LIFEWAYS ADMISSION FORM

Date: _____

Referred From: _____ Referral Phone #: _____

Driver's License / State ID Number (required for DUII): _____ State Issued: _____

Gender: M / F/ Other (*circle one)*

Last Name **First Name** **Middle Initial**

Last Name at Birth (*Required)* **Date of Birth** **Social Security Number**

Address:

Physical Address City State Zip Code

Mailing Address (*if different*) County of Residence

Home Phone (*000*) *000-0000* Cell / Message Phone Work Phone

Highest Grade Completed _____

Emergency Contact Name: _____ **Emergency Phone: _____**

Medical Doctor Name (PCP): _____ Phone: _____

Dentist Name: _____ Phone: _____

Financially Responsible Party: (*fill out if different from client or if client is a minor*)

Last Name First Name DOB Social Security #

Mailing Address City State Zip Code

Phone (*if different than client's phone*) _____

Are you interested in registering to vote? Yes ___ No ___ *(Response Requested)*

Interpreter: ☐ Foreign Language ☐ Hearing Impaired ☐ None

Source of Income: ☐ Wages/Salary ☐ None ☐ Public Assistance ☐ Retirement/Pension/SSI

☐ Disability/SSDI ☐ Unknown ☐ Other _____

Gross Household Monthly Income: _____

Number of Dependents: ***(List the Number of dependents supported by monthly income)***

_____ # of Child Dependents (Age 0 – 17) _____ Total # in Household (Including yourself)

Veteran:
☐ Yes, Veteran and not specified Branch of Service
☐ Yes, Veteran and Current or Former Active Duty Military
☐ Yes, Veteran and Current or Former Guard/Reserve Military
☐ No, but Current or Former Guard/Reserve Military
☐ No ☐ Unknown

Marital Status:

- ☐ Never Married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Unknown

Race:

- ☐ Alaskan native
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Other Single Race
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White (Non-Hispanic)
- ☐ Two or More Unspecified Race

Ethnicity:

- ☐ Cuban
- ☐ Hispanic
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Specific Origin Not Specified
- ☐ Not of Hispanic Origin
- ☐ Unknown

Living Arrangements:

- ☐ Alcohol and Drug Free Housing
- ☐ Foster Home
- ☐ Jail
- ☐ Oxford Home
- ☐ Prison
- ☐ Private Residence(at home)
- ☐ Private Residence (with relative)
- ☐ Private Residence (with non-relative)
- ☐ Other Private Residence
- ☐ Residential Facility (BRS)
- ☐ Residential Facility (CSEC)
- ☐ Residential Facility (PRTS)
- ☐ Residential Facility (SCIP/SAIP)
- ☐ Secured Residential Facility (SRTF)
- ☐ Residential Facility (RTF for YAT)
- ☐ Residential Facility (SUD)
- ☐ Residential Facility (SRTF for YAT)
- ☐ Residential Sub-Acute Care Facility
- ☐ Residential Facility
- ☐ Room and Board
- ☐ Supported Housing
- ☐ Supportive Housing (congregate setting)
- ☐ Supportive Housing (scattered setting)
- ☐ Transient/Homeless
- ☐ Unknown

Competitive Employment:

- ☐ Full Time (35 hrs/wk or more)
- ☐ Part Time (less than 35 hrs/wk)
- ☐ Unemployed (looking or layoff)
- ☐ Student
- ☐ Homemaker
- ☐ Retired
- ☐ Disabled (unable to work for physical or psychological reasons)
- ☐ Other Reported Classification (e.g., volunteers)
- ☐ Sheltered / Non-Competitive/Subsidized Employment (e.g., WITCO)
- ☐ Not in Labor Force (not actively looking for work)
- ☐ Unknown

Employer Name: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Tribal Affiliation:

- ☐ Burns Paiute Tribe
- ☐ Confederated Tribes of Coos, Lower Umpqua & Siuslaw
- ☐ Confederated Tribes of Grand Ronde
- ☐ Confederated Tribes of the Siletz
- ☐ Confederated Tribes of the Umatilla
- ☐ Confederated Tribes of Warm Springs
- ☐ Coquille Indian Tribe
- ☐ Cow Creek Band of Umpqua Indians
- ☐ Klamath Tribes
- ☐ Not Applicable
- ☐ Other

Additional Information:

Pregnant? ☐ Yes ☐ No ☐ Not Applicable ☐ Unknown

Tobacco use? ☐ Yes ☐ No

Substance use during last 90-days? ☐ Yes ☐ No

Arrests *(Substance Use & Prevention Clients only)*

Number of Arrests in Past Month _____ Number of Arrests in Lifetime: _____

Number of DUII Arrests in Past Month _____ Number of DUII Arrests in Lifetime: _____

Legal Status:

- ☐ Parole
- ☐ Probation
- ☐ Psychiatric Security Review Board (PSRB)
- ☐ Juvenile Psychiatric Security Review Board (JPSRB)
- ☐ Guardianship (Court)
- ☐ Guardianship (Child Welfare)
- ☐ None
- ☐ Unknown

Other Agencies that are providing services to you: (*select all that apply*)

- ☐ ADES
- ☐ Community Corrections
- ☐ DHS Child Welfare
- ☐ DHS Self Sufficiency
- ☐ Juvenile Department
- ☐ Oregon Youth Authority
- ☐ Public Health Department
- ☐ Lifeways Recovery Center
- ☐ Seniors & People with Disabilities
- ☐ Vocational Rehabilitation
- ☐ Other (specify): _____
- ☐ Substance Abuse Treatment & Prevention Program other than Lifeways (*please specify*): _____
- ☐ Mental Health Treatment Program other than Lifeways (*please specify*) _____

Are you interested in receiving supported employment services?

☐ No ☐ Yes

Are you currently employed or enrolled in school?

☐ No ☐ Yes

Do you have a Declaration of Mental Health Treatment?

☐ Yes ☐ No – I have received a copy of *A Guide to Oregon's Declaration for Mental Health Treatment.*

Is a copy available?

☐ Yes ☐ No

INSURANCE INFORMATION

Primary Payer Type:

☐ Private Insurance/Managed Care Org.	☐ Medicare	☐ Medicaid/OHP
☐ Other (e.g., TRICARE – VA, CHAMPUS)	☐ None	

Primary Insurance:

Insurance Company's Name _____ Phone _____

Address _____ Insurance ID # / Group # _____

Name of Insured Person _____ Relationship _____

Secondary Insurance:

Insurance Company's Name _____ Phone _____

Address _____ Insurance ID # / Group # _____

Name of Insured Person _____ Relationship _____

I authorize the release of any mental health or alcohol and drug treatment information necessary to process insurance claims. Furthermore, I authorize direct payment of health care benefits to Lifeways, Inc., for any service provided. I understand that I am ultimately responsible for all charges whether or not paid by my health insurance or any other payer source, including DHS if I make use of the sliding fee scale.

Guarantor Signature: **X** _____

Acknowledgment of Receipt of Lifeways Client Handbook and Privacy Notice:

By signing below, I acknowledge receipt of the Lifeways' Notice of Privacy Practices in my primary language

☐ Refused

X _____ _____ _____

Signature of Client, Client's Parent, Guardian, or Personal Representative | Date signed | Relationship if not Client

Consent for Use and Disclosure of Protected Health Information:

By signing below, I consent to the use and disclosure of health information about me in order that LIFEWAYS and its employees and contractors may provide treatment to me, obtain payment (for the treatment) from my third party payers (e.g. the Oregon Medicaid program or my HMO) and carry out their health care operations. I specifically authorize their use and disclosure of my health information about treatment of mental illness, HIV/AIDS test results, and alcohol and drug abuse treatment program services (if any) for such treatment, payment and health care operations purposes. I understand that this consent to use and disclose information expires when I terminate treatment and that I may revoke this consent prior to that time, except to the extent to which LIFEWAYS has taken action in reliance upon this consent. However, I also understand that no revocation of this consent is valid with respect to inspection of records necessary to validate expenditures on behalf of governmental entities.

X _____ _____ _____

Signature of Client, Client's Parent, Guardian, or Personal Representative | Date signed | Relationship if not Client