Blueprints For Recovery

Application for Admission

P.O. Box 10878 • Prescott, AZ 86304 • (888) 391.9772

www.BlueprintsforRecovery.com

Upon completion of application, please fax to (928) 441.2444
Application Instructions

We appreciate, value, and welcome your interest in Blueprints for Recover as well as beginning the recovery process.

Please complete the following application as thoroughly and honestly as possible. The information presented will help us in determining the appropriateness of our program for the applicant. Should the applicant be accepted and admitted, the accuracy of the information in each section will assist us in effectively understanding and helping the applicant with their recovery process.

Admission Requirements and Criteria

Blueprints for Recovery is not a medical facility. In the event that the applicant is not medically appropriate for admission, Blueprints for Recovery will require the applicant to enroll in a medical detoxification program. We will help facilitate an appropriate referral. Blueprints for Recovery does not accept any responsibility for the transportation, monitoring, or making arrangements for the applicants medical care but we are here to help you with that process.

Blueprints for Recovery is a voluntary program that challenges young men to participate in their recovery process. We are committed to this process and in creating a safe environment for the applicant to flourish in their recovery.

Additionally, it is understood that if the applicant is unwilling to participate, refuses to engage in the curriculum, or recalcitrant at any time during their tenure, Blueprints for Recovery reserves the right to immediately discharge the participant. In that situation, we assume no responsibility for the transportation, monitoring, or making arrangements for transfer to another facility.

Upon completion of the application, please fax to (928) 277-4349 for review.
Applicant’s Information

First Name: __________________________   Last Name: _____________________________
Address: ___________________________   Phone Number: __________________________
City: ___________________________   State: ________   Zip: ___________________
Date of Birth: ________________________
Cell phone: _____________   E-mail address: ________________________

Financial Sponsor Information

Full Name: ________________________________   Relationship: ____________________
Agency/Organization (if applicable): ____________________________________________
Address: ___________________________   Phone Number: _________________________
City: ___________________________   State: ________   Zip: ____________________
Work Number: ________________________   Fax: ______________________________
Cell Phone: __________________________   E-mail address: ________________________
Date of Birth: ________________________

Father’s Information

Full Name: ________________________________   Relationship: ____________________
Address: ___________________________   Phone Number: _________________________
City: ___________________________   State: ________   Zip: ____________________
Work Number: ________________________   Fax: ______________________________
Cell Phone: __________________________   E-mail address: ________________________
Date of Birth: ________________________

Mother’s Information

Full Name: ________________________________   Relationship: ____________________
Address: ___________________________   Phone Number: _________________________
City: ___________________________   State: ________   Zip: ____________________
Work Number: ________________________   Fax: ______________________________
Cell Phone: __________________________   E-mail address: ________________________
Date of Birth: ________________________
Referral Source Information

How did you first come to hear about Blueprints for Recovery?

____________________________________________________________________________________________

If you found Blueprints for Recovery on the internet, please list key words/phrases that you used to find us:

____________________________________________________________________________________________

Please tell us of any specific person who referred you to us.

_____ Please initial here if we have your permission to contact this person.

Name of Referral Source: _____________________________________________

Their Relationship to you: _____________________________________________

Address: _________________________________   City:   State:   Zip:   

Telephone: ______________________________   E-mail address: _______________________________________

Emergency Contact Information (if other than applicant’s parent(s))

Full Name: _________________________________

Relationship to the applicant: _____________________________________________

Address: _________________________________   Phone Number: _________________________________

City:   State:   Zip: _________________________________

Work Number: _________________________________   Fax: _________________________________

Cell Phone: _________________________________   E-mail address: _________________________________

Date of Birth: _________________________________
Therapeutic and Medical History

Applicant’s Name: _____________________________

Professional Involvements (Use additional pages if necessary)

Please list all mental health professionals and treatment programs that the applicant has been involved with. Please indicate those professionals and/or organizations that ongoing involvement with the applicant and/or family is required.

Full Name: _____________________________ Update: ___ Yes ___ No

Program Name (if applicable): ____________________________________________________

Types of services: ______________________________________________________________

Date of Service: _______________________

Address: _____________________________ Phone Number: _____________________________

City: _____________________________ State: _______ Zip: _____________________________

Work Number: __________________________ Fax: _____________________________

Cell Phone: __________________________ E-mail address: _____________________________

Date of Birth: ________________________

Full Name: _____________________________ Update: ___ Yes ___ No

Program Name (if applicable): ____________________________________________________

Types of services: ______________________________________________________________

Date of Service: _______________________

Address: _____________________________ Phone Number: _____________________________

City: _____________________________ State: _______ Zip: _____________________________

Work Number: __________________________ Fax: _____________________________

Cell Phone: __________________________ E-mail address: _____________________________

Date of Birth: ________________________

Full Name: _____________________________ Update: ___ Yes ___ No

Program Name (if applicable): ____________________________________________________

Types of services: ______________________________________________________________

Date of Service: _______________________

Address: _____________________________ Phone Number: _____________________________

City: _____________________________ State: _______ Zip: _____________________________

Work Number: __________________________ Fax: _____________________________

Cell Phone: __________________________ E-mail address: _____________________________

Date of Birth: ________________________
Comments:
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**Significant Medical History**

Does the applicant currently have any medical or physical limitations or diagnoses? _____ Yes _____ No
If yes, what?
__________________________________________________________________________________________
__________________________________________________________________________________________

Is the applicant on a special or restricted diet for medical or personal reasons? _____ Yes _____ No
If yes, what?
__________________________________________________________________________________________
__________________________________________________________________________________________

Does the applicant have any allergies? _____ Yes _____ No
If yes, what?
__________________________________________________________________________________________
__________________________________________________________________________________________

History of surgeries/broken bones?
If yes, what?
__________________________________________________________________________________________
__________________________________________________________________________________________

Has the applicant ever been hospitalized other than for the previously mentioned?
If yes, what?
__________________________________________________________________________________________
__________________________________________________________________________________________
**Addiction**

Please tell us about applicant’s addiction: (drug of choice, frequency of use, length of time using)

_________________________________________________________________________________________________
_________________________________________________________________________________________________
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**Medications**

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Date Prescribed</th>
<th>Dosage/Schedule</th>
<th>Reason for Medication</th>
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</thead>
<tbody>
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Are you in agreement with current medication related to diagnoses? ______ Yes ______ No

Comments:
_________________________________________________________________________________________________
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**Emotional/Mental Health Inventory**

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

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Date Given</th>
<th>Name of Professional</th>
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<tbody>
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</tbody>
</table>
Please check any that apply to the applicant:

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Check if applicable</th>
<th>Behavior</th>
<th>Check if applicable</th>
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</thead>
<tbody>
<tr>
<td>Depression</td>
<td></td>
<td>Running away</td>
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<tr>
<td>Anxiety</td>
<td></td>
<td>Death of a family member</td>
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<tr>
<td>Hearing Voices</td>
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<td>Death of a friend</td>
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<tr>
<td>Cruelty to animals</td>
<td></td>
<td>Arrested/on probation</td>
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<tr>
<td>Arson/fire setting</td>
<td></td>
<td>Violence towards others</td>
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<tr>
<td>Psychiatric hospitalization</td>
<td></td>
<td>Suicide threat or attempt</td>
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</tbody>
</table>

For any that were checked as applicable, please provide an explanation:

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
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__________________________________________________________________________________________________

**Legal History:**

Has the applicant ever been arrested? If yes please provide an explanation.

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Does the applicant have any pending charges or legal concerns? If yes, explain.

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

If applicable, please answer the following:

Name of Probation Officer: __________________________ Phone Number: __________________________

Name of Attorney: _________________________________ Phone Number: _______________________________
Other Relevant Information:

With whom is the applicant living with most recently?_____________________________________

Does the applicant have children? ___________________________________________________

Is the applicant adopted? _____________________________________________________________

If adopted? Age when adopted: ____________ Has the applicant met biological parents: ______________________

Please explain the applicant’s academic history (highest grade completion, performance, areas of interest or study):

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please explain the applicant’s work history (places of employment, performance, areas of interest, skills, etc.):

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Is there anything else that we should know about the applicant?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

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