ASSESSMENT PACKETS ARE TO BE FAXED OR MAILED TO:

Crossroads Recovery Center

15094 County Barn Rd.

Gulfport, MS 39503

PHONE: 228 863 0091

FAX: 228 864 2241

**If the application is not completed or all documents (I.D., proof of income, proof of residency, or proof of insurance) are not submitted, your application will not be reviewed! **

Prior to admission to Crossroads Recovery Center, all outside affairs that are not directly pertaining to treatment must be resolved; this includes medical, financial, and legal matters. CRC staff will not be required to attend to any business that is not a part of the client's treatment plan. This is to keep the client's focus on his/her recovery. In the event of a medical discharge, the client must wait until the next available bed space is open to return to treatment.

Client Signature: ____

All new admissions are required to be at CRC on time the day of being accepted, unless prior approval has been given by the director. You will have to reschedule your appointment for a later date.

Initial: _______

CRC will not be responsible for paraphernalia which has been deemed inappropriate within this facility.

Initial: _______

CRC will not be responsible for any items left at the center longer than 72 hours after the client is discharged.

Initial: _______

There is a ten-day stabilization period which includes no phone calls or visitation.

Initial: _______

Scheduled Telephone Use

Wednesdays 4:00 pm until 8:30 pm

Saturdays and Sundays: 10 am until 6:00 p.m.

All clients will be allowed one 20-minute phone call on Wednesday, Saturday, and Sunday. If you cannot connect to the individual that you are attempting to call, you must report this fact immediately to the Program Assistant on duty. Clients wishing to use the phone will sign up to use it. We will go down the list until all names are exhausted. Then any clients who could not reach someone on their first attempt may try again. Your therapist will not be able to make personal phone calls for you.

Initial: _____

Visitation Policy:

*Only those immediate family members authorized by the client during the admissions process is allowed for family therapy/visitation.

Initial: ____

Family members may bring money, clothing etc. on visitation day. Any items brought into the facility must be turned into the office first.

Crossroads Recovery Center

A Division of Gulf Coast Mental Health Center

15094 County Barn Road, Gulfport, MS, 39503-4200

To: Prospective Client

From: CRC

Subject: Residential Treatment

Crossroads Recovery Center is a 30- day residential alcohol and drug treatment facility. The program is based on the 12 steps of Alcoholics Anonymous. During your stay here, you will be expected to participate in group and individual therapy, classroom lecture, recreational therapy, meditation exercises, and view educational videos, daily exercise and one group outing per week is to be expected. The therapeutic community attends 12-step meetings (AA/NA) in the area of Harrison County. You will be provided with 12-step work as well as weekly assignments. There will be other activities as well.

The admissions process begins with the completion of the pre-assessment packet (enclosed). Be sure to respond to every question. If you see that a question is not applicable to you, respond with N/A (not applicable) or none so that we will be aware of your understanding of the question. Once completed, you must come to the center for an interview, where we will review it with you. Fill out the assessment completely.

Program cost is assessed at $4,500.00. The assessed fee for treatment is due upon intake in full in the form of a cashiers' check, money order, or may be put on one of the four major credit cards (American Express, MasterCard, Visa, or Discover) and is non-refundable. We also accept Mississippi Medicaid. Upon completion of the application packet and the interview, a bed date will be given, or you will be put on a waiting list.

Required prior to admission: Driver's license or picture ID. Social Security Card.

Proof of income (recent check stub, tax return etc.)

Mississippi Medicaid card if applicable.

Scholarship forms to be filled out before assessment.

Items that you will need to bring to CRC upon entering treatment:

- Towels, washcloths, blankets and pillowcases
- Quarters or $1 bills (for the vending machines)
- Laundry soap and bleach (no tide pods; liquid detergent only)
- Shampoo, conditioner, disposable razors, etc. (no electronical razors; this includes clippers)
- Clothes hangers
- All shoes including flip-flops must be worn with socks
- No TANK-TOPS (shirts must have sleeves)
- Shorts (must be approved by staff and may worn on outings only and leggings must be worn with a long shirt upon approval)
- Washers and dryers are provided and are free to use daily
- You may bring stamps, envelopes, writing utensils, and paper
- ABSOLUTELY NO outside food or drinks
- No electronical devices
- No playing cards or dice games
- No rolling tobacco or snuff (cigarettes are allowed but vapes or juuls are not)
- Automobiles **are not** to be parked in the CRC parking lot (someone must drop you off or pick up your vehicle)

MEDICATION:

Bring your own prescription and over the counter medications.

Prescription Medication must be in bubble wrap. Inhalers must be accompanied with prescription also.

Crossroads Recovery Center is not responsible for the purchase of your medications. Bring enough medication to last you throughout your stay.

Medication is to be turned in to the office upon arrival. Doctor will access medications.

Initial: _____

No Herbal or Performance enhancing products will be allowed. One a Day vitamins are allowed.

Date: ______________

Please answer ALL questions. Give as full a response as possible.

Last Name: ____________________ First Name: ____________________

Middle: ____________________ Maiden Name: ____________________

Social Security # ____________________ Age: _____ D.O.B.: ____________

Driver's License # ____________________ State: _____ Valid: ____Yes ____No

Do you have picture ID? Yes or No Do you have Mississippi Medicaid? Yes or No

If Yes, what is the Medicaid Card Number? ______________________________

Permanent Address: ____________________________________

City: ______________________ State: _____ Zip: __________

County: ____________________

Place of Birth: City____________________ State: ________

Home Phone: ____________________ Work Phone: ____________________

Description:

Gender: Male ____ Female _____

Ethnic Group: __________ HT: _____ WT: _____ Eyes: ______ Hair: ________

List of birthmarks, tattoos, surgery or accident scars:

____

____

Presenting Problem:

Who referred you here? ____

Who is most responsible for you coming here currently?

Self-___Parent ___Doctor____ Friend ___ Court ___Probation ___ Employer ___Other ____

Is this Treatment voluntary? Yes___ No ____

Are you court ordered to treatment? Yes____ No_____

Explain Why you want treatment here?

____

Mental Health History:

Is there a history of mental illness in your family? If yes, what?

____

Have you ever thought of suicide? Yes____ No____ Ever attempted suicide? Yes____ No_____

How many times? _________ How? ____

Have you thought of homicide? Yes____ No____ Ever attempted homicide? Yes_____ No____

List events that have been traumatic in your life (E.g. Death, Rape, Suicide, Murder, Divorce and arrest etc.)____

Have you ever joined AA? Yes___ No____ Have you ever joined NA? Yes____ No______

If yes, how did you feel about the program? ______________________________________

Have you had or do you have a sponsor? Yes_____ No______

Arrest History: List any felonies or misdemeanors (Most Recent)

Charge	Date	Outcome

Are you on Parole or Probation? Yes_____ No______ Drug Court? Yes_____ No_____

Officers Name: ________________________

City: ____________________

County ____________________

Are you DHS ordered? Yes____ No____

Caseworker's Name and Court:

____

City: __________________________

County: __________________________

Medical History:

Do you have allergic reactions to anything (Drugs, Bites, and Foods etc.)? List Below.

____

Physical Health Condition? Good_____ Fair_____ Poor_______

Family Physician: Name: ______________________________

Address: ____________________________

Phone: ______________________________

Date and reason for last visit: ____

If female, do you think or know that you are pregnant? Yes_____ No______

Are you currently taking any prescription medication? If so what?

____

____

Are you on any form of birth control? Yes______ No_______

Are you prescribed any medication that you are not taking? Yes____ No_____

What? ____

Are you under a doctor's care for any reason? Yes_____ No_____

List any medical problems, conditions, or illnesses you now have or have had in the past. (E.G. blood pressure, asthma, heart related, or seizures etc.)

____

Do you have any physical or mental limitations? ______ If so, please explain; _______________

____

____

Check any that apply to you

___Headaches	___Frequent Earaches	___Constipation	___Hypoglycemia
___Difficulty seeing	___Dizziness	___Vomiting	___Sores that don't heal
___Difficulty Hearing	___Dental Problems	___ Hemorrhoids	___Cirrhosis
___Frequent Colds	___Indigestion	___ Vomiting Blood	___Prostate problems

Continued: Check any that apply to you

___Menstrual Problems	___Tremors/Shakiness	___Skin Problems
___ Palpitations/Heart murmur	___Muscle Cramps/Twitching	___Pancreatitis
___Weakness /Tiredness	___Neck/Shoulder/Back Pain	___Lice/Crabs/Scabies
___Numbness in Limbs	___Joint Pain	___Athletes Foot
___Difficulty sleeping	___ Abdominal Pain/Cramping	___Rashes
___Burning Urinations	___Frequent Urinations	___Blood in Stool/Urine
___Unusual discharge	___Chest Pains	___Shortness of breath
___High Blood Pressure	___Recent weight loss/gain	___wear Prosthesis
___Use a crutch or cane	___ Use a wheelchair	

Have you ever had any of the following? Circle the one(s) that apply:

Measles	Arthritis	Hepatitis A, B, C	Tuberculosis	Mumps
Ulcers	Polio	German measles	Chicken Pox	Cancer

Stroke	Typhoid	Kidney Problems	Gonorrhea	Positive TB test
Syphilis	Diabetes	Rheumatic Fever	Scarlet Fever	Positive HIV test
Heart Disease		Liver Problems	Mental Illness	
Positive Hepatitis A, B, C, Test			Seizure Disorder	

Drug and Alcohol History:

Have you ever overdosed? _____ How many times? ______ How many times have you been in substance abuse rehabilitation? ____

When was your last drink? ______________ How much? ____________________

When was your last drug use? _____________ Substance(s) used? ______________________

How much? _____________________

Are you experiencing withdrawal now? ____Yes ___No

If so explain: ____

Have you ever mainlined or injected drugs? _____ If so, when was the last time? ____________

What is your drug(s) of choice? ____

What is the longest period you have gone without using drugs? ____________________

Have you experienced the following?

___Shakes ____DT'S ____Sweats ____Hearing Voices

___Blackouts ____Convulsions ____Hallucinations ____Seizures

Alcohol/Drug History:

Substance	Age (First used)	How Often? (Daily/week/binge)	Current Dosage	Method (IV/Snort/oral)
______________________	_____	_____________	_________	_______
______________________	_____	_____________	_________	_______
______________________	_____	_____________	_________	_______
______________________	_____	_____________	_________	_______

______________________ _____ ____________ ________ ______

______________________ _____ ____________ ________ ______

Do you smoke cigarettes, cigars, dip snuff, chew tobacco? Circle all that apply.

How much per day? ____________________

Family History of Drug/Alcohol Abuse:

Father: ____

Mother: ____

Siblings: ____

Grandparents: ____

Mate, Spouse, Girl/Boyfriend: ____

Has drinking or drugging caused problems in any of the following areas?

Check the ones that apply.

___Financial ___Job loss ___Job problems ___Family ___Health

___Marital ___Separation ___Children ___Parents ___Divorce

___Accidents ___Legal ___Arrest ___DUI ___Injuries

___DHS ___Police ___Youth Court

What is your biggest reason for wanting to come to treatment? ____________________

____

Educational History:

What is your highest grade completed in school? ______________________________

If you did not complete, what was your reason for stopping? ___________________________

____

Have you attended college or vocational school or training? Yes_____ No_____

Where? _________________________________

How long? ______________________

Major: _________________________

Did you graduate? Yes_____ No_____ Degree obtained? ______________________________

Work History:

Are you currently employed? Yes _____ No_____

Income: Weekly $_________Bi-weekly $ _________ Monthly $________ Yearly $__________

Position? _________ Supervisor? ____________________

How long have you been employed there? __________________

Does your job know you will be here? Yes______ No______

Is your job responsible for you getting into treatment? Yes____ No____

Have you gotten in trouble for drinking or drugging on your job? Yes _____No_____

What kind of special training or skill do you have (e.g. welding, electrician, typing etc.?

____

Military History:

Were you ever in the military? Yes____ No_____

Branch of service: _______________ Rank: ________________________________

Number of years of service: __________ From: __________ To: __________

Place(s) you have served: ____

Are you a combat veteran? Yes_____ No_____

Were you ever disciplined for alcohol/drug activity in the military? Yes____ No_____

If yes, explain: ____

What type of discharge did you receive? ____

Do you have a service connected disability? Yes_____ No _____

Religion/Spirituality:

What religion are you? ______________________

What does spirituality mean to you? ____

How do you feel about God? ____

How do you think God feels about you if that applies?

____

How would you describe your experience with religion as you were growing up?____

Are you familiar with Alcoholics anonymous or Narcotics Anonymous? Yes _____ No_____

Do you believe spirituality can help you maintain sobriety? Yes____ No_____

Explain: ____

Sexual History:

Sexual Preference (Circle one(s) that apply. Heterosexual, Homosexual, Bisexual, Asexual(none).

At what age was your first sexual experience? _______

Do you have any concerns about your sex life? Yes____ No____

Have you been sexually assaulted? Yes____ No____ When? ____________________

Have you received therapy for this? Yes____ No____

Have you been charged with any sexual offenses? Yes______ No______

What charges? ____

Outcome/result: ____

Family History:

Father's complete name: ____________________________________

Is your father living? Yes___ No___ Age: ____ Age of Death: _____ Cause: _________________

Mothers complete name: ____________________________________

Is your mother living? Yes___ No___ Age: ____ Age of Death: _____ Cause: _________________

Are your parents married, divorced or separated? ____________________________________

What number child are you? _____ Brothers? _____ Sisters? _____

Describe your relationship with your father: ____________________________________

____

Describe your relationship with your mother: ____________________________________

____

Describe your relationship with your brothers and sisters? ______________________

____

Are you? (Circle one) Single and uninvolved   Single and involved   Married

Separated   Widowed   Divorced

How long have you been married or involved with your mate/spouse? ____________

How many times have you been married? __________

Do you have children? Yes____ No____ Who has custody? __________________

Age _____ Sex: M/F

_____ M/F

_____ M/F

_____ M/F

_____ M/F

Who are the people most concerned about you?

____

Date: ________________

Who do you want to be contacted in an emergency?

Name: ____________________Relation: ____________________

Address: ____

Home phone: ________________ Work Phone: ____________________

Employer: ____________________

Do you live? Alone_____ with Family______ with a friend_____ Homeless______

(This section is to be completed after interview.)

Please answer.

- I am not an opioid user.
- I have been offered medication assisted treatment and decline at this time.
- I have been offered and will participate in medication assisted treatment. ____________________

Client Signature ______________________________

Date: ____________________

Department of Mental Health

Bureau of Alcohol and Drug Services
Scholarship Application

STATE OF MISSISSIPPI
COUNTY OF__________

I,________________________________, being first duly sworn, depose and state that based upon my personal knowledge and oath, the following responses are true and correct:

1. State your full name: ____

   Present address: ____
   ____
   ____

   Social Security Number: XXX-XX-______________
   Telephone number: ______________________
   Full name of Spouse: ______________________

   Number of dependents
   for whom you provide support: ______________

2. Did you file a Federal Income Tax Return for either of the preceding two years? Yes No
   a. If yes, please attach a copy of your tax return(s) to this affidavit.

3. Did you receive an income tax refund or earned income credit for either of the last two tax years? Yes No
   a. If so, in what amount last year? ______________________________
   b. In what amount for the preceding year? ______________________________

4. Are you presently employed? Yes No
   a. If yes, state the amount of your salary or wages per month and give the name and address of your employer.
      i. Monthly salary or wages: ______________________________
      ii. Present employer: ______________________________
      ____
      ____

5. Did you receive any monetary income from any source such as SSI, disability, DHS transfer payments, pension wages, child support, regular gifts, etc? Yes No

a. If yes, state the amount of income received on a monthly basis and the source:

____

____

6. Have you received within the past twelve months any income from a business, profession or other form of self-employment, or in the form of rental payments, interest, dividends or other source? Yes No

   a. If yes, describe each source of income and state the amount received from each during the past twelve months.

   ____

   ____

   ____

7. Do you own any cash or have a checking or savings account? Yes No

   a. If yes, state the name of each bank or financial institution where an account is maintained, each account number and the balance in each account.

   ____

   ____

8. Do you own any personal property, including but not limited to stock, bonds, promissory note, motorized vehicle of any type, jewelry, guns, boats, trailers or other property (excluding ordinary household furnishings, common personal effects and clothing)? Yes No

   a. If yes, describe the property and state its approximate value. If additional space is required, please use an additional sheet of paper.

Property	Value	Amt. of debt secured by this property

9. Do you own an interest of any kind in any real estate? Yes No

   a. If yes, describe the real property and state its approximate value. If additional space is required, please use an additional sheet of paper.

Property	Value	Amt. of debt secured by this property

10. Do you have insurance?

a. Medicaid — Yes No

b. Private Insurance — Yes No

FURTHER, I do solemnly swear that I am a citizen of the United States of America and of the State of Mississippi and because of my poverty I am not able to pay costs or give security for same in this action.

FURTHER, I understand that a false statement or answer to any question or instruction in this affidavit will subject me to penalties for perjury.

FURTHER, I understand that the treatment facility may assess costs against me or dismiss the action I commenced if it finds that the allegation of poverty is untrue.

Signature: ______________________________

Print name: ______________________________

Date: ______________

Letter of Support:

I, ______________________________________, am supporting ______________________________________ while they are currently living in my home, and I am assuming all financial responsibilities at this time.

My address and phone number:

Signature: ______________________________