averte
A TRIVIUM LIFE SERVICES PROGRAM

2122 Lower Plain
Bradford, VT 05033
802-222-9394

Application for Admission

Today's Date: _____

Applicant Name:_____DOB:_____

Mailing Address: _____

Phone:_____ Email:_____

Name of Person Completing Application: _____

Relationship to Applicant: _____ Phone:_____

Email:_____ Fax:_____

Applicant has (*check all that apply*):

Legal Guardian_____ Power of Attorney_____ Rep Payee _____

Other legal representative/designee _____ Please explain: _____

Official documentation of legal representative must be included with application

Name: _____

Phone:_____ Email:_____

Reason applicant is seeking residential treatment or long-term care (include diagnosis, current living situation, goals of treatment, etc.):

Does applicant have a history of (*check all that apply*):

Self-Harm ☐	Violence/aggression ☐	Elopement ☐
Substance misuse ☐	Arrests ☐	Nightmares ☐
Paranoid thoughts ☐	Manic episodes ☐	Incontinence ☐
Med non-compliance ☐	Delusions ☐	Hallucinations ☐
Suicidal ideation/gestures/attempts ☐	Homicidal ideation/gestures/attempts ☐	
High risk sexualized behaviors/boundary concerns ☐	Other High-Risk Behaviors ☐	

If any of the above are checked, please explain:

Please submit records of mental health treatment/medical history (i.e. documentation from hospitalizations, therapy, psychiatry, assessments) in order to proceed with application.

Does the applicant have any allergies, medical issues, or other physical wellness concerns?

Date of last physical exam: _____

Name of Current PCP: _____ Phone: _____

Address: _____

Please submit record of most current physical list to proceed with application.

Name of Current Psychiatrist: _____ Phone: _____

Address: _____

Please submit record of most current medication list to proceed with application.

Name of Current Dentist: _____ Phone: _____

Address: _____

Name of Current Optometrist: _____ Phone: _____

Address: _____

Person(s) financially responsible for applicants' care: _____

Address: _____

Phone:_____ Email: _____

If same as person completing application, check here and leave next section blank: _____

Emergency Contact:_____ Phone: _____

Relationship to Applicant:_____ Phone:_____

Other important relationships/contacts (i.e. therapist, case manager, family members, friends, etc.):

Name(s):_____

Relation to Applicant: _____Phone:_____

Name(s):_____

Relation to Applicant: _____ Phone:_____

Averte requires a signed release of information for any organization or individual with whom the applicant would like us to communicate regarding their application and/or care.

Insurance Information

Check if applicant does not have private insurance: _____

Private Insurance Provider: _____

Primary Insured: _____

ID#: Group#

Medicare Parts A+B #: _____ Date Effective: _____

Part D Plan Name: _____ ID#:_____

RX Bin #: Date Effective:

Medicaid ID#: _____ Date Effective: _____

Please include a copy of all active insurance plans

Is there a person or an organization we can thank for this referral?