



212 4th Ave E.
Twin Falls, ID 83301

2091 4th Ave. E.
Twin Falls, ID 83301

676 Shoup Ave. W.
Twin Falls, ID 83301

Application for Admission

Full Name: _____ Date: _____
Last First M.I.

Are you on Probation or Parole? YES NO If yes, give the name of your Probation or Parole Officer and phone number below.

Name: _____ Phone #: _____

How long have you been on Probation or Parole? _____

Are you attending chemical dependency outpatient treatment(s)? YES NO

Where are you attending chemical dependency outpatient treatment? _____

What program are you attending? (I.e., relapse prevention, IOP, Aftercare, etc). _____

Do you have a target date for completion of treatment? _____

Do you have a support structure such as Family, or a Recovery Coach/Sponsor in the Twin Falls Area? YES NO

When released, will you have a cell phone? YES NO

Will you need assistance re-acquiring State or Government issued ID? YES NO

Upon release, will you have a vehicle? YES NO

Upon release, will you need a food box? YES NO

Upon release will you have access to season-appropriate clothing, such as coats/gloves/boots/etc.? YES NO If no, list your sizes below:

Shoe: _____ Shirt: _____ Pants: _____

Application for Admission Contd.

What are your plans for employment once released?

Give complete treatment history:

Please complete the following Rental Application, Consent, House Rules & Rental Agreement form, and email a copy to info@realcoveryidaho.com

All residents will be required to attend 12-step meetings, currently in outpatient treatment and attending meetings, or have completed a valid treatment program.

I certify that my answers are true and complete to the best of my knowledge. If this application leads to housing, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____



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Rental Application

Applicant Information

Full Name: _____ DOB: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____ Email: _____

Gender: _____ Race/Culture: _____ Occupation: _____

Referred by: _____

MARITAL INFORMATION

Single Living with partner Married Separated Divorced Widowed

Previous or Current Employment

Employer: _____ Phone: _____

Address: _____ City, State, Zip: _____

Job Title: _____ Supervisor: _____

Responsibilities: _____



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Consent to Release and Exchange Information

I, _____ herby authorize Realcovery to request and/or disclose
(Client Name)
 my medical records, or other various legal information, verbal or written, as identified below:

Please initial next to all applicable items requested below

The records requested are for the following services:

- | | |
|---|---|
| <input type="checkbox"/> Substance/Alcohol Abuse Services | <input type="checkbox"/> Mental Health Services |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> HIV/AIDS Related Information |
| <input type="checkbox"/> RSS Services (Other) | <input type="checkbox"/> Legal Services |

Please initial next to all applicable items requested below

Specific Information Requested:

- | | |
|---|--|
| <input type="checkbox"/> GAIN Assessment | <input type="checkbox"/> Court Related Information |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Case Management Plans/Progress |
| <input type="checkbox"/> Social/Medical History | <input type="checkbox"/> Probation/Parole Progress Reports |
| <input type="checkbox"/> Laboratory Data (Drug Testing) | <input type="checkbox"/> Exchange Information |
| <input type="checkbox"/> Admission/Discharge Summary | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Medication Records | |

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, as well as the Health Information Portability and Accountability Act (HIPAA) if 1996, 45 CFR parts 160 and 164 Subparts A and E, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent any time, by either written or verbal notification, except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: resident has moved off of the premises or was asked to leave by a manger (termination of contractual agreement).

I also understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that this agency may not condition treatment, payment, enrollment, or eligibility for benefits whether or not I sign this authorization, unless allowed by law. I understand that I may inspect or copy any information used or disclosed under this authorization.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____



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House Rules/Rental Agreement

1. ____ I agree there will be no illicit drugs or alcohol on my person, on the property or in my automobile at any time.
2. ____ I agree I will not be under the influence of illicit drugs or alcohol at any time during my stay at a Realcovery facility, on or off property.
3. ____ I will not have in my possession weapons of any type to include firearms, knives, explosives, or unauthorized chemicals.
4. ____ Realcovery has a **NO VISITOR POLICY** in which only tenants of the house are allowed in the premises.
5. ____ If you are not working the night shift you must be at the residence by 10:00PM, unless pre-approved by the house manager(s).
6. ____ A chore list will be posted, and you **must** complete your chores to the satisfaction of the house manager(s).
7. ____ Your room **must** be clean; this is to include bed made daily, laundry completed and dirty laundry in laundry baskets, floors swept or vacuumed.
8. ____ All residents will be required to attend 12-step meetings, currently in outpatient treatment and attending meetings, or have completed a valid treatment program.
9. ____ There will be one house meeting per week. Your attendance is **mandatory**.
10. ____ It is understood that any Probation or Parole Officer can enter this house and your room at any time, day, or night.
11. ____ Individuals who are on Probation or Parole must attend **ALL** meetings required by your Probation or Parole Officer. *It is the philosophy of Realcovery that individuals must be in chemical dependency outpatient treatment.*
12. ____ Rent will be **\$450** per month subject to change by owner with appropriate notification. Entire rent amount will be due upon move-in either by tenant themselves or by other approved funding agencies. Rent is **NONREFUNDABLE** for any reason.
13. ____ Smoking/vaping is not allowed in the house. You must smoke/vape outside in a designated area.
14. ____ You may be subject to random urinalysis or breath alcohol tests.
15. ____ Rooms and personal vehicles are subject to random searches. Failure to allow these searches will lead to immediate termination of residency.

Failure to follow these rules will result in the resident being asked to vacate the property immediately.

Resident Signature: _____ Date: _____

Staff Signature: _____ Date: _____



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Resident Signature: _____ Date: _____

Staff Signature: _____ Date: _____