FOUR WINDS
Behavioral Health

REQUEST FOR SERVICES

APPLICANT INFORMATION

Treatment Episode Duration (please check all that apply)

☐ **90 Days Treatment**	☐ **Onsite Treatment (Intensive Out Patient)**
☐ **6 months Treatment**	☐ **Day Treatment (Out Patient)**

NAME:			
Date of birth:	Age:	SSN:	E-Mail:
Phone (Home):	Phone (Cell):	Phone (Other):	
Current address:			
City:	State:		ZIP Code:
Gender: Male ☐	Female ☐		

REFERRING AGENCY

☐ ***New Intake***	☐ ***Voluntary***
☐ ***Re-admission***	☐ ***Court Ordered***

Referring Agency:
(Probation/Parole, Court Compliance, CYFD, etc.)

If yes, please provide agency contact information:

Phone #:_____ Email:_____ Fax:_____

Phone #:_____ Email:_____ Fax:_____

Phone #:_____ Email:_____ Fax:_____

EMERGENCY CONTACT

NAME:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		

REASON FOR SEEKING TREATMENT

Substance (s) of choice:
Date of last use:

4100 Barbara Loop SE
Rio Rancho, NM 87124
info@fwbh.org
www.fourwindshealthcenter.org
Phone 505.702.8547
Fax 505.796.5551

FOUR WINDS
Behavioral Health

REQUEST FOR SERVICES		
MEDICAL HISTORY		
Conditions:		
Medications:		
Dosages:		
Times Taken per Day:		
MEDICAL INSURANCE		
Insurance Company:		
Address:		Phone:
City:	State:	ZIP Code:
Insurance ID #:	Group ID #:	
CRIMINAL OFFENSE HISTORY		
Have you been convicted of a felony? Yes ☐ No ☐		
If yes, explain:		
Have you been convicted of a misdemeanor? Yes ☐ No ☐		
If yes, explain:		
Do you currently have any pending charges? Yes ☐ No ☐		
If yes, explain:		
By signing below, I certify all information is true and correct to the best of my ability and grant permission for Four Winds Behavioral Health to contact Probation/Parole/Court Officer if necessary.		
Applicant Signature:	**Date:**	

CLINICAL DIRECTOR ONLY	
APPROVED:	DECLINED:
CLINICAL DIRECTOR SIGNATURE:	DATE:

FOUR WINDS BEHAVIORAL HEALTH

Acknowledgment of Approved and Prohibited Items

It is the policy of FWBH that <u>any</u> prohibited items are not allowed on property at any time without written approval by the Executive Director. Prior to admission, a thorough search of your person and property will be conducted. Possession of any of the prohibited items may result in revocation of your application and intake status or offer. Possession of any prohibited items after the intake process is completed may result in your immediate discharge from the facility.

<u>Approved Items Allowed Upon Intake</u>

- Pants/Jeans (up to 10)
- Sweat Pants (up to 10)
- Sweat Shirts (up to 10)
- Shirts(up to 10)
- Shoes (up to 3)
- Underwear(up to 10)
- Bras (up to 10)
- Socks (up to 10)
- Jackets/light sweater
- Shower Shoes (1)
- Slippers (1)
- Pajamas (up to 3)
- Robe (1)
- Belts (1)
- Hats (2)
- Towels (5)
- Washcloths (5)
- Undershirts (7)
- Musical Instruments - Ex: Drums (1-2)
- Art Supplies
- 30 day supply of all current medication and medical supplies.

<u>Starter Kit (Must be brought within 36 hours of Admission)</u>

***Once starter kit has been exhausted you will need to purchase additional items from FWBH onsite store.*

- Basic Hygiene Items- Shampoo, Conditioner, Soap, Guarded Razors, Shaving Cream, and Feminine hygiene products.
- Laundry Detergent
- One carton of cigarettes.

<u>Non Approved Items</u>

- No Outside Food or Drinks
- Cell Phones/Electronics (Confiscated for first 30 days of Treatment)
- Nail Polish/Polish Remover
- Hairspray
- Perfume
- Coconut Oil
- Straight Razors
- Sharpie Markers
- Bandanas
- DVD Players/Portable DVD Players
- Gaming Console, Fire Stick, Roku, Google TV, or any media streaming devices.
- Sexually oriented materials and/or products.
- Essential Oils
- Power Strips/3 Way Connectors
- Guns/Ammunition/Knives
- Pepper Spray
- Stun Gun/Tasers
- Multi Use Tools (Leatherman)
- Any item fashioned as a weapon

Acknowledgement Signature:_____ **Date:**_____

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Rio Rancho, NM 87124

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AUTHORIZATION
RELEASE/EXCHANGE OF INFORMATION

CLIENT NAME: _____ CLIENT DOB: _____ CLIENT ID: _____

I hereby request and authorize Four Winds Behavioral Health to ☐ **release information to** ☐ **receive information from** _____ for the express purpose of aiding and collaboration and coordination of services OR (list other specific reason): _____

I authorize release or exchange of the following information:
(Please INITIAL all that apply)

_____ **Complete Assessment/Evaluation**[1]
_____ **Diagnosis**
_____ **Medication Management Information**
_____ **Appointment Date/Times (Schedule)**
_____ **Treatment Plan**
_____ **Summary of Progress**
_____ **Attendance/Participation Records**

_____ **Screening/Assessment Tools used in Treatment**
_____ **Educational Information about Program**
_____ **Complete Medical Record**
_____ **Toxicological Reports/Drug Screens**
_____ **Transfer/Referral/Discharge Information**

_____ **Other Information (describe below)**

_____

_____

Redisclosure: I understand that Four Winds Behavioral Health cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I can revoke authorization at any time and for any reason.
I understand that my authorization will automatically expire one year from the date of my signature unless I request it be revoked earlier. (see below)

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

I, _____ hereby immediately revoke this and any other previous authorizations to disclose my protected health information to the individual or agency named above.

_____ _____
Signature of Client Date

[1] Includes Mental Health and Substance Use Assessment

This form cannot be used for the re-release of confidential information provided to Four Winds Behavioral Health by other individuals or agencies. Such requests should be referred to the original individual or agency.