Extended Care Program
Admission Application

Date of Application:____/____/____

Applicant Information

First Name: ____ Last Name: _______________________________________

Address: ____ Phone Number: _________________________________

City: ____ State: _____________ Zip: __________________

Date of Birth: ______/_______/______ Age: ____ Social Security Number: __________________________________

Cell Phone Number: _________________________________ email address: ____________________________________

Father's Information

Name: ____ ____ Living ____ Deceased

Address: ____ Phone: __________________________

Work Phone: _______________________ Fax: ____________________ Cell Phone: ________________________________

Email address: ____

Stepmother / Significant Other's Full Name (if applicable): ____

Mother's Information

Name: ____ ____ Living ____ Deceased

Address: ____ Phone: __________________________

Work Phone: _______________________ Fax: ____________________ Cell Phone: ________________________________

Email address: ____

Stepfather / Significant Other's Full Name (if applicable): ____

Financial Responsibility Information

Guarantor's Name: ____

Relationship to Applicant: ____

Guarantor's Social Security Number: ____

Guarantor's Mailing Address (if different from above) ____ ______________

Guarantor's Employer/Address: ____

Sibling/Children Information

Name: ________________________________ Age:______

Name: ________________________________ Age:______

Name: ________________________________ Age:______

Name: ________________________________ Age:______

Emergency Contact Information

Name: ____ Phone: ______________________

Relationship to Applicant: ____

Referral Source Information

How did you first come to know about Turning Point Foundation?

____

Date of Last Use

____/____/____

Emotional/Mental Health Diagnoses

Has the applicant been given a diagnosis by a qualified mental health professional?

Diagnosis	Date Given	Name of Professional

Current Medications

Name of Medication Date Prescribed Dosage/Schedule Reason for Medication

Name of medication	Name of Prescribing Physician	Date Prescribed	Dosage/Schedule	Reason for medication

Significant Medical History

General health condition: Excellent: ____ Good____ Average____ Poor _____

Does the applicant have any food restrictions? _____ Yes _____ No If yes, please explain: ____________
____

Allergies____

List/Explain any chronic conditions (asthma, heart murmur, diabetes, enuresis, etc.)
____
____
____

History of surgeries/broken bones____
____
____

Has applicant ever been hospitalized other than for above described surgeries or fractures? If so, why and for how long?
____
____

Please check any of the following that apply to the resident:

Behavior	Yes	No	Behavior	Yes	No
Depression			Running away		
Suicide			Death of parent or guardian		
Hearing Voices			Death of close friend		
Arson / Fire setting			Has been arrested		
Cruelty to animals			On probation		
Psychiatric Hospitalization			Violence towards others		

For any of the items that are marked “Yes”, please provide explanation:

____
____
____
____

Previous Addiction Treatment/Hospitalization

Mental health professional(s) (psychiatrist, psychologist, educational consultant, therapist, etc.)

Name: ______________________________ Dates of Treatment: ____________________

Address: ____ ______________________

Phone: ____________________ Fax: ______________

Name: ______________________________ Dates of Treatment: ____________________

Address: ____ ______________________

Phone: ____________________ Fax: ______________

Name: ______________________________ Dates of Treatment: ____________________

Address: ____ ______________________

Phone: ____________________ Fax: ______________

Treatment Programs/Hospitalization:

Program/Facility Name: _________________________ Dates of Service: __________________

Type of Services: ____

Program Name: ___________________________ Dates of Service: __________________

Type of Services: ____

Program/Facility Name: _________________________ Dates of Service: __________________

Type of Services: ____

Program Name: ___________________________ Dates of Service: __________________

Type of Services: ____

Program/Facility Name: _________________________ Dates of Service: __________________

Type of Services: ____

Program Name: ___________________________ Dates of Service: __________________

Type of Services: ____

Addiction History (Please check and comment)

Substance		Type	Frequency	Age of first use	Last use
	Alcohol				
	Marijuana				
	Cocaine				
	Opiates				
	Benzodiazepine				
	Bupenorphrine				
	Barbiturates				
	Phencyclidine (PCP)				
	Methadone				
	Suboxone				
	Methamphetamines				
	Inhalants				
	Nitrous				
	Ecstasy				
	Ketamine				
	Tramadol				
	Hallucinogens				
	Other (list)				

Education History

High School Graduate (Yes/No): ____________________Highest Grade Completed: ______________________________

School(s): Name: ____ Location: ___________________________

College Attended: ____ Number of Years: ______________________

Graduated (Yes/No): ___________________________ Degree/Concentration: _________________________________

Extra-Curricular Activities: ____

____

Recent Employment History

Employer: ____ To/From: ____________________________

Title/Job Responsibilities: ____

Employer: ____ To/From: ____________________________

Title/Job Responsibilities: ____

Employer: ____ To/From: ____________________________

Title/Job Responsibilities: ____

Hobbies/Activities of Interest

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____

____

____

If you have any questions regarding this application or the admissions process in general, please contact us at 203.497-3799 to speak with one of our staff. When complete, please fax to 203.468.8359.

- END -

Extended Care Program
Program Guidelines

I am committed to participate in the Turning Point Foundation Extended Care program and recognize that the facility is neither a treatment center nor a medical facility. I am committed to meet with an independent therapist, and to pay for his/her services directly.

I am committed to keep my living quarters clean, neat, and tidy. I agree to dress appropriately. I agree to do my share of a daily rotating schedule of chores. I agree to do my share of a daily rotating schedule of food preparation. I am aware that all these activities are part of a process designed to encourage me to learn and to implement life skills. I will be courteous in my manner when interacting with others. I will also be prompt for and attend all scheduled events.

I clearly understand that to remain at Turning Point, I must remain sober, abstinent and comply with all rules, guidelines and staff directives. I agree to random drug and alcohol screenings, as well as an inspection of my personal belongings at any time.

The consequence for not complying with any of these guidelines is grounds for immediate dismissal and forfeiture of any monies paid to Turning Point.

Applicant's Name: ____

Applicant's Signature: ________________________________ Date:____/____/_______

Guardian's Name: ____

Guardian's Signature: ________________________________ Date:____/____/_______

If you have any questions regarding this agreement or the admissions process in general, please contact us at 203.497-3799 to speak with one of our staff. When complete, please fax to 203.468.8359.

Extended Care Program
Client Financial Policy

The Turning Point Foundation is committed to providing our residents with a safe, secure environment in which to continue their recovery from drug and/or alcohol addiction. This financial policy has been established to avoid any misunderstanding or disagreement concerning payment.

Resident Financial Policies:
- The Turning Point Foundation Extended Care program is available to all males over the age of 17. However, all participants must demonstrate the ability to pay and accept responsibility for payment.
- All parties signing this agreement will assume full financial responsibility for monies owed to Turning Point and 3rd party services providers including therapists and counselors.
- The Extended Care program fee is billed on a 28-day (one month) billing cycle.

Private Pay:
- We are a self-program and do not accept insurance. Clients are expected to pay all fees upon admission unless prior arrangements have been made with us. We may require a non-refundable deposit.
- Outstanding balances are due immediately, unless a prior payment arrangement has been made.

Methods of Payment:
- Payment may be made by personal check or credit card.
- We do not accept post-dated checks.

Resident Account
- Turning Point maintains cash accounts for its resident. Residents may withdraw up to $10.00 per day for incidental items including cigarettes, snacks, toiletries, etc. Residents are expected to maintain a $20.00 minimum balance.

Refunds:
- Due to the nature of the program, dismissal for any reason will automatically result in the forfeiture of any and all monies paid to Turning Point Foundation.
- Should the resident decide to leave prior to completing Phase II, refunds for monies paid will made on a case by case basis and at the discretion of senior management.

Thank you for choosing the Turning Point Foundation. We are here to help you. We firmly believe that our relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to Al Samaras at 203-497-3755.

Guarantor's Name: ____

Guarantor's Signature: ______________________________ Date:____/____/______

Resident's Name: (if different from above):______________________________

Resident's Signature: (if different from above):__________________ Date:____/____/______