|  |  |
| --- | --- |
|  |  Patient ID #       |
|  |  |

## Online IOP application form PLEASE COMPLETE AS MUCH INFORMATION AS POSSIBLE

**Intensive Outpatient Program is 36 sessions – 3 hours a day and offered 3 days a week. Monday, Wednesday and Thursday’s for ALL Clinics**

**Center of Excellence – West Clinic 9:00 am – 12:00 noon**

**Main Clinic 9:00 am – 12:00 noon**

**North Clinic 5:00 am – 8:00 am**

**San Tan 10:00 am – 1:00 pm**

Referral Date:       Start Date:

## Applicant Information Section 1

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |      |       |       | DOB: |        |
|  | Last | First | M.I. |  |  |

|  |  |  |
| --- | --- | --- |
| Address: |        |       |
|  | Street Address | Apartment/Unit # |

|  |  |  |  |
| --- | --- | --- | --- |
|  |       |       |       |
|  | City | State | ZIP Code |

Home Telephone #:       Cell #:

*Can we leave a message on this number? Yes* *[ ]  No* *[ ]  Can* we leave a message on this number? Yes [ ]  No [ ]

Social Security #:       Email:

Which is your closest clinic? Main [ ]  North [ ]  West [ ]  San Tan [ ]

## Health Information Section 2

Are you on AHCCCS (Medicaid) or Medicare? Yes [ ]  No [ ]

AHCCCS (Medicaid) ID #:       Medicare ID #:       CIS ID #:

Other Insurance information if not AHCCCS?

Are you receiving services from any other behavioral health provider? Yes [ ]  No [ ]  If yes, where?

Do you have any medical issues? Yes [ ]  No [ ]  If yes, please provide details:

Are you receiving services from a medical provider? Yes [ ]  No [ ]  If yes, who/where?

What medications are you currently prescribed?

Are you taking your medications as prescribed? Yes [ ]  No [ ]

If not, Why?

Are you pregnant? Yes [ ]  No [ ]

If yes, please provide details: (due date, OBGYN etc.)

## Class Information Section 3

Reason for attending IOP Classes? (please explain:)

Who referred you to IOP Classes?(please state:)

Are you required to take IOP Classes? Yes [ ]  No [ ]

How many classes are you being required to take? (please state:)

Have you ever been in IOP Classes before?Yes [ ]  No [ ]

If yes, when and where?

## Current Drug Use Section 4

If using a substance, what substance are you currently using?

Quantity?

When was the last time you used the substance?

Method?

If IV use, how many years have you used IV drugs?

Are you taking Fentanyl? Yes [ ]  No [ ]

If yes, what amount and frequency?

## Additional Information Section 5

Do you need transportation to your IOP Classes? Yes [ ]  No [ ]

Do you have any disability requirements, so we can ensure we have the appropriate transportation? Yes [ ]  No [ ]

If yes, please provide details:

Do you need Interpreter services? Yes [ ]  No [ ]

If yes, what language? Please provide details:

## Disclaimer and Signature Section 6

**THANK YOU FOR CHOOSING INTENSIVE TREATMENT SYSTEMS (ITS) TO HELP YOU!**

I certify that my answers are true and complete to the best of my knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** |       |
| **Print Name:** |        |  |  |

**How did you hear about ITS?** Please provide details:

## Staff Review – Office use only Section 7

**Form checked and reviewed by:**

Name:       Position:

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_

Transportation booked? Yes [ ]  Not required [ ]

Interpreter booked? Yes [ ]  Not required [ ]

Clinic Confirmed? Yes [ ]  No [ ]  Which one? Main [ ]  North [ ]  West [ ]  San Tan [ ]