PrescreenApplication

Serenity Treatment Center 3.1 Low Intesnsity Residential Care

Facility 21703 Phone: 301-898-2627 Fax;

Please complete ALL applicable sections - MUST BE LEGIBLE

Date: Full Name: [ ]

Date of Birth: [ ]

Gender Identity: [ ] SSN: [ ]

☐ Male ☐ Female ☐ Transgender
☐ Other ☐ Prefer not to answer

Have you been in treatment at Serenity Treatment Center Before?

☐ Yes ☐ No

If currently in treatment, where?

[ ]

Name of Case Worker/Counselor/Contact Person: [ ]

Best phone number to contact you or your case worker at this time: [ ]

When would you be available to start treatment at Serenity if you are in treatment right now, what is your discharge date?)

[ ]

Do you have insurance at this time?

☐ Yes ☐ No

Insurance Type:

☐ Medicaid
☐ Medicare
☐ Other Private Insurance

MA #: [ ]

Are you a registered sex offender?

☐ Yes
☐ No

Do you have any pending legal issues at this time? If so, please list them below:

Do you have any active warrants at this time?

☐ Yes
☐ No

What is your primary drug of choice?

When was your date of last use?

How often do you use this substance?

Most recently, how would you use it?

How old were you the first time you used it?

What is your secondary drug of choice?

When was your date of last use?

How often do you use this substance?

Most recently, how would you use it?

How old were you the first time you used it?

What is your tertiary drug of choice?

When was your date of last use?

How often do you use this substance?

Most recently, how would you use it?

How old were you the first time you used it?

The following items must also be submitted to the Serenity Treatment Center Admissions Team as part of the application process:

- A recent clinical evaluation such as a Biopsychosocial or Substance Use Disorder Assessment.
- A Psychiatric Evaluation and/or History and Physical-if available.
- If applicable-A copy of the patient's COVID-19 vaccination record.