OFFICE USE ONLY
Date of Application: _____
Referring Agency:
_____
Contact Name & Phone #:
_____

HIGH COUNTRY BEHAVIORAL HEALTH
A New Way of Thinking

HCBH
Housing Application

Important: Applications contain sensitive client information and must be submitted via encrypted email to HCBHHousingProgram@hcbh.org. Unencrypted applications will not be reviewed.

Personal Information

First Name: _____ MI _____ Last Name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Mobile Phone: _____

DOB: _____ Age: _____ SSN: _____

Sex: (check one) ☐ Male ☐ Female Sexual Orientation: _____

Veteran: (check one) ☐ Yes ☐ No Wyoming Resident: (check one) ☐ Yes ☐ No

Marital Status: (check one) ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Children: (check one) ☐ Yes ☐ No If yes, list ages: _____

Pregnant: (check one) ☐ Yes ☐ No

Current/Past IV Drug Use: (check one) ☐ Yes ☐ No If yes, date of last IV Use: _____

Court Ordered? (check one) ☐ Yes ☐ No

Emergency Contact: _____ Relationship: _____
Phone number(s): _____ _____

Additional Contact Person: _____ Relationship: _____
Phone number(s): _____ _____

Legally Appointed Payee: (check one) ☐ Yes ☐ No
Payee Name: _____ Email: _____
Phone Number: _____

Guardian: (check one) ☐ Yes ☐ No
Guardian Name: _____ Email: _____
Relationship to the Client: _____ Phone #: _____

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Afton Office: 389 Adams St, PO Box 376, Wyoming 83110 (307-885-9883)
Evanston Office: 190 Overthrust Rd, Wyoming 82930 (307-789-4224)
Kemmerer Office: 821 Sage Ave, Wyoming, 83101 (307-877-4466)
Bridger Valley Office: 14 Mountain St, PO 458, Wyoming 82939 (307-782-3097)
Pinedale Office: 24 Country Club Ln, PO Box 856, Wyoming 82941 (307-367-2111)
Douglas Office: 1841 Madora Ave, Douglas, Wyoming 82633 (307-358-2846)
Thermopolis Office: 121 S 4th St, Wyoming 82443 (307-864-3138)
Thayne Office: 250 VanNoy Parkway, Rm B-125, (307-885-9883)
Idaho Falls Office: 1248 E. 17th St, Idaho, 83404 (208-542-1026)
Pocatello Office: 420 S 4th Ave, Idaho 83201 (208-478-9071)
Rawlins Office: 721 W Maple St, PO Box 1056, Wyoming 82301 (307-324-7156)
Lusk Office: 905 S Main, PO Box 1365, Wyoming 82225 (307-334-3666)

Medical/Health Coverage

Does the client have medical/health insurance? (check one) ☐ Yes ☐ No

Please check one: ☐ **Medicaid** (*Title 19, Equality Care*) ☐ **Medicare** ☐ **Private** ☐ **None**
Please check one: ☐ **SSI** ☐ **SSDI** ☐ **NONE** If you have applied, when: _____

Education/Vocational History:

School/Employment	Dates attended	Degree or Certificate

Legal History

Date	Location	Charge	Disposition

Is the client currently on probation? (check one) ☐ Yes ☐ No

Type of Probation: (check one) ☐ Supervised ☐ Unsupervised

Probation Officer: _____ Phone Number: _____

Medical History:

Current Medical Conditions:

Diagnosis	Diagnosed by	Date of Diagnosis	Medications prescribed

Has the client been prescribed medications for medical reasons that they are not taking? (check one) ☐ Yes ☐ No

Psychological History:

Diagnosis	Diagnosed By	Date of Diagnosis	Medications Prescribed

Has the client been prescribed medications for psychiatric symptoms that they are not taking? (check one) ☐ Yes ☐ No

If the client is taking prescribed medications for any reason, how are/will they pay for them?

Residential History:

Facility Name	Date of Attendance	Nature of Discharge

Chemical Use History:

Substance	Route of Administration	Date of last use

Prior Mental Health/Substance Use Treatment

Date Range	Facility/Provider	Services	Nature of Discharge

History of suicidal thoughts: Last 30 days ☐ Lifetime: ☐ Number of Attempts: _____
If yes, has the client vocalized a current plan? (check one) ☐ Yes ☐ No
If yes, please provide details

History of homicidal thoughts: Last 30 days ☐ Lifetime: ☐ Number of Attempts: _____
If yes, has the client vocalized a current plan? (check one) ☐ Yes ☐ No
If yes, please provide details

Does the client report hearing voices or seeing things other people don't see? (check one) ☐ Yes ☐ No

If yes, please provide details

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ADMISSION CRITERIA:

All persons admitted to either house shall be seriously mentally ill and defined as persons aged 18 or older who have a severe or persistent mental disability which results in a long-term limitation of their capacity to function in primary activities of daily living and are unable to remain in the community without supportive treatment and services of long-term or indefinite duration. Ohana/Solutions House does not discriminate against potential residents based on race, creed, sex, religion, HIV status or sexual orientation.

To expedite your admittance, we've included an HCBH Release of Information (ROI) form with this application. If applicable, please obtain signed ROIs for the referring agency, emergency contact, probation officer, guardians, and payee, and submit them along with your completed application. This will help streamline the process.

Please include the following information with your application, if available:

- Admission Information/Discharge Plan
  (if currently hospitalized or in residential treatment facility)
- Psychosocial Assessments/Testing
- Medical Information Regarding Ongoing Treatments
- Current Medication List
- Clinical/Progress Notes (if hospitalized) from most recent counselor/psychiatrist/psychologist
- SSI/SSDI Application Status, if applicable
- Photocopy of all Identification
- Proof of Insurance
- Legal Documentation for Guardian/Payee
- Brief summary by the client describing what they hope to gain by residing at the Ohana or Solutions House
- All pertinent legal documents regarding convalescent leave, probation/parole status, court orders.

To ensure timely processing of your application for the waitlist or admittance, please submit all required documentation. Kindly note that incomplete applications may result in delays. Even if the client has previously received services from HCBH, please do not assume that we have the documents within our system. A complete application package is necessary for consideration.

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Consent for Use and/or Disclosure of Protected Health Information

1. **AUTHORIZATION:** I hereby authorize the use or disclosure of protected health information about me as described below. I understand that the information to be released and/or requested does not pertain to the exceptions to confidentiality as outlined in 42 CFR Federal confidentiality regulations.

   Client: _____
   (Last Name) (First Name) (Middle Name) (Maiden Name)

   Date of Birth: _____ Client ID#: _____

   Address: _____

   Authorize: [ ] High Country Behavioral Health or [ ] Other: _____

   To exchange information with: _____
   Specific Description of person(s) and/or Organization (*only one entity per form)*

   Phone: _____ Fax: _____ Email: _____

2. **INFORMATION TO BE USED OR DISCLOSED:** (Place initials next to the information to be used or disclosed, not valid unless initialed.)

   ___ Diagnosis
   ___ Results of Psychiatric Testing
   ___ Treatment Planning Information
   ___ Number of un/kept appointments
   ___ All Records generated by HCBH
   ___ Psychiatric Evaluation
   ___ Assessment Information
   ___ Reason for Termination
   ___ Recommendations
   ___ MH/SA Evaluation
   ___ Reproductive Health (pregnancy, etc.)
   ___ Medication(s)
   ___ Communicable Disease Info
   ___ Progress Notes
   ___ Other: _____

3. **PURPOSE OR NEED FOR USE OR DISCLOSURE:** (Place initials next to the information to be used or disclosed, not valid unless initialed.)

   ___ Collaboration with School
   ___ For Client Treatment
   ___ To Comply with Court Order
   ___ Other: _____

4. [ ] This information may be shared by fax, e-mail, telephone, or documents sent by mail.

5. This authorization will expire as noted below. (Place initials next to the information to be used or disclosed, not valid unless initialed.)

   ___ At the end of 60 Days
   ___ 30 days following termination of my treatment or at the end of 1 year, whichever is first
   ___ At the happening of the following date (less than 1 year from date signed): _____

6. I understand that I may revoke this authorization by completing Part 9 below. However, I understand that if I revoke this authorization, it will not have any affect on actions already taken by High Country Behavioral Health in reliance on this authorization.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

8. I understand that my records are protected by federal and state laws and cannot be disclosed without my written permission except as noted in High Country Behavioral Health's Notice of Privacy Practices. I understand that this release also includes any reference to drug and or alcohol treatment as protected by federal law.

Signature of Client or Representative	Date	Witness Signature	Date
Printed Name of Client or Representative	Date	Description of Representative Authority to Act for Client (Relationship)	

DO NOT complete below unless you wish to revoke this authorization.

9. **REVOCATION:** I wish to revoke this authorization.

Signature of Client or Representative	Date	Person witnessing revocation	Date

NOTE: The receiving individual or organization understands that it IS NOT TO RE-RELEASE any of the confidential information received. Once the information is used and/or disclosed by HCBH, it is no longer protected by the federal privacy regulations and may be subject to re-disclosure by the recipient.