Harbor Care

Keystone Hall
615 Amherst Street
Nashua, NH 03063
Phone: 603-881-4848 FAX: 603-598-3644

Eligibility Form

MUST BE **FULLY** COMPLETED BY THE PERSON REQUESTING SERVICES

If not fully completed, the form will be returned to you for completion.
Please answer "N/A" if a section does not apply to you. Do NOT leave any spaces blank.

Today's Date:	Your Name:	Last 4 Numbers of Social Security #:
Do you need an interpreter or bilingual counselor? Yes/No If yes, what language?_____		
Male: ____ Female:_____	DOB:	Age:
How did you hear about Keystone Hall, were you referred: (for example: Hospital, Emergency room, counselor, friend, website)		
Are you pregnant? Yes/No If so, when is your due date?_____ Do you have any children under the age of 18? Yes/No If so, what are the ages?_____ If so, is DCYF involved? Yes/No		
Are you a Resident of NH? Yes/No If not, do you agree to pay full price? Yes/No Do you have a valid (not expired) government issued photo ID? Yes/No		
Physical Address: Mailing Address, if different from physical Address:	Name of Insurance: Name of the Subscriber: Insurance # : Co-pay:	
Phone number: Is it OK to leave a message at the above number? Yes/No	Number of authorized visits:	
Which service are you requesting? LADC Evaluation:_____ Individual Counseling:_____ Intensive Outpatient Program:_____ Relapse Prevention Group:_____ Residential 28 day:_____ Residential 90 day:_____ Cynthia Day Family Center:_____	Have you been referred by an Impaired Driver Care Management Program? Yes/No If so, which one?_____ If not, did anyone else refer you? Yes/No If so, who?_____	

What is the reason you are requesting treatment at this time:

Were there any specific events that led up to seeking treatment:

Are you currently prescribed Suboxone / Methadone? Yes No If yes, how many milligrams_____
If so, who is the prescribing physician? _____

What is your main drug of choice: Age you first used this substance?

How do you use typically use it? Circle all that apply: Oral, Snort, Smoke, IV
How often are you or were you using this substance? Circle the closest answer:
Daily 3X to 4 X a week, 1X to 2 X a week, 3X to 4X a month, 1X to 2X a month

If other, please explain:

How much do you typically use in a day, when you use this substance? (Use amounts in grams, ounces, liters etc):

Date you last used this substance?

What is your 2nd drug of choice: Age you first used this substance?

How do you use typically use it? Circle all that apply: Oral, Snort, Smoke, IV
How often are you or were you using this substance? Circle the closest answer:
Daily, 3X to 4 X a week, 1X to 2 X a week, 3X to 4X a month, 1X to 2X a month

If other, please explain:

How much do you typically use in a day, when you use this substance? (Use amounts in grams, ounces, liters etc):

Date you last used this substance?

What is your 3rd drug of choice: Age you first used this substance?

How do you use typically use it? Circle all that apply: Oral, Snort, Smoke, IV
How often are you or were you using this substance? Circle the closest answer:
Daily, 3X to 4 X a week, 1X to 2 X a week, 3X to 4X a month, 1X to 2X a month

If other, please explain:

How much do you typically use in a day, when you use this substance? (Use amounts in grams, ounces, liters etc):

Date you last used this substance?

Have you used any other substances not described above within the last 30 days?
If so, please list those substances and the date of last use:

What was your longest period of time that you were ever sober/abstinent from any and all substances?

What were the tools you used to remain sober during the time described above?

After this period of sobriety, what was the date of your relapse?

Please list all prior substance abuse treatment events, listing the level of care (Residential, Detox, Intensive Outpatient or Outpatient), the dates of attendance and whether you completed each program successfully.

Level of Care	Dates of Attendance	Completed, Discharged or Left ASA

Have you ever been diagnosed with any mental health diagnosis? Yes No
If so, what were the diagnoses?

Who diagnosed you?

Are you currently receiving mental health counseling? Yes No
If so, who do you see?

What medications are you currently taking?	List the reason for each medication.
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Who prescribes the above medications?

Do you have a family history of mental health diagnoses? Yes No
Do you have a family history of substance use disorder? Yes No
Do you have a history of trauma / abuse? Yes No

Have you ever had any suicidal thoughts? Yes/No If so, when was the last event?

Have you ever had any suicide attempts? Yes/No If so, how many in your lifetime?

When was the last time you attempted suicide? What method was used?

Do you have a legal history? (arrests, incarcerations, etc.) If so, please list type convictions:

Do you have a history of arson? Yes / No violent crime (s)? Yes / No sexual assault? Yes / No

Are you currently incarcerated? Yes / No If yes, where?
If yes, date of incarceration? Date eligible for release?
Are you on probation or parole? Yes / No If yes, how much longer do you have?

Who is your Probation/Parole Officer? What County is your probation/parole out of?

Probation/Parole Officer's Phone number:

Please be aware that your Probation/Parole Officer will need to know when you are in treatment and you will need to sign a release of information so that we may communicate with him or her.

You are requested to have NO outstanding appointments and/or court dates upon admission. If there are extenuating circumstances in regards to emergent medical appointments, prior approval must be granted by Keystone Administrative team **BEFORE ADMISSION**.

By initialing here I agree to the above statement and take full responsibility for rescheduling, postponing or missing outside appointments / commitments knowing that once admitted into the program I am to remain on property grounds for the length of my treatment. _____
Client's Initials

By signing below, I agree that the above information is true to the best of my knowledge.

_____ _____
Client's Signature Date

THIS SECTION FOR KEYSTONE HALL STAFF ONLY

The above information was reviewed with the client and the level of care recommended is:

LADC Evaluation:_____ WLG Group: _____
Individual Counseling:_____ Residential 28 day:_____
Intensive Outpatient Program:_____ Residential 90 day:_____
Relapse Prevention Group:_____ Cynthia Day Family Center:_____

Additional Notes: _____
_____

_____ _____
Counselor's Signature Date