



## PROGRAM APPLICATION

The Empowerment Center (TEC) provides a residential program that requires a ***mandatory 5 month*** client commitment, with a 60 day blackout. During blackout you are required to remain on campus and may not possess a cell phone or other personal electronics. The program combines a strong 12-step recovery component with an Outpatient Treatment component. This program is for ***women only*** who are **sincerely** dedicated to achieving and maintaining a clean and sober productive lifestyle.

Your entry into TEC program indicates that you agree to:

- Complete 5-month (150 day) program - Including Blackout & finding a job
- Actively participate in all treatment requirements - Groups & 1:1 counseling
- Actively work a 12-step recovery program - Outside meetings & finding a sponsor
- Provide a current TB test result

TEC does not serve individuals who have been convicted of a sexual offense, a violent crime, a crime against minors, or a crime against seniors.

Every section of this application must be completely filled out. ***Incomplete applications will not be considered.***

Please write/print legibly.

## DEMOGRAPHICS

Name	Date
Current Address	NDOC#
City, State, Zip	Referral Source
Date of Birth (month/day/year)	Phone#
Social Security Number	Veteran? Yes No Status _____
State Issued ID: Yes No If yes, ID# _____	
Marital Status: Never Married Married Partnered Divorced Widowed	
Ethnicity: Hispanic / Latino Not Hispanic / Latino	
Race: American Indian / Alaskan Native Black / African American Asian Native Hawaiian Pacific Islander White	
Language: English Spanish Other _____	

## DEMOGRAPHICS (cont.)

### Emergency Contact

Name	Phone#
Address	Relationship

### Spouse

Name	Phone#
Address	

### Employment

Name of last employer	Start date	End Date				
Did you have insurance through your employer?	Yes	No				
Name of insurance company						
Address						
Primary policy holder	Self	Spouse	Parent	Partner	Group#	Policy ID#

### Education

What is your highest level of education?
If you have special training, a degree or certification, what field?

### Financial / Insurance / Benefits

Do you have an income?	Yes	No	If yes, specify monthly income
------------------------	-----	----	--------------------------------

### Cash Income

Unemployment	SSI/SSDI	TANF	Child Support	Retirement	Spouse Support	Veteran Pension
Veterans Disability	Other	_____				

### Non-Cash Benefits

TANF	WIC	Section 8	Rental Assistance	VA Medical Support	Tribal Support	Medicaid	Medicare
Other	_____						

### Do you have State Issued Insurance?

Medicaid – ID#	Medicare – ID#
SilverSummit – ID#	Health Plan of Nevada – ID#
Molina Healthcare – ID#	Anthem – ID#

# CRIMINAL HISTORY

Do you have a criminal history?    Yes    No

If yes, please provide ALL past and current criminal charges. A criminal history does NOT exclude you from entry into TEC program. Your accurate information will help us to understand your current situation and any additional services you may need.

Crime Convicted of (List current first)	Date of Conviction (Month/Year)	Sentence

Currently incarcerated    Yes    No                      Name of facility

PED    MPR    EXP

Currently under supervision of a Specialty Court?    Yes    No

If yes, Specialty Court                                      Case Manager    Phone#

Have you been convicted of a violent offense, offense against a minor/senior, or a sexual offense?    Yes    No

If yes, please explain in detail, use additional sheets if necessary.

If incarcerated, have you had any write-ups/disciplinary actions in the past 2 years?    Yes    No

If yes, what were they for? What was each infraction? Use additional sheets if necessary.

What was your role in the crime(s) for which you were convicted?

## CRIMINAL HISTORY (cont.)

Do you have any other criminal issues that have not yet been resolved that may come up during your time at TEC?	Yes	No

## MENTAL HEALTH / SUBSTANCE USE HISTORY

Your health information is confidential. It will not be released without your signed consent in accordance with federal law. Accurate information will help us to understand your current situation and additional services you may need.

NOTE: If you have had a drug/alcohol evaluation in the past 12-months, please submit a copy with your application if available. If you do not have a copy, please sign the release of information at the end of the application.

### Mental Health History

Are you currently under the care of a Mental Health Professional? (Psychiatrist, Psychologist, Therapist or Counselor)	Yes	No				
If yes, Agency/Provider Name						
Have you every had a Mental Health or Substance Evaluation?	Yes	No				
If yes, when?	Agency/Provider Name					
Have you been diagnosed with the following? (Check all that apply)						
ADHD	Alcohol Use Disorder	Anger/Irritability	Anorexia/Bulimia	Anxiety	Autism	Bipolar Disorder
Borderline Personality Disorder	Cocaine Disorder	Cannabis Disorder	Depression	Dysgraphia	Dyslexia	
Insomnia Disorder	Methamphetamine DO	OCD	Opioid Disorder	PTSD	Schizoaffective	Schizophrenia
Other _____	Other _____		Other _____			
Other _____	Other _____		Other _____			
Have you ever been hospitalized for suicide attempt/suicidal ideations?	Yes	No	If yes, How many times?			
Name(s) of hospital(s)						
Date(s) of hospitalization(s)						
Have you ever been admitted to a hospital or psychiatric facility for a mental health crisis?	Yes	No				
If yes, name of facilities / hospital(s)						
How many times?	Date(s) of admission					
Have you attended or completed any substance use/mental health rehabilitation programs? (Examples: New Frontier, Step II, Bristlecone, RBH etc.)						
	Yes	No				
Program	Completed	Yes	No	Date		
Program	Completed	Yes	No	Date		
Program	Completed	Yes	No	Date		
Program	Completed	Yes	No	Date		

## MENTAL HEALTH / SUBSTANCE USE HISTORY (cont.)

### Substance

Please check past illicit substance use including past prescription medication used that was not prescribed to you.

Adderall	Alcohol	Cannabis	Cocaine	Ecstasy	Fentanyl	Heroin	Kratom	LSD	Methamphetamine
Methadone	Morphine	PCP	Percocet	Psilocybin	Suboxone	Vicodin	Xanax	Other _____	
Other _____			Other _____			Other _____			
What is your drug of choice?			Date of last use		Method of use		Frequency		
What is your drug of choice?			Date of last use		Method of use		Frequency		
What is your drug of choice?			Date of last use		Method of use		Frequency		

### Current Psychiatric Medication

Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber

### Past Psychiatric Medication

Abilify	Amitriptyline	Ativan	Buspirone	Cymbalta	Depakote	Doxepin	Effexor	Haldol	Invega
Lamictal	Lexapro	Methadone	Mirtazapine	Olanzapine	Prozac	Ritalin	Risperdal	Seroquel	
Suboxone	Trazodone	Valium	Xanax	Other _____			Other _____		

# MEDICAL HISTORY

Your medical information is confidential. Your personal health information will not be released without your signed consent in accordance with federal law. Your medical information is not considered when determining your eligibility for TEC program. Accurate information will help us to understand your current situation and additional services you may need.

## Medical Conditions

Have you been diagnosed with a medical condition?    Yes    No    If yes, please check all that apply.

Asthma	Bowel/Gastro Conditions	Cancer	Chronic Pain	COPD	Diabetes	Epilepsy	Heart Condition
Hepatitis	HIV	Hypertension	Insomnia	Sleep Apnea	Thyroid Disorder	TBI	Other_____
Other_____	Other_____	Other_____					

Please explain medical condition(s) noted above.

Are you currently under the care of a medical provider?    Yes    No

Physician Name \_\_\_\_\_ Phone# \_\_\_\_\_

Last TB Test \_\_\_\_\_ Are you currently pregnant? \_\_\_\_\_

## Current Medication

Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber
Medication Name	Dose	Frequency	Prescriber

## Pharmacy

Pharmacy Name \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_

## GENERAL

The following two questions provide important information to help us understand who you are, and why you are seeking treatment. If necessary, use additional sheets of paper, be thorough and WRITE LEGIBLY.

**In your own words, why are you seeking services at a recovery program?**

---

---

---

---

---

---

---

---

**What changes do you hope to make as a result of coming into The Empowerment Center?**

---

---

---

---

---

---

---

---

**I hereby state that ALL above information and statements contained in this application are true to the best of my knowledge.**

**Please return this application to:**

Email **\*\*Preferred\*\***  
**admission@empowermentcenternv.org**

In Person or by Mail  
**The Empowerment Center: Admissions**  
**7400 South Virginia St**  
**Reno, NV 89511**

---

**Applicant Name (print)** \_\_\_\_\_ **Date** \_\_\_\_\_ **Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

The Empowerment Center is compassionately dedicated to helping women who suffer from substance abuse to restore their dignity and quality of life. Our nonprofit organization empowers women to build a better future through treatment and workforce development in a safe living environment. We believe in the power of recovery to change outlooks, lives and ultimately our community.



## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone# \_\_\_\_\_

### I Authorize

### To Release To

Name of Agency/Person	Name of Agency/Person <b>The Empowerment Center</b>
Address	Address: <b>7400 S. Virginia Street</b>
City, State, Zip	City, State, Zip <b>Reno, Nevada 89511</b>
Phone# _____ Fax# _____	Phone# <b>(775) 853-5441</b> Fax# <b>(775) 243-4510</b>

### Information that may be released (Initial to authorized release)

Mental Health Evaluation   
  Substance Use Evaluation   
  Psychiatric Evaluation/Treatment Plans   
  Progress Notes  
 Medication Management Records   
  Billing Records   
  Other (specify) \_\_\_\_\_

### Purpose for which information is to be used

Continuing Care   
  School/Vocational Rehabilitation   
  Disability Benefits   
  Legal  
 Personal/Employment Conditions   
  Other (specify) \_\_\_\_\_

This consent expires one year from the date below unless otherwise specified: (not to exceed one year)

### INFORMATION FOR INFORMED CONSENT

This consent expires one year from the date below unless otherwise specified: (not to exceed one year)

#### INFORMATION FOR INFORMED CONSENT

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including Nevada Revised Statutes. These Statutes, Rules and Regulations require that the patient give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations.

**NOTICE OF REDISCLOSURE:** I understand the information and records disclosed pursuant to this consent may be protected under 42 CFR Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and 45 CFR parts 160 and 164, State Confidentiality laws and regulations, and cannot be released without my consent unless otherwise provided for by the regulations. State and Federal regulations prohibit any further disclosure of such information and records without my specific written consent unless otherwise permitted by such regulation.

The information I authorize for release may include records that may indicate the presence of communicable disease, which may include, but is not limited to the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I understand that information used or released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may inspect or copy the information prior to its disclosure, and I may refuse to sign the release. I understand I have the right to withdraw this authorization in writing, at any time.

I, \_\_\_\_\_, the client, am aware of and have been advised of the existing State and Federal Statutes, Rules and Regulations and health information practices. I understand and have been explained my right to confidentiality of the information of these records. I realize this is not a required consent and I must voluntarily and knowingly sign this authorization before any records can be released.

\_\_\_\_\_  
**Client Name (print)**                      **Date**                      **Client Signature**                      **Date**

Revocation: I hereby revoke the above authorization                      \_\_\_\_\_  
 \_\_\_\_\_  
**Client Signature**                      **Date**



# THE EMPOWERMENT CENTER (TEC) CONTRACT FOR RESIDENCY

1. Alcohol/narcotic consumption and gambling are prohibited on or off site as a resident of TEC. Noncompliance will result in immediate discharge.

2. All weapons are strictly forbidden.

3. Residents of TEC agree to random urinalysis and breathalyzer testing.

4. Staff has the right to search your possessions if alcohol, narcotics, weapons, contraband, trafficking or theft is suspected.

5. Theft is not tolerated. Residents are responsible for their own possessions. Living quarters are to be locked when not occupied. TEC is not liable or responsible for missing items.

6. Violence, including all forms of physical, mental, or emotional violence, intimidation, injury, abuse, negligent treatment, maltreatment, or exploitation, including sexual abuse, or harassment is strictly forbidden. This includes, but is not limited to verbal or physical conduct that creates an intimidating, hostile, offensive environment, or sexual in nature directed toward any resident, visitor, staff or volunteer of TEC.

7. TEC is an all-female facility. There are no intimate or sexual relationships allowed among residents, or on property in any form.

8. Smoking is not allowed on property.

9. Residents are required to use the sign in/out sheets when leaving the facility. All fields must be completely filled out, legible, include your full name and your time of departure and anticipated return.

10. All residents are expected to know what phase they are on and comply with all requirements as documented in their phase packets.

11. All residents are required to abide by a 60 day blackout. You may not possess personal electronics of any kind. You may not leave campus w/o TEC staff.

12. All visitors must be approved by TEC staff.

13. Each client is required to complete their phase book monthly as provided in their Resident Handbook. Additional recovery work assigned by their Peer Support and/or Counselor is expected to be completed in the time agreed.

14. In the instance of illness, staff MUST be immediately notified. Residents must disclose to medical personnel that they are in recovery from an addictive disorder and may not be prescribed narcotics. Residents must provide staff with copies of all prescriptions and comply with all medication management policies and safe keeping requirements.

15. Upon discharge, you must remove all your personal belongings. If your property is not removed within seven (7) days it will be considered abandoned. If you are unable to personally remove your property, you may give written authorization for a person of your choosing to retrieve your property.

**VIOLATION OF THIS CONTRACT MAY RESULT IN IMMEDIATE DISMISSAL FROM THE PROGRAM.**

---

Applicant Name (print)

Date

---

Applicant Signature

Date