ◯ Last grade completed? _____

Difficulty reading? Yes ◯ No ◯ College? Yes ◯ No ◯

Difficulty writing? Yes ◯ No ◯

Do you have any kind of advanced education? Yes ◯ No ◯

Vocational/occupational skills: _____

Special areas of study: _____

MEDICAL INFORMATION

Are you on Medicaid? Yes ◯ No ◯

Do you have insurance? Yes ◯ No ◯

If yes, please list your insurance information: _____

_____

Do you have dental problems? If yes, explain: _____

_____

Are you currently on any medications? (Prescribed or Over-the-counter) Yes ◯ No ◯

If yes, what medications are you taking? _____

_____

Who is paying for and/or providing your medications? _____

*** This party will need to sign an affirmation that they will pay for these medications ***

Are you currently under the care of a physician? Yes ◯ No ◯ If yes, list contact info:

_____

Reason: _____

Have you had a TB test in the past year? Yes ◯ No ◯

If yes, positive or negative? _____

When was the last time you had unprotected sex? _____

Have you ever been tested for HIV/AIDS, STDs, HEP A,B,C,D? Yes ◯ No ◯

Date: _____ Results: _____

List any medical problems: _____

_____

_____

Have you ever been hospitalized for any illnesses? Yes ◯ No ◯

If yes, hospital(s) and date(s) _____

_____

History of: (Check all that apply)

Asthma ◯ TB ◯ Diabetes ◯ Hepatitis ◯ Heart Disease ◯ Epilepsy ◯

ALLERGIES: Are you allergic to:

Penicillin or sulfa Yes ◯ No ◯

Aspirin, codeine, morphine Yes ◯ No ◯

Mycins or other Antibiotics Yes ◯ No ◯

Merthiolate, Mercurochrome Yes ◯ No ◯

Adhesive tape Yes ◯ No ◯

Nail polish, other cosmetics Yes ◯ No ◯

Any other drug Yes ◯ No ◯

If yes, what? _____

Any foods Yes ◯ No ◯

If yes, what? _____

INJURIES: Have you had any:

Broken/cracked bones Yes ◯ No ◯

If so, when? _____

Sprains Yes ◯ No ◯

If so, when? _____

Lacerations Yes ◯ No ◯

If so, when? _____

Concussions/head injuries Yes ◯ No ◯

If so, when? _____

Dislocations Yes ◯ No ◯

If so, when? _____

Have you ever had any seizures? Yes ◯ No ◯

If yes, when and why? _____

_____

SURGERIES: Have you had any of the following surgeries:

Tonsillectomy ◯ Appendectomy ◯ Any other operation:

Type/Explanation of surgery: _____ Year: _____

Type/Explanation of surgery: _____ Year: _____

Type/Explanation of surgery: _____ Year: _____

If you have ever been advised to have any surgical operation which has not been done:

Details: _____

Mental Health Information

Have you ever been hospitalized and/or treated for any mental health issues? Yes ◯ No ◯

Voluntary or Involuntary? _____

Hospital(s) and Date(s) _____

_____

Reason/Diagnosis _____

Have you ever been given a mental health diagnosis? Yes ◯ No ◯ If yes, please list your specific diagnosis(es): _____

_____

Have you ever heard voices? Yes ◯ No ◯ If yes, when? _____

Outcome? _____

Have you ever had visual hallucinations? Yes ◯ No ◯ If yes, when? _____

Outcome? _____

Have you ever been sexually assaulted? Yes ◯ No ◯ If yes, date(s) _____

Have you received counseling for this? Yes ◯ No ◯

Are you currently suicidal? Yes ◯ No ◯

Have you ever tried to commit suicide? Yes ◯ No ◯ If yes, date(s) _____

Have you ever exhibited any self-harm behaviors such as cutting, bulimia, etc? Yes ◯ No ◯

If yes, please explain: _____

Have you ever overdosed? Yes ◯ No ◯ How many times? _____

Circumstances surrounding overdose (when, where, why, how): _____

_____

Have you ever been a victim of a violent crime? Yes ◯ No ◯

If yes, please explain: _____

_____

Do you currently have a mental health provider? Yes ◯ No ◯ If yes, please list current provider(s): _____

_____

Have you received counseling in the past? Yes ◯ No ◯ If yes, please list past provider(s):

_____

_____

On a scale of 1 to 10, how serious is your problem with drugs and alcohol? (Circle one)

(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 positive changes in your life? (Circle one)

(Not motivated) 1 2 3 4 5 6 7 8 9 10 (Very motivated)

AFFIRMATION

I affirm that my answers and information provided by me in this application are true and accurate. I understand that if I am accepted in the program, any misinformation and/or dishonest answer may be grounds for my dismissal from the FIRST at Blue Ridge Program. I also understand that should any other information concerning me arise while I am in the FIRST at Blue Ridge Program that renders me ineligible to continue, I will be discharged.

Signature _____ Date _____

FIRST at Blue Ridge, Inc.

Information for Applicants

- No violence, threats of violence or use of drugs/alcohol will be tolerated - you will be discharged and the proper authorities will be notified.
- The preppie phase will last 30 days or until initial treatment plan goals have been met, depending on your participation in the program. During the preppie phase, between the hours of 6:30am – 10:00pm, clients will be scheduled for a variety of activities including educational classes, group therapy, 12-step meetings, work assignments, chores, etc.
- A 15-minute personal phone call is allowed to an approved number once per day, and any time on the weekends.
- Business calls may be made after 9:00am on weekdays for legitimate reasons only.
- After the preppie phase, residents can earn a day pass every 30 days.
- You may be eligible to go on a 4-day home visit after 6 months, depending on how well you are doing in the program.
- If you bring cash, credit cards or debit cards, they will be stored in the administrative office, not kept on the client. No more than $200 will be allowed to be stored at any time.
- Do not bring computers, cell phones, TVs, stereos, weapons, pornography, or clothing with alcohol/drug symbols or profanity.
- Do not bring any tight-fitting or revealing clothing.
- All clients will receive a work assignment after completion of the preppie phase in order to help support the facility. These will be based upon client skills, house needs and other criteria.
- You must use the chain of command if you have any questions. If you need anything, ask your Peer Leader or House Manager.
- Be humble and do what is asked of you. If you have a problem with something you are asked, do it to the best of your ability, then follow the chain of command to let someone know how you feel about the situation.

By signing below, you are confirming that you have been made aware of these rules during the Application process, and if accepted into the program, agree to abide by them.

Applicant's signature_____ Date _____

FIRST at Blue Ridge, Inc.

Items to Bring

Necessary Items:

Court document(s) if probated/court ordered to FIRST at Blue Ridge, Inc.
Identification (State I.D./S.S. Card)
Veterans Identification (if eligible: DD-214 form is required)
(30) day supply of medication(s) and AT LEAST a 90 day refill.
(10) day supply of clothing (work, casual, and formal)
Steel Toe Boots

Suggested Items:

Hygiene materials (alcohol free)
Alarm clock
Electric razor/beard trimmer or disposable razors
AA/NA Books
Bible
Writing paper
Pens/pencils
Hobby/leisure items such as musical instruments and/or art supplies
Hair clippers (for personal use ONLY)

Items NOT to bring:

Weapons (real or fake)
Anything containing alcohol (cologne, mouthwash, etc.)
Pornography
Vapes
Stereos, Televisions, Computers, cellphones/pagers, Bluetooth devices
Drug paraphernalia, clothing with alcohol/drug symbols or profanity
Anything of value (such as jewelry)

FIRST Inc. will not be responsible for items left after a resident leaves the program.

***NOTE**: Unauthorized items may be confiscated.*

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. The list above is all-inclusive; there are no exceptions.

_____	_____	_____
Print Name	Signature	Date

FIRST at Blue Ridge, Inc.

AUTHORIZATION TO RELEASE INFORMATION

(CRIMINAL JUSTICE SYSTEM REFERRALS)

Resident's Name _____ authorize the following:

Name of program which is to exchange information:

FIRST at Blue Ridge, Inc.
32 Knox Road
P.O. Box 40
Ridgecrest, NC 28770

Name or title of the person(s) or organization(s) with which the disclosure is to be made:

- Court having jurisdiction over the resident
- Probation and/or parole officers or their agencies
- TASC referral units
- Prosecuting attorney withholding charges against the resident
- Defense attorney
- Department of Social Services and/or its agents

Purpose or need for the disclosure:

For assessment and treatment planning, to monitor progress in treatment and compliance with conditions of referral.

Extent or nature of information to be exchanged:

Any and all pertinent information contained in files.

This consent is subject to revocation at any time except to the extent that FIRST, Inc. has already taken action in reliance on it. If not previously revoked, this consent will terminate three hundred sixty-five (365) days after termination of treatment.

Signature of Resident _____ Date _____

Signature of Witness _____ Date _____

FIRST at Blue Ridge, Inc.

AUTHORIZATION TO RELEASE INFORMATION

(GENERAL CONSENT)

Resident's Name _____ authorize the following:

Name of program which is to exchange information:

FIRST at Blue Ridge, Inc.
32 Knox Road
P.O. Box 40
Ridgecrest, NC 28770

Name or title of the person(s) or organization(s) with which the disclosure is to be made:

Family and significant others of resident; employers and potential employers; funding sources; the Department of Social Services; psychiatric, medical, or treatment personnel; Social Security Administration; Food Stamp offices.

Purpose or need for the disclosure:

In order to provide relevant information as to resident's treatment status or progress and for follow-up investigation.

Extent or nature of information to be exchanged:

Only such information is reasonable and necessary for the particular circumstance.

This consent is subject to revocation at any time except to the extent that FIRST, Inc. has already taken action in reliance on it. If not previously revoked, this consent will terminate three hundred sixty-five (365) days after termination of treatment.

Signature of Resident _____ Date _____

Signature of Witness _____ Date _____

Client:_____ DOB_____

STANDING ORDERS FOR MEDICATION

PROGRAM: FIRST at Blue Ridge, Inc.

	MEDICATION	TREATMENT GOALS	STRENGTH	ADMINISTRATION DIRECTIONS	Notes
	Daytime Cold and Flu: Acetaminophen 325mg Dextromethorphan Hydrobromide 10mg Phenylephrine 5mg	For relief of cough and cold symptoms.	Acetaminophen 325mg Dextromethorphan Hydrobromide 10mg Phenylephrine 5mg	Swallow one to two soft gels PRN with water every four hours. Do not exceed four doses in 24 hours.	
	Pepto Bismol/ Bismuth Subsalicylate 262mg	For relief of loose bowel movements.	262mg	Take one to two caplets PRN every ½ hour to one hour as needed. Do not exceed more than eight doses in 24 hours.	
	Milk of Magnesia/ Magnesium Hydroxide 1200mg	For relief of Constipation	1200mg	Take one to four tablespoonfuls PRN per day.	
	Tylenol/ Acetaminophen 500mg	For relief of minor aches & pains, and /or fever	500mg	Take one to two caplets PRN every six hours. Do not exceed more than 8 caplets in 24 hours.	
	Ibuprofen 200mg	For relief of minor aches & pains, and /or fever	200mg	Take one to two caplets PRN every four to six hours. Do not exceed more than 12 caplets in 24 hours.	
	Cetirizine Hydrochloride 10mg	For relief of allergy symptoms.	10mg	Take one tablet PRN by mouth once daily.	
	Benadryl/ Diphenhydramine 25mg	For relief of allergy symptoms.	25mg	Take one to two caplets PRN every four to six hours. Do not exceed six doses in 24 hours.	
	Mucus Relief/ Guaifenesin 400mg	Expectorant. To loosen mucus and make coughs more productive.	400mg	Take one caplet PRN every four hours. Do not exceed six doses in 24 hours.	
	Antacid/ Calcium Carbonate 750mg	For relief of heartburn or acid indigestion	750mg	Chew one to two tablets PRN every two to four hours. Do not exceed 5 tablets in 24 hours.	
	Melatonin 3mg	For aid falling asleep.	3mg	Swallow one to two caplets PRN at bedtime.	
	Fish Oil 1000mg	Dietary Supplement	1000mg	Take one caplet with meals up to three times daily.	
	Calamine Lotion Aloe Vera Hydrocortisone Cream 1% Antibiotic Ointment: Bacitracin Zinc/ Neomycin Sulfate/ Polymyxin B Sulfate		Use as directed for minor scrapes, burns, cuts, or itchy skin.		

By my signature below, I acknowledge that during my participation in the First at Blue Ridge, Inc. Residential Treatment Program, I will take only take those Over-The-Counter medications listed above. Further, *I agree only to take recommended doses and for the indicated uses on the Over-The-Counter medication packages. I recognize that it is my responsibility to review the package information, with each dose taken, for any potential adverse interactions and contraindications to my use*. **Further, I hereby agree to hold First at Blue Ridge Inc., and the healthcare provider listed below harmless if I take any over the counter medication not listed above or outside the parameters of recommended dosages, uses and warnings or contraindications.**

Ordered by:_____ Date:_____

Prescriber Signature

PRINT :_____

Client Signature:_____ Date:_____

Medication Self Administration/Self Possession Authorization

Self-administration means _____ (the client) can administer his/her medication in a manner directed by their physician without additional direction or supervision by FIRST at Blue Ridge Inc staff. Self-possession means that under the direction of the physician, the client may carry medication on his/her person to allow for immediate and self-determined administration. For medication other than inhalers, topical creams, patches and sprays, only that day's supply (24 hours) of medication is to be carried. FIRST at Blue Ridge Inc recommends that spare medication, properly labeled in its original container, to be kept in the FIRST at Blue Ridge Medical Office.

The client agrees to:

1. Never share his/her medication with another person
2. Carry the medication in a responsible manner so as not to lose it
3. Take medication only at the prescribed frequency and dose
4. Keep a copy of this form and back up medication in the FIRST at Blue Ridge Inc Medical Office

If the client fails to meet any of the agreements listed above, FIRST at Blue Ridge Inc may discontinue the Self-Administration/Self-Possession privilege without notice. If FIRST at Blue Ridge Inc revokes the Self-Administration/Self-Possession privilege, client may be discharged from the program.

Physician's Printed Name _____

Physician's Signature _____ Date _____

Client's Signature _____ Date _____

FIRST at Blue Ridge, Inc.

PHYSICIAN ORDERS

Client: _____ _____ _____
Last Name First Name Middle Initial

DOB:
ALLERGIES:

PRESCRIBED MEDICATION: List **ALL** medication prescribed by Medical Professionals **INCLUDING ALL OVER THE COUNTER ITEMS.** Sample medication should be dated & marked by Physician.

Clients **MUST** have a 30-day supply and **AT LEAST** a 90-day refill to gain acceptance into our program.

Date	Medication Name	Strength	Administration Directions (Please include route)	Quantity	# of Refills

Even if not on prescription medications, **ALL** forms must be signed.
PLEASE INCLUDE CREDENTIALS.

Qualified Provider (MD, DO, NP, PA) SIGNATURE _____

Qualified Provider (MD, DO, NP, PA) PRINT _____

32 Knox Road
PO Box 40
Ridgecrest, NC 28770
Phone: (828) 669-0011 Ext. 1106/1111
Fax: (828) 669-0596
Website: www.firstinc.org

Mark J. Merrick, MA, QP
Executive Director

32 Knox Road
PO Box 40
Ridgecrest, NC 28770
Phone: (828) 669-0011
Office Fax: (828) 669-0589
Admissions Fax: (828) 669-0596
www.firstinc.org

FIRST at Blue Ridge, Inc.

AGREEMENT TO ACCEPT TREATMENT AT FIRST AT BLUE RIDGE

I, _____ (print name), acknowledge and agree to each of the following:

As a client and participant in the long-term treatment program offered at FIRST at Blue Ridge, I am expected to participate in work therapy assignments under the direction of FIRST staff and its community partners. I understand this means that any and all situations where my ability to participate in work therapy as directed is compromised or otherwise affected may conflict with FIRST's goals for my long-term treatment, and therefore such situations require FIRST's reconsideration as to my appropriateness for the program.

_____ (initial and date)

Such situations include, but are not limited to: recommendation for Intensive Outpatient Programs, medical diagnosis that affect my ability to participate in work therapy, changes in medication that affect my ability to participate in work therapy, prescriptions for medications that are not allowed in the FIRST program, operations and surgery that affect my ability to participate in work therapy, and recommendations for treatment that conflict with, or are contrary to, FIRST's recommendations for treatment.

_____ (initial and date)

I understand and agree that FIRST makes every effort to assist with transition planning for its clients, and that my acceptance and pursuit of other treatment recommendations may mean that my transition would best be handled by those making such recommendations. This includes, but is not limited to, other agencies and their personnel, family, friends, doctors, and other medical providers.

_____ (initial and date)

By signing and dating below, I am acknowledging and agreeing to the above and confirming that I desire the treatment provided by FIRST at Blue Ridge.

_____ (sign name)

_____ (date)

_____ (witness to the agreement)

Outline for Applicant's Autobiography

"We admitted we were powerless over our addiction and that our lives had become unmanageable."

It would be impossible to overestimate the importance of being thoroughly and completely honest with yourself and others. Each client is required to write an autobiography including a history of their substance use, mental health issues, and goals for treatment and recovery.

Issues to be covered in your autobiography are:

1. Describe your substance use history, including what and how long you have used it.
2. Have you ever been in the hospital for mental health reasons? Explain in detail.
3. Have you ever tried to commit suicide?
4. Discuss any mental health issues including diagnoses and history.
5. List what medications you are taking and why.
6. Describe your present situation – be as specific as possible.
7. Why do you want to be admitted to FIRST?
8. Discuss specific changes you want to make in your life.
9. What goals do you want to achieve while at FIRST?
10. What are your goals for recovery?
11. How will you contribute to the program and your fellow residents?

Length: Your personal autobiography should be at least 1500 to 2500 words and should be neatly written or typed in chronological order as to how and when the events occurred. Please do not exceed 6 pages.

This autobiography is CONFIDENTIAL. At your request, it will be returned to you at time of discharge. This autobiography will help us determine if you are appropriate for our program and how we may best serve you.