

PASSAGES TO RECOVERY

A division of
Aspen Health Services

APPLICATION FORM

**Aspen Health Services
P.O. Box 379
30 South Main Street
Loa, Utah 84747
(866) 625-8809
(435) 836-1400
Fax (435) 836-2258**

ASPEN HEALTH SERVICES

Student/Sponsor Information:

Date: _____

Name of Person Filling
Out These Forms: _____ Relationship to Student: _____

Address: _____

Telephone Numbers: _____

Student's Name: _____ Student's Date of Birth: _____

Student's Soc. Sec. No.: _____ Grade: _____ Age: _____

Natural Child? _____ Adopted?: _____ If adopted, when? _____

REFERRED TO ASPEN YOUTH SERVICES BY:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AYS Employee | <input type="checkbox"/> Hospital | <input type="checkbox"/> Program | <input type="checkbox"/> EAP |
| <input type="checkbox"/> AYS Call Center | <input type="checkbox"/> Court/Probation | <input type="checkbox"/> Periodical | <input type="checkbox"/> Ed Consultant |
| <input type="checkbox"/> AYS Newsletter | <input type="checkbox"/> Previous Parent | <input type="checkbox"/> Media Advertisement | <input type="checkbox"/> Professional |
| <input type="checkbox"/> Parent Alumni | <input type="checkbox"/> School | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Insurance/MCO |

- Internet – How were you referred to our web site?
 Search (Key word/phrase used): _____
 Another site or link: Name of site: _____
 Other resource as indicated above: Name: _____

Financial Sponsor (to whom bills should be sent):

In case of an emergency - Name, address, telephone number of person(s) to be notified:

Name	Relationship	Address	Telephone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FOR OFFICE USE ONLY: Approved By: _____ Date: _____
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Family information:

Name: _____ Age: __ Relationship to student _____

Address: _____ Home Phone: (____) _____

Occupation: _____ Business Phone: (____) _____

Fax: _____ E-mail: _____

Birth Date: _____ Deceased: _____ If so, date of death: _____

List any major illnesses and emotional, physical or mental problems:

Participating in treatment? Yes ____ No ____ Attending family workshop? Yes ____ No ____

Name: _____ Age: __ Relationship to student _____

Address: _____ Home Phone: (____) _____

Occupation: _____ Business Phone: (____) _____

Fax: _____ E-mail: _____

Birth Date: _____ Deceased: _____ If so, date of death: _____

List any major illnesses and emotional, physical or mental problems:

Participating in treatment? Yes ____ No ____ Attending family workshop? Yes ____ No ____

Name: _____ Age: __ Relationship to student _____

Address: _____ Home Phone: (____) _____

Occupation: _____ Business Phone: (____) _____

Fax: _____ E-mail: _____

Birth Date: _____ Deceased: _____ If so, date of death: _____

List any major illnesses and emotional, physical or mental problems:

Participating in treatment? Yes ____ No ____ Attending family workshop? Yes ____ No ____

Name: _____ Age: __ Relationship to student _____
Address: _____ Home Phone: (____) _____
Occupation: _____ Business Phone: (____) _____
Fax: _____ E-mail: _____
Birth Date: _____ Deceased: _____ If so, date of death: _____
List any major illnesses and emotional, physical or mental problems:

Participating in treatment? Yes _____ No _____ Attending family workshop? Yes _____ No _____

Name: _____ Age: __ Relationship to student _____
Address: _____ Home Phone: (____) _____
Occupation: _____ Business Phone: (____) _____
Fax: _____ E-mail: _____
Birth Date: _____ Deceased: _____ If so, date of death: _____
List any major illnesses and emotional, physical or mental problems:

Participating in treatment? Yes _____ No _____ Attending family workshop? Yes _____ No _____

Name: _____ Age: __ Relationship to student _____
Address: _____ Home Phone: (____) _____
Occupation: _____ Business Phone: (____) _____
Fax: _____ E-mail: _____
Birth Date: _____ Deceased: _____ If so, date of death: _____
List any major illnesses and emotional, physical or mental problems:

Participating in treatment? Yes _____ No _____ Attending family workshop? Yes _____ No _____

Student Information:

What is student's current living arrangement? (With whom? How long?)

Has the student had previous placements outside the home? _____ If YES, please list institutions, treatment center, jail etc.: **Please arrange for a copy of any evaluations or records to be sent to the Admissions Office.**

Placement	Dates	Reason for Admittance	Reason for Leaving
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Siblings: Please list all siblings, including step and half siblings:

Name	Birth Date/Age	Sex	Health	Current Residence
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Please describe the history of the relationship with his/her siblings:

Please describe the student's strengths:

Please describe your family's strengths and/or any existing support systems for the student:

Has the student had any traumatic events (abuse, divorce, death, illness, imprisonment, etc.) or changes in his/her life?
Please explain:

Has the student had any involvement with the legal system? _____ If YES, please describe in detail:

Date: _____ Incident: _____
Date: _____ Incident: _____
Date: _____ Incident: _____

Has the student demonstrated violent behavior? _____ If YES, please describe:

Has the student demonstrated any gang-related behavior? _____ If YES, please describe:

Has the student ever threatened or attempted suicide? _____ If YES, please describe:

Date: _____ Incident: _____
Date: _____ Incident: _____
Date: _____ Incident: _____

Please describe the history of any specific disorder (depression, behavioral, anorexia, etc.) that the student has had and the diagnosis, if known:

Is the student sexually active? Has he/she been involved in any inappropriate sexual behaviors?

Describe any recent changes in behavior and/or mood (sad, anxious, withdrawn, angry, aggressive, suspicious, excited, other)? Yes _____ No _____ if YES, explain when this change occurred:

Has the student had abnormal thoughts? Yes _____ No _____ if YES, describe:

Does the student hear imaginary voices or see things that are not there? If YES, do voices ever accuse or instruct him/her? Briefly describe:

Please list religious affiliations of the student and family members and whether active or not:

Does the student have any special needs related to gender, age, sexual orientation, culture, religion, nationality, race, or ethnic identity? Yes _____ No _____ if YES, please describe _____

What are the student 's current problems in your opinion? _____

What does the student hope to achieve by enrolling in the program?

Substance Abuse: (past and present, prescription, over the counter, alcohol, illegal drugs)

Drug: _____ Freq./Quantity Consumed: _____ Onset Age: ___ Last Usage: _____ Period of Abstain. _____
Negative Consequences: _____ Sell? Y/N: ___ Signify: Abuse "A" Depend "D" _____

Drug: _____ Freq./Quantity Consumed: _____ Onset Age: ___ Last Usage: _____ Period of Abstain. _____
Negative Consequences: _____ Sell? Y/N: ___ Signify: Abuse "A" Depend "D" _____

Drug: _____ Freq./Quantity Consumed: _____ Onset Age: ___ Last Usage: _____ Period of Abstain. _____
Negative Consequences: _____ Sell? Y/N: ___ Signify: Abuse "A" Depend "D" _____

Drug: _____ Freq./Quantity Consumed: _____ Onset Age: ___ Last Usage: _____ Period of Abstain. _____
Negative Consequences: _____ Sell? Y/N: ___ Signify: Abuse "A" Depend "D" _____

Drug: _____ Freq./Quantity Consumed: _____ Onset Age: ___ Last Usage: _____ Period of Abstain. _____
Negative Consequences: _____ Sell? Y/N: ___ Signify: Abuse "A" Depend "D" _____

Has student ever hidden substances? _____ on their person? _____ Explain in detail:

Psychiatric Treatment Information:

Has the student received psychotherapy or counseling? _____

Please list the name and address of the therapist(s) (psychologist, psychiatrist, etc.) plus frequency of visits and duration of treatments:

Therapist Name and Address	Frequency/Duration	Date of Service
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Education History:

What is the student's highest completed level of education? _____

Does student have learning challenges? _____ If YES, please explain:

Aspen Health Services
STUDENT HEALTH HISTORY

Name: _____ Age: _____ Birth Date: _____ Sex: _____
Height: _____ Weight: _____

Psychiatrist's name: _____

Address: _____

Telephone Number: _____

Physician's name: _____

Address: _____

Telephone Number: _____

Optometrist's name: _____

Address: _____

Telephone Number: _____

Dentist's name: _____

Address: _____

Telephone Number: _____

Orthodontist's name: _____

Address: _____

Telephone Number: _____

Does the student wear contacts or glasses? _____ (If so, attach prescription)

NOTE: Student must have glasses, No contacts in the field.

Date of last dental exam: _____

Does the student wear braces or retainers? _____ If YES, date of last exam: _____

Does the student have any problems with speech or hearing? _____ If YES, please explain:

Has the student ever been in a hospital? _____ If YES, please explain (Include dates):

Date: _____ Details: _____ Date: _____

Details: _____ Date: _____

_____ Details: _____

Has the student ever been involved in a serious accident? _____ If YES, please explain (Include dates):

Has the student ever broken a bone or had a serious injury? _____ If YES please explain (Include dates): _____

Is the student currently on medication? _____ If YES, please give type, dosage and for how long? _____

What current physiological, and /or medical conditions has the student been diagnosed with? _____

Is student allergic to any food or medicine? _____ If YES, please describe:

Does the student have any physical problems or challenges that might impair his/her involvement in the physical aspect of the program? _____ If YES, please explain:

Has the student ever had any of the following diseases, illnesses or problems? **If so, please give dates.**

- | | | |
|-----------------------------------|-----------------------------|---|
| _____ Anemia | _____ Measles, German | _____ Frequent cold/sore throats |
| _____ Anorexia/Bulimia | _____ Measles, Red | _____ Frequent ear infections |
| _____ Arthritis | _____ Mononucleosis | _____ Frequent constipation or diarrhea |
| _____ Bladder or Kidney infection | _____ Mumps | _____ Hepatitis Type A-B-C |
| _____ Bone conditions | _____ Muscle weakness | _____ High blood pressure |
| _____ Chicken Pox | _____ Obesity | _____ Scoliosis |
| _____ Convulsions or seizures | _____ Pneumonia, Bronchitis | _____ Cancer, type and when treated? |
| _____ Dermatitis, Eczema | _____ Polio | _____ Ulcers |
| _____ Diabetes | _____ Rheumatic Fever | _____ Venereal Disease |
| _____ Epilepsy | _____ Scarlet Fever | _____ Whooping Cough |

Aspen Health Services Corporation

ASSIGNMENT OF INSURANCE BENEFITS

PATIENT NAME: _____ ADMIT DATE: _____

INSURANCE COMPANY _____

ADDRESS OF INSURANCE COMPANY _____

TELEPHONE NUMBER OF INSURANCE COMPANY _____

GROUP # _____ POLICY _____

INSURED NAME _____ INSURED SS# _____

INSURED EMPLOYER _____

For the purpose of paying all or part of monies owing to ASPEN HEALTH SERVICES for services it has or will render to the above patient, the undersigned hereby irrevocably assigns to ASPEN HEALTH SERVICES any benefit payments payable for the benefit of said patient by the above insurance company or companies and all rights and interest in said policy but only to the extent necessary to pay ASPEN HEALTH SERVICES in full. Undersigned hereby grants to ASPEN HEALTH SERVICES the right to bill the above insurance company at retail or at the contract rate. Undersigned acknowledges and agrees, however, that ASPEN HEALTH SERVICES is not obligated or required to bill the insurance company, and may choose to bill the undersigned directly notwithstanding any insurance coverage that may exist. Undersigned agrees to remain liable to pay the full amount of all monies billed by ASPEN HEALTH SERVICES as a result of rendering services to the above-mentioned patient and undersigned's liability will only be reduced by the amount of benefit payments received by ASPEN HEALTH SERVICES from the above referenced insurer. Notwithstanding the above, undersigned's liability will not be reduced until ASPEN HEALTH SERVICES has collected its full retail or contract rate. Undersigned understands that the nature of patient's disability may be such that no benefit payments will be payable under the policy specified above. ASPEN HEALTH SERVICES verifies insurance as a courtesy to the undersigned, and is not responsible for any misinformation received from the insurance company regarding benefits. It is the responsibility of the insured to understand his/her benefits and allowable coverage under the policy. ASPEN HEALTH SERVICES may bill the insurance company as a courtesy only. To the extent necessary to determine liability for payment and to obtain reimbursement, the undersigned authorizes ASPEN HEALTH SERVICES to disclose information from the treatment received to persons or corporations that may be liable for all or any portion of the facility's charges, including but not limited to insurance companies, health plans and Workers' Compensation carriers. Such information may include psychiatric evaluations, diagnoses, history and physical examination reports, program notes, physicians' orders and laboratory results, as well as school information. Such records may contain psychiatric or substance abuse information. Any monies owing by the undersigned under the terms of this Agreement shall be paid in full within thirty (30) days after billing by ASPEN HEALTH SERVICES unless other arrangements have been made. In the event that collection efforts are undertaken by ASPEN HEALTH SERVICES to enforce any of the terms of this Agreement, all expenses associated therewith, including attorneys' fees, will be paid by the undersigned. The undersigned acknowledges that he or she is entitled to receive a copy of this assignment/authorization.

DATE

POLICY HOLDER AND/OR PARENT

Please attach a photocopy of the student's medical insurance card in case of necessity.

CONTINUUM OF CARE AGREEMENT

In order to ensure optimum success of the program, it is necessary that families be involved in the processes of learning, writing, communicating and counseling.

We require that families commit to the following activities while the student is in our program:

1. Receive counseling from local therapist if recommended
2. Provide name, address and telephone number of local therapist/sponsor/addiction counselor so the Aspen staff can coordinate treatment with him/her
3. Complete family education assignments
4. Be available for teleconference with Aspen staff
5. Participate in the 2-day graduation workshop held at the end of the program
6. Continue family counseling and/or attendance in community-based support groups following completion of the Aspen program.

Commitment to the above responsibilities is necessary for successful family reintegration after student completes the Aspen program.

HOME THERAPIST/ SPONSOR/ ADDICTION COUNSELOR INFORMATION:

Name: _____

Address: _____

Phone: _____

E-mail address: _____

By signing this form, the student/sponsor commits to the foregoing, and grants a release of information allowing Aspen staff to communicate with therapist identified above.

Student: _____

Date: _____

Sponsor: _____

Date: _____

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENT, that I _____ hereafter known as the "Participant"), do hereby certify to Aspen Health Services, which owns and operates the program known as Passages To Recovery, that I hereby execute this Power of Attorney for the purpose of providing educational, therapeutic and clinical services in connection with the Passages to Recovery Program (hereinafter known as the "Program").

Without limiting or qualifying the general Power of Attorney granted and delegated by Participant to Aspen in the paragraph above, Participant specifically grants to Aspen the following powers:

1. To provide or obtain all medical, dental, psychiatric treatment and hospital care, and to authorize a physician to perform any and all procedures that may appear to be medically necessary for my well being;
2. To physically restrain me should I become a danger to myself or to anyone else, as deemed necessary by Aspen;
3. To allow me to participate in all activities that may risk physical injury or illness, as outlined in Aspen's Enrollment Agreement and Program Description, and
4. To search my person and personal effects at any time as Aspen Health Services in its discretion deems appropriate, and seize and confiscate any items deemed by Aspen to be contraband or counterproductive to any successful completion of the Program. The search of my person may require me to remove all of my clothing and may include a "strip search" of all or any portions of my body, including cavities in which contraband could be hidden.
5. To restrict my access to telephone calls, visitors and delivered materials.

This Power of Attorney shall be effective from date of arrival, beginning _____, 20 ____ and ending upon my completion of the Program, unless terminated by my withdrawal from the Program prior thereto.

I have executed this Power of Attorney on this _____ day of _____, 20 ____.

I declare under penalty of perjury that the foregoing is true and correct.

Signature of Participant

Home Address

Date of Birth

Driver's License Number

PHARMACY/ CLINIC FORM

In the event that a prescription is needed for an individual staying at an Aspen Health Services program, the following information will greatly help the pharmacy staff.

Name of the student _____ (please print)

Student's date of birth _____

Does the student's current medical insurance have prescription coverage? _____

Name of the insurance carrier _____

Name of cardholder on the insurance _____

Cardholder identification number _____

Group number on insurance card _____

Telephone number of the insurance company (Usually on back of insurance card)

() _____

Person Code of the student (i.e. cardholder is 01, spouse 02, 1st child 03, 2nd child 04, etc.)

Please list all allergies to any medications, prescription or over the counter.

Please list all current medications and the indications for which it was prescribed for. (Over the counter and prescription)

We will do our best to process the prescription under your insurance, but please understand that some insurance companies do not contract with all pharmacies. **Therefore we require that you submit a credit card number to cover any expenses that may incur for medical reasons.** You will remain fully liable for any amounts not paid by your insurance. **Please also enclose a copy of the current insurance card(s), to help us serve you better.**

I authorize Aspen Health Services to use my credit/debit card for services rendered to _____ In the amount of _____

The credit card number is _____.

The credit card is (Visa or MasterCard only please) _____

Expiration Date: _____

I/We agree that a photocopy and/or facsimile of this authorization will be as valid as the original.

Signature

Date

Thank You