Therapeutic Living Services, Inc.
A Community Mental Health Center

5601 Domingo Rd NE, Albuquerque, NM 87108 Phone: 505-268-5295 Fax: 505-268-9967

Important! Before you submit this packet!

This application packet cannot be processed until all items on the check list below are completed and included in the packet before submission. If any of the items below are missing, this will hold up your application from being processed. By submitting a completed application packet, we will be able to process your application more quickly!

- ☐ **Completed Application**
- ☐ **Birth/Baptismal Certificate**
- ☐ **Social Security Card (copy only)**
- ☐ **Recent medical records (if applicable)**
- ☐ **Clients Medicaid Card (copy only)**
- ☐ **Signed releases of information (copy only)**
- ☐ **Proof of income (Award Letter from SSI)**
- ☐ **State I.D. or Driver's License**
- ☐ **Full Psychiatric Evaluation :**

Completed within the Last Six Months. This should include DSM-5 diagnosis and ICD-10-CM Codes! Additionally, neuropsychological and psychological evaluation are very helpful and should be included if the consumer has recently had one of these evaluations, however a Full Psychiatric Evaluation completed within the last six months must be included in order for us to process this application packet!

FAIR AND EQUAL OPPORTUNITY HOUSING

POLICY:

Therapeutic Living Services, Inc (TLS) will not discriminate in housing placement on the basis of race, creed, national origin, political affiliation, religion, gender, sexual orientation, or handicapping conditions. Housing placement includes, but is not limited to: application, processing, leasing, transfers, delivery or management services, access to common facilities and termination of occupancy.

PROCEDURE:

1. Every application will receive the policy statement in the application packet.
2. TLS will provide any applicant or resident who believes his/her rights have been violated under the Fair Housing and Equal Opportunity Laws with Form HUD-903, "Housing Discrimination Complaint." The Department of Housing and Urban Development developed this form specifically for reporting agencies which are suspected of discriminating in housing practices. The form should be completed and mailed to:

Dept. of Housing and Urban Development		Therapeutic Living Services, Inc.
Attn: Fair Housing and Equal Opportunity		Attn: Executive Director
PO Box 2905		5601 Domingo Road N.E.
Fort Worth, TX 76113		Albuquerque, NM 87108

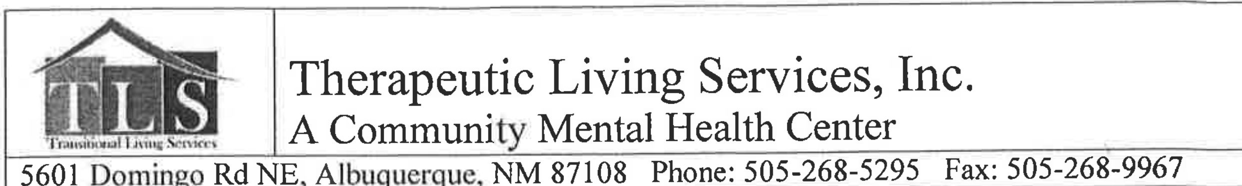
3. The Executive Director will meet with the Intake Coordinator and Client Care Committee of the Board of Directors to investigate the complaint and take any corrective actions necessary.

NOTICE TO APPLICANTS
RELEASES OF INFORMATION

The authorization forms included in this application allow TLS to receive and share information about you and your application with other agencies and professionals who have provided services to you in the past, as well as interested family members and others that you may wish us to contact. We ask for this information in order to make the best decisions about which of our services are right for you, and so that we may coordinate the care we give you with others as long as you remain a part of TLS.

You are not required to give us your consent to communicate with people you don't want us to contact, although in some cases this could delay or disqualify your application. Even if you do allow us to communicate with someone, you always have the right to revoke that permission. The authorizations you give us automatically expire in one year and we must renew them after that.

TLS or the person who helps you fill out this application may designate specific agencies or individuals that would be helpful to contact. This can be done whenever it is necessary. For your own protection, please DO NOT SIGN any authorization form until it has been completely filled out, especially if the space for the name of the agency or individual is left blank. To protect your confidentiality, TLS will automatically invalidate and destroy any incomplete authorization forms.



APPLICATION FOR SERVICES

Please read all sections and fill out carefully. Incomplete applications will not be considered for services until all necessary information is completed and on file.

Mail or fax your completed application to TLS, Attn: Intake Coordinator.

Date of Referral: ________________ **Applicant's Name:** ____

Name of Referring Person: ____

Agency: ____

Applicant Contact information:

Address: ____

Phone: (   ) ____
*** May messages be left at this number? Yes or No**

Fax: (   ) ____

Consumer's Date of Birth: __________________________ **SSN:** ____________________________________

Type of Insurance *(circle)* **Medicaid** *(circle type)* Molina Presbyterian Lovelace Value Options
Private Medicare None Other *(specify)* ______________________

Benefits Currently Received *(circle all that apply)* Medicaid Medicare AFDC SSI SSDI VA
Unemployment Food Stamps General Assistance Workman's Comp Pensions
Retirement Accounts Alimony Child Support Section 8 Housing DD

Waiver **Monthly Income and Source:** __________

Services Requested:*

- ☐ Case Management
- ☐ Psychosocial Rehab
- ☐ Therapeutic Group Home
- ☐ Rental Assistance/Independent Living

Race *(circle)* American Indian/Alaskan Native Asian White Black/African American
Native Hawaiian/Other Pacific Islander

Ethnicity (circle) Hispanic Non-Hispanic

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Gender _____ Height _______ Weight _________ Hair _________ Eyes _________ Marital Status _______

Are You: A Veteran? ________ A U.S. Citizen? ___________ Currently in a Domestic Violence Situation? ____

Emergency Contact Name ______________________________________ Phone ___________________

Address ____

Legal/Treatment Guardian Name _________________________________ Phone ___________________

Address ____

Medical/Physical Conditions or Developmental Disabilities ____

Food/Drug Allergies ____

Approximate Household Income per Year * ______________________________________

HELP SPEED UP YOUR APPLICATION

I agree to allow TLS to contact the individuals named below to discuss my application for services.

____ ____________
Signature Date

Name	Address	Phone/Fax
CURRENT PSYCHIATRIST		
CURRENT COUNSELOR/THERAPIST		
CURRENT CASE MANAGER		
FAMILY MEMBER(s) *(SPECIFY RELATION)*		
CURRENT PRIMARY CARE DOCTOR		
PROBATION/PAROLE OFFICER *(IF APPLICABLE)*		

Please list any counseling/mental health agencies you have received treatment from in the last five years, including inpatient hospitalizations and outpatient psychiatry, counseling, PSR and case management. *(Use additional paper if necessary.)*

Agency Name	Location	Services Received	Dates

Please list your current medications and dosages (Please include any over the counter drugs or herbs you may take)

Medication/Strength	Dosage (How Much, How Often)	Prescribing Doctor

Consumer's Diagnoses:

Mental: ______________________________

____

Medical: ______________________________

____

____

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Please list any inpatient treatment facilities you have ever been in for alcohol or drug abuse.

Facility Name	Location	Substances Treated	Dates

Have you used any of the following in the past year? *(circle all that apply)*

Alcohol Amphetamines Cocaine/Crack Hallucinogens Opiates (Heroin, Morphine, etc.)

Barbiturates (Seconal, Nembutal, etc.) Non-Prescribed Benzodiazepines (Valium, Xanax, etc.)

Cannabis Inhalants Abuse of Prescription Drugs

If you have used any of the above in the past 30 days, please list ____________________

Are you currently using any other non-prescribed drugs? Yes No

If yes, please list ____________________

Have you ever been convicted of a felony or other crime? Yes No If yes, please list below.

Date ________ Conviction ____________________ Location ____________________

Date ________ Conviction ____________________ Location ____________________

Date ________ Conviction ____________________ Location ____________________

Are you currently awaiting trial or sentencing? Yes No If yes, list details ____________________

____

Are you currently on parole/probation? Yes No If yes, provide officer's name, address & phone below.

____

____

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Authorization to Request/Release Information

Client Name__________________ Date of Birth__________ Social Security#____________
I herby authorize: Name__________________________________
Address:____
Phone:_____________________________ Fax:
_________________________________ To: (send to) __x__ Therapeutic Living Services,
Inc. the information designated below:

( ) Psychosocial History
(x) Psychological Testing Results
( ) Behavior Problems
(x) Service Plans
(x) Case Notes
( ) Other (specify)____

(x) Summary Reports
(x) Intelligence Testing Results
( ) Vocational Testing Results
(x) Medical reports
( ) Personality Profiles

(x) Progress Reports
(x) Psychiatric History
(x) Psychiatric Evaluations
(x) Psychological Reports
( ) Entire Record

Receive from: __x__ Therapeutic Living Services, Inc. the information designated below:

( ) Psychosocial History
( ) Psychological Testing Results
( ) Behavior Programs
( ) Service Plans
( ) Case Notes
( ) Other (specify)

( ) Summary Reports
( ) Intelligence Testing Results
( ) Vocational Testing Results
( ) Medical Reports
( ) Personality Profiles

( ) Progress Reports
( ) Psychiatric History
( ) Psychiatric Evaluations
( ) Psychological Reports
( ) Entire Record

____

I authorize that the information exchanged may include records relating to (initialing authorizes those checked):

(x) Psychiatric Conditions Initial________
(x) Substance Use Information Initial_______
(x) AIDS/HIV Testing initial_______

The above information will be used for the following purposes:

(x) Planning Appropriate Treatment or Program
( ) Continuing Appropriate Treatment or Program
(x) Determining Eligibility for Benefits or Program

( ) Case Review
( ) Updating Files
( ) Other

(specify)____

I authorize that information shared may be communicated via telephone, fax, or e-mail as needed.Initial___
I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that I may revoke this consent at any time by providing written notice, however if I do revoke my signed consent, it may affect my eligibility for services at TLS. I understand that after one year this consent expires. I have been informed what will be given, it's purpose and who will receive the information.

Signature of Client ______________________________ Date __________
Signature of Witness ______________________________ Date __________
Signature of Representative/Guardian ____________________ Date__________
If client is unable to sign, state reason: ________________________________

This information is disclosed from records whose confidentiality is protected. The receiving agency is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose. The information is protected both by State (section 34-2A18 NMSA 1953) and Federal (42 CFR Part 2) Regulations.