The EMPOWERMENT CENTER
Supporting MARVEL WAY COMPLEX

PROGRAM APPLICATION

The Empowerment Center (TEC) provides a transitional living program that requires a ***minimum mandatory 5 month*** client commitment, with a 30 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 transitional living 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):	Requested Bed Date:
Social Security Number:	Phone #:
State Issued ID: ◯ Yes ◯ No If yes, ID# _____	Veteran: ◯ Yes ◯ No Status _____
Marital Status: ◯ Never Married ◯ Married ◯ Partnered ◯ Divorced ◯ Widowed	
Sexual Orientation: ◯ Heterosexual ◯ Gay/Lesbian ◯ Bisexual ◯ Other:_____	
Sex at Birth: ◯ Female ◯ Male ◯ Intersex	
Gender Identity: ◯ Women/Female ◯ Man/Male ◯ Trans-Female ◯ Trans-Male ◯ Other:_____	
Ethnicity: ◯ Hispanic / Latino ◯ Not Hispanic / Latino	
Race: ◯ American Indian / Alaskan Native ◯ Black / African ◯ American Asian ◯ Native Hawaiian ◯ Pacific Islander ◯ White	
Language: ◯ English ◯ Spanish ◯ Other: _____	
Current Living Situation: ◯ Homeless (Living on street, in car, etc.) ◯ Emergency Shelter ◯ With family/friends ◯ In Program ◯ Jail/Prison	
◯ Independent Housing ◯ 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#

Health & Medical Screening

Our facility is not a medical or nursing care facility and cannot accommodate individuals with acute medical needs, significant physical limitations, or those requiring specialized care. This packet collects information to ensure our program is a good fit for you. All information provided is confidential and protected under applicable privacy laws.

General Health Status

Do you consider yourself generally healthy and able to live independently without assistance? ◯ Yes ◯ No
If no, please explain:

Can you perform all Activities of Daily Living (ADLs) independently, including bathing, dressing, toileting, eating, and moving around without help? **If no, describe the assistance needed:** ◯ Yes ◯ No

Do you use any mobility aids (e.g., walker, cane, wheelchair)? ◯ Yes ◯ No
If yes, provide details:

Have you fallen or been at risk of falling in the past 12 months? ◯ Yes ◯ No
If yes, provide details (frequency, cause):

Medical History

Do you have any of following medical conditions? ◯ Yes ◯ No
If yes, please check all that apply.

☐ Asthma ☐ Bowel/Gastro Conditions ☐ Cancer ☐ Chronic Pain ☐ Epilepsy ☐ Seizures/Seizure Disorder ☐ Stoke ☐ TBI

☐ Recent Heart Failure (e.g., heart attack) ☐ Heart Condition ☐ High Blood Pressure ☐ COPD ☐ Respiratory Conditions Requiring Oxygen

☐ Memory Problems/Cognitive Problems ☐ Dementia/Alzheimer's/Parkinson's Disease ☐ Sleep Apnea ☐ Insomnia ☐ HIV

☐ Thyroid Disorder ☐ Hepatisis ☐ Diabetes ☐ 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? ◯ Yes ◯ No

Have you been hospitalized or undergone surgery in the past 6months? ◯ Yes ◯ No
If yes, provide details (dates, reasons, recovery status):

Medical History (cont.)

Are you scheduled for surgery or anticipating any major medical procedures in the next 6 months? ◯ Yes ◯ No
If yes, describe:

Specialty Care

Have you been referred to any specialty care providers (e.g., cardiologist/neurologist/pulmonologist) in the past 12 months? ◯ Yes ◯ No

If yes,list the specialty, reason for referral, and current treatment status:
[Example: Cardiologist, high blood pressure, currently on Losartan, or blood pressure stable]

Oxygen or Medical Equipment

Do you require oxygen therapy or other medical equipment (e.g., CPAP, feeding tubes, catheters, etc.)? ◯ Yes ◯ No
If yes, specify equipment and frequency of use:

Do you require a specialized bed (e.g., an extra-large or hospital-style bed) for medical or physical reasons? ◯ Yes ◯ No
If yes, specify the type of bed and reason for need:

Current Medication

Medication Name	Dosage	Frequency	Reason for using	Prescriber
1.)				
2.)				
3.)				
4.)				
5.)				
6.)				
7.)				
8.)				

Pharmacy

Pharmacy Name Phone#

Address

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

Behavioral Health 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.

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 in the past 12 months? ◯ Yes ◯ No
If yes, provide details:

Name(s) of hospital(s)

Date(s) of hospitalization(s)

Do you have a history of substance use (e.g., alcohol, opioids, stimulants, other) that required medical treatment or detoxification in the past 12 months? **If yes, provide details:** Yes ◯ No ◯

If yes, substances used:

Name(s) of hospital(s) Date(s) of admission

Treatment received (e.g., detox, rehab, medication-assisted treatment):

Have you ever experienced complicated withdrawal from drugs or alcohol (e.g., seizures, hallucinations, delirium tremens, hospitalizations)? **If yes, provide details (substance, symptoms, dates, treatments)** ◯ Yes ◯ No

Behavioral Health History (cont.)

Have you attended or completed any substance use/mental health rehabilitation programs? ◯ Yes ◯ No
(Examples: New Frontier, Step II, Bristlecone, RBH etc.)

Program	Completed ◯ Yes ◯ No	Date
Program	Completed ◯ Yes ◯ No	Date
Program	Completed ◯ Yes ◯ No	Date
Program	Completed ◯ Yes ◯ No	Date

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?	Age of first use	Amount	Method	Frequency	Date of last use
1.)					
2.)					
3.)					
4.)					
5.)					

Past Psychiatric Medication

Have you ever taken medications for mental health conditions in the past (e.g., depression, anxiety, bipolar disorder, schizophrenia)?
If yes, list medications, approximate dates, and reasons for discontinuation.
Use the list below to help identify medications you may have taken. If a medication is not listed, write it in the "Other" section.

Antidepressants:
- ☐ Fluoxetine(Prozac)
- ☐ Sertraline (Zoloft)
- ☐ Escitalopram (Lexapro)
- ☐ Citalopram (Celexa)
- ☐ Paroxetine (Paxil)
- ☐ Venlafaxine (Effexor)
- ☐ Duloxetine (Cymbalta)
- ☐ Bupropion (Wellbutrin)

Antipsychotics:
- ☐ Quetiapine (Seroquel)
- ☐ Risperidone (Risperdal)
- ☐ Olanzapine (Zyprexa)
- ☐ Aripiprazole (Abilify)
- ☐ Haloperidol (Haldol)
- ☐ Lurasidone (Latuda)
- ☐ Clozapine (Clozaril)

Mood Stabilizers:
- ☐ Lithium
- ☐ Valproate/Valproic Acid (Depakote)
- ☐ Lamotrigine (Lamictal)
- ☐ Carbamazepine (Tegretol)

Anti-Anxiety:
- ☐ Buspirone (Buspar)
- ☐ Lorazepam (Ativan)
- ☐ Alprazolam (Xanax)
- ☐ Clonazepam (Klonopin)
- ☐ Diazepam (Valium)

Non-Stimulants:
- ☐ Atomoxetine (Strattera)
- ☐ Guanfacine (Intuniv, Tenex)
- ☐ Viloxazine (Qelbree)

Stimulants:
- ☐ Methylphenidate (Ritalin, Concerta)
- ☐ Amphetamine/Dextroamphetamine (Adderall)
- ☐ Lisdexamfetamine (Vyvanse)

Sleep:
- ☐ Mirtazapine (Remeron)
- ☐ Doxepin (Silenor)
- ☐ Zolpidem (Ambien)
- ☐ Eszopiclone (Lunesta)
- ☐ Zaleplon (Sonata)
- ☐ Ramelteon (Rozerem)

Other:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Behavioral Health History (cont.)

For each mental health medication taken in the past please provide the following:
(Example: Lithium | 2023-2024 | Mood | Side effects)

Medication Name	Date Taken	Reason for Use	Reason Stopped
1.)			
2.)			
3.)			
4.)			
5.)			
6.)			
7.)			

Medication Management

Can you manage your medications independently (e.g., read/understand medication instructions, take as prescribed, refill prescriptions)? **If no, describe assistance needed:** Yes ◯ No ◯

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.

I understand that The Empowerment Center is not a medical or nursing facility and cannot accommodate individuals requiring extensive medical care, assistance with daily activities, oxygen therapy, or those with acute medical conditions such as unmanaged severe medical problems, severe mobility issues, or recent/pending surgeries. I certify that the information provided is accurate and complete to the best of my knowledge. I authorize The Empowerment Center to contact my healthcare providers or case managers to verify the information provided, if necessary.

Submission Method	**Delivery Details**
Email *(Preferred)*	admission@empowermentcenternv.org
In Person or By Mail	Admissions, 7400 South Virginia Street, 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.

The Empowerment Center
Supporting Marvel Way Complex

TWO PARTY CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Client Name _____ **Date of Birth** _____ **Phone#** _____

I Authorize	**To Release To**
Name of Agency/Person:_____	Name of Agency/Person **The Empowerment Center**
Address: _____	Address: **7400 S. Virgina Street**
City, State, Zip: _____	City, State, Zip **Reno, Nevada 89511**
Phone #: _____ Fax #:_____	Phone# **(775) 853-5441** Fax# **(775) 243-4510**

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Name of Agency/Person **The Empowerment Center**	Name of Agency/Person:_____
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Information that may be released (Initial to authorized release **or type initials**)

____Mental Health Evaluation ____Substance Use Evaluation ____Psychiatric EvaluationTreatment 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)

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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
Supporting Marvel Way Complex

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_____ Date

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_____	_____	_____	_____
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 client of TEC. Non-compliance will result in immediate discharge.

2. All weapons are strictly forbidden.

3. Clients 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. Clients are responsible for their own possessions. Living quarters are to be locked when not occupied. TEC is not liable or responsible for missing /broken 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 client, visitor, staff, or volunteer of TEC.

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

8. Smoking is not allowed on property.

9. Clients 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 clients are expected to know what phase they are on and comply with all requirements as documented in their phase packets.

11. All clients are required to abide by a 30 day blackout. You may not possess personal electronics of any kind. You may not leave campus without 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 Client Handbook. Additional recovery work assigned by their Therapist, Counselor, or Peer Support is expected to be completed in the time agreed.

14. In the instance of illness, staff MUST be immediately notified. Clients must disclose to medical personnel that they are in recovery from an addictive disorder and may not be prescribed narcotics. Clients 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.

16. As part of your participation in the program, you will be charged a monthly fee of $60.00. This fee helps cover the ongoing services and resources we provide. Once you become employed, the program fee will be adjusted based on a sliding scale according to your monthly income.

I acknowledge that I have received, read, and understood the rules and polcies of TEC. I agree to abide by all stated expectations and understand that any violation of this contract may result in immediate dismissal.

_____	_____	_____	_____
Applicant Name (print)	**Date**	**Applicant Signature**	**Date**