YOUTH RECOVERY CENTER

Phone: (970)384-7470 **Referral & Development Dept Direct:** (970)384-7484 **Fax:** (970)945-8491

APPLICATION FOR ADMISSION

Section A: Client Information

Client Name ______________________________
Last First Middle

Address:______________________________
City State Zip

Phone: ______________ Social Security #:______________

Date of Birth: ______________ Age: __________ Sex: __________

Email Address:______________________________

Section B: Parent/Guardian Information

Mother/Guardian Name______________________________ Relationship______________

Address______________________________
Street/PO Box City State Zip

Home Phone#______________ Work Phone# ______________

DOB: ______________ Social Security#______________

Employer's Name______________ Occupation: ______________

Insurance Provider ______________

Email Address: ______________________________

Father/Guardian Name______________________________ Relationship______________

Address ______________________________
Street/PO Box City State Zip

Home Phone#______________ Work Phone# ______________

DOB: ______________ Social Security#______________

Employer's Name______________ Occupation: ______________

Insurance Provider ______________

Email Address: ______________________________

Section C: Insurance Information

ΨPX.AΠΠ

Insurance Company: ______________________________ Responsible Party: ______________________________

County: ______________________________ Telephone: ______________________________

Section D: Medicaid Information

Medicaid #: ______________________________ Policy #: ______________________________

Benefits #: ______________________________ Policy Holder: ______________________________

Section E: Professionals

Caseworker: ______________________________ Telephone: ______________________________

Agency: ______________________________ Fax: ______________________________

Address: ______________________________

City State Zip

Email Address: ______________________________

Probation: ______________________________ Telephone______________________________

Agency: ______________________________ Fax: ______________________________

Address: ______________________________

City State Zip

Email Address: ______________________________

Clinician/Therapist: ______________________________

First Name Last Name

Agency______________________________

Address______________________________

Street/PO Box City State Zip

Work Phone # ______________________________ Fax# ______________________________

Email Address: ______________________________

Physician:______________________________

First Name Last Name

Agency______________________________

Address______________________________

ΨΡΧ.ΑΠΠ

Street/PO Box City State Zip

Work Phone # ______________________________ Fax# ______________________________

Email Address:____

School Name: ____

Principal/Counselor:____
First Name Last Name

Address____
Street/PO Box City State Zip

Phone#_________________________________ Fax # ___________________________

Email Address:____

Proposed Aftercare Placement Options & Party Responsible for Pick Up:

____

____

Other:____
First Name Last Name

Agency____

Address____
Street/PO Box City State Zip

Work Phone # ______________________________ Fax# ______________________________

Email Address:____

YOUTH RECOVERY CENTER

<u>**Please fax or mail to:**</u>

YOUTH RECOVERY CENTER

at Valley View Hospital

Fax: (970)945-8491

1906 Blake Avenue

Glenwood Springs, CO 81601

ΨΡΧ.ΑΠΠ