



PROGRAM APPLICATION FOR FAIRVIEW HOUSING



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:

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:	
BIN Number:		Pharmacy ID # (RX):	
Discharge Date:		Date Bed Needed	
Preferred Name:		Ethnicity/Race:	
Gender Identity:		Preferred Pronouns:	

Current Housing Needs:

What is the applicant's current housing plans if not accepted?	
Is the applicant at high risk for Homelessness?	Yes ☐ No ☐

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 ☐ 3.5 ☐ 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: _____
Will the resident be receiving Medication Assisted Treatment Services and/or will that follow up be scheduled prior to their discharge from your facility?	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
Marion, VA - Men's Program: (276) 289-3023
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
Marion Lifestyle Recovery at ACH (Men) Fax: 423-342-3205