

**Marion, Illinois VA Medical Center
Residential Rehabilitation Treatment Program Application**

**Admission Department
Residential Rehabilitation Treatment Program
2401 West Main Street
Marion, IL 62959**

**Phone 1-866-289-3300 ext. 59173
Fax 1-618-997-8247**

The Residential Rehabilitation Treatment Program (RRTP) is a 14 bed residential program for Male and Female Veterans providing Veteran-centered, evidence based treatment in four specialty areas that specifically target your needs. These areas are designed for Veterans experiencing one or more of the following:

- ✓ Post Traumatic Stress Disorder (military related)
- ✓ Substance Use Disorders (alcohol or drug use/abuse/dependence)
- ✓ Serious Mental Illness (Bipolar Disorder, Major Depression, Schizophrenia, etc.)

Our philosophy of care uses an approach to recovery that addresses the **Mind, Body, and Spirit**. Mental health, physical conditions, and spiritual connections all play a part in the recovery process. Spiritual connections are not limited to religion, but may include connections with nature, music, art, etc. The RRTP will provide guidance in your development and commitment to realistic and achievable recovery goals, and supporting a smooth transition back into your community.

INSTRUCTIONS

- ☐ Please make sure you complete all parts of the application packet; attach additional pages if needed. A more detailed application enables us to make timely & appropriate admission decisions.
- ☐ Once the application is complete mail to the address listed above.
- ☐ **Please submit a copy of your DD-214**
- ☐ Call the number above if you have questions or would like help completing your application.

Section 1 - Tell us about Yourself

Name: _____ Today's Date: _____

Complete Social Security Number: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female ☐ Other

Current Address: _____

City: _____ State: _____ Zip: _____

Home phone number: _____ Work: _____ Cell: _____

Preferred written language _____ Preferred spoken language _____

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Current Marital Status: ☐ Married ☐ Never Married ☐ Divorced ☐ Separated ☐ Widowed

Do you have a Service Connected Disability? ☐ Yes ☐ No

If yes, Condition(s) and SC: _____

Are you covered by Private Insurance? ☐ Yes ☐ No

If yes, what company? _____

Who is the Policy Holder: _____ Subscription ID #: _____

What branch of service were you in? Describe your military service. What were your service dates? Highest rank? Were you in combat or conflict zones? If yes, where? _____

Do you have children? If yes, please list names and the type of relationship (distant, loving, close, no contact) you currently have with them. If you are the care provider, do you have someone that could provide care for them while you are in the RRTP? _____

Are you currently working? If yes, please tell us about it. If not, why? _____

What do you feel are some of your most positive qualities? What are your strengths that will help you be successful during your stay with us? _____

What would you like to accomplish in treatment during the first thirty days? _____

What will be different about you or your life after treatment? _____

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Are you court ordered to treatment? Do you have any current or pending legal problems? If yes, please explain

Are you able and willing to participate in assigned classes and/or therapy groups? ☐ Yes ☐ No

Section 2 – Tell us about your Mental Health (Mind)

The RRTP offers three core treatment areas. Which areas do you need help? You may pick more than one area.

Post Traumatic Stress Disorder: _____ Substance Use Disorder: _____

Serious Mental Illness: _____

Which track is the most important to you and why? _____

Please tell us about your current Mental Health: _____

Please circle any of the following that you are currently experiencing or have experienced in the last 90 days:

Overwhelmed	Frustrated	Sad	Joyful	Agitated
Excited	Alarmed	Guilty	Hopeless	Lonely
Nervous	Helpless	Unmotivated	Tearful	Elated
Guarded	Hollow	Happy	Lost	Restless
Hopeful	Manic	Jittery	Insomnia	Exhausted
Negative Thoughts	Motivated	Optimistic	Hyper-sexual	Flashbacks
Hearing voices	Delusional	Avoidant	Focused	Stressed
Numb	Alienated	Outburst of Anger	Nightmares	Unable to concentrate

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Have you ever been hospitalized for a Mental Health problem?

☐ Yes

☐ No

If yes, please list reasons and approximate dates: _____

Have you ever attended outpatient treatment for Mental Health?

☐ Yes

☐ No

If yes, please list where and when: _____

Have you had thoughts about suicide or murdering yourself?

☐ Yes

☐ No

If yes, what is your plan? _____

Have you attempted suicide?

☐ Yes

☐ No

If yes, how many times and how did you try? _____

Have you had thoughts of homicide or murdering someone else?

☐ Yes

☐ No

If yes, what is your plan? _____

NOTE: Both men and women live and share space here. You need to be in a place that you can exist with the both men and women. Do you feel comfortable residing in a co-ed facility?

☐ Yes

☐ No

Has anyone ever stated that you have a substance use problem? If yes, please explain _____

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Are you currently using or have used any of the following substances in the past month?

	Date Last Used:
_____ Alcohol	_____
_____ Tobacco	_____
_____ Methamphetamine	_____
_____ Cocaine	_____
_____ Marijuana	_____
_____ Other	_____

Have you ever participated in a substance use treatment, including AA/NA? If yes, please explain. _____

Have you ever been hospitalized for drug or alcohol detox? If yes, please explain. Do you feel you need detox at this time? _____

The RRTP will have frequent random drug and alcohol screenings throughout your stay.

Do you agree to random drug and alcohol screenings? ☐ Yes ☐ No

Section 3 – Tell us about your Physical Health (Body)

The RRTP is happy to help you with your medication and are a handicap accessible facility. However we do not provide any type of skilled nursing or moderate/complex medical care. You must be able to take care of your basic needs such as bathing, grooming, cooking and cleaning.

How would you describe your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any current Medical issues: _____

Have you been hospitalized for Medical issues in the past 12 months? ☐ Yes ☐ No

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If Yes, please give the reasons and dates: _____

Please list all current medications, dosages and how you take them including vitamins, herbs, and over the counter drugs/medicines/remedies: _____

Do you have medications that have been prescribed, but you do not take? ☐ Yes ☐ No

If yes, please list and why? _____

Are you able to self-administer your medication? ☐ Yes ☐ No ☐ With help

Are you able to organize your medication? ☐ Yes ☐ No ☐ With help

Are you able to safe-guard your medication? ☐ Yes ☐ No ☐ With help

Have you ever had, or currently have:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Traumatic Brain Injury (TBI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oral/Dental Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
COPD/Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	PTSD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Problems (Other than glasses)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart/Cardiovascular Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Significant Skin Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis A/B/C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Significant Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Vascular Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you able to take care of your basic needs such as bathing, grooming, cooking and cleaning? ☐ Yes ☐ No

Section 4 – Tell us about your Inner Self (Spirit)

This information is to help understand and support the spiritual needs of those in treatment.

Do you have a sense of spirituality/religion/faith or connection to nature/arts/etc? Tell us about it.

Do you attend church or other type of organized group? How important is it to you? _____

Section 5- Referral Source

Who referred you for residential treatment? ☐ Self ☐ Provider ☐ Other

Name of Person making referral: _____ Position: _____

Address: _____ City: _____

State: _____ Zip: _____

Phone: _____ Ext: _____ Fax: _____

Did someone assist you in filling out this application? If yes, who? _____

Congratulations! This completes the first step applying for admission to the MH-RRTP!

- ✓ You will be contacted that we have received your application.
- ✓ A screening team will review your application along with your VA medical records looking at your current physical and mental health. This helps to assess if you are able and ready to actively participate in the type of treatment we offer.
- ✓ We may ask you to provide additional information about medical or mental health treatment, or legal issues outside of the VA.
- ✓ Once the screening team is done, you will be contacted again to discuss the program further.

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- a. If our program might be a good match we will set up an interview with you. This interview can be done by phone, face-to-face, or using tele-video equipment at your local VA. This is our opportunity to speak with you and for you to have any remaining questions answered.
- b. Unfortunately, our program may not be the best match for everyone. If this is the case we will talk to you about other options.

Please sign this form to indicate that the information you have provided is correct to the best of your knowledge. Thank you for your interest in the MH-RRTP, we look forward to future contact.

Signature

Date

Best phone numbers and time to reach you:

1. _____ Day / Evening
2. _____ Day / Evening
3. _____ Day / Evening

If you do not have a phone, is there someone we can contact to get a message to you either by phone or by mail?

Name

Relationship

Address

Phone