FAIRVIEW HOUSING

PROGRAM APPLICATION FOR FAIRVIEW HOUSING

BRISTOL Lifestyle Recovery

MARION Lifestyle Recovery at ACH

MENDED WOMEN LIFESTYLE RECOVERY

Referring Facility or Agency:

Facility Name:			
Facility Address:	_____ **Street** **City** **Zip Code**		
Person Making Referral:			
Contact Number:		**Fax Number:**	
Date of Referral:			

Facility requested:

☐ **Bristol Lifestyle Recovery** ☐ **Mended Women Lifestyle Recovery** ☐ **Marion Lifestyle Recovery at ACH**

Applicant Information:

Full Legal Name: (First, Middle, Last)			
Mailing Address	_____ **Street** **City** **Zip Code**		
Date of Birth:		**Social Security Number:**	
Phone Number:		**Second Contact Number:**	
Primary Insurance:		**Medicaid ID Number: Pharmacy ID # (RX):**	
Discharge Date:		**Date Bed Needed:**	
Preferred Name:		**Ethnicity/Race:**	

Current Housing Needs:

What is the applicant's current housing plans if not accepted?	
Is the applicant at high risk for Homelessness?	

Has the applicant been convicted or accused of any sexual offenses? If so, please describe.	**Yes**	**No**	
Has the applicant been convicted or accused of any violent offenses? If so, please describe.	**Yes**	**No**	
What level of care will the applicant require?	**2.1**	**3.1**	**Unknown**

Screening Information:

Does the applicant need medical detox? **If yes, this needs to be completed before admission, please note completion date to the right.**	**Yes No** **If applicable, estimated detox completion date: _____**
Has the applicant been diagnosed with a substance use disorder (SUD)? If so, please include the diagnosis (Dx codes are acceptable)	**Yes No** **Diagnosis: _____** **Diagnosis: _____**
	Yes No **_____** **Potential Follow up Provider**
Are there any medical issues that are currently not under control or being addressed by a physician? For example, uncontrolled diabetes, high blood pressure, chronic kidney disease.	**Yes No** **Complete medical portion or submit a copy of medical records. Medical records will be required for anyone deemed to need medical clearance.**
Is the applicant in need of mental health services? **Please list primary symptoms:**	**Yes No** **Symptoms:**
Any current suicidal thoughts? **Any history of suicidal attempts?** **If yes, was there a hospitalization?** **RECORDS MAY BE REQUIRED**	**Yes No** **Yes No When?** **Yes No Where?**
Summarize why the applicant wants to receive services at Fairview Housing	

Medical Information and Medication

Diagnosis or Description	Name of Physician	Contact Info for Physician

List of Medications: (You may attach your facility Medication List instead if you prefer)

Name of Medication	Dosage	Frequency	Prescriber

Questions? To speak with an Admissions Specialist:

Bristol, VA - Men's Program: (276) 821-8030
Abingdon, VA - Women's Program: (276) 451-3996

Business Hours: 8:30 am-4:30 pm EST, Monday-Friday

FOR FASTEST PROCESSING OF YOUR APPLICATION:

PLEASE FAX COMPLETED FORM, ALONG WITH CURRENT MEDICAL RECORDS AND 'BRIEF MEDICAL HISTORY' FORM TO:

Bristol Lifestyle Recovery (Men) Fax: 423-900-2435
Mended Women Lifestyle Recovery (Women) Fax: 276-451-7626