Thank you for inquiring about Northern Arizona VA Health Care System (NAVAHCS). The Domiciliary is a residential program situated on the grounds of the Bob Stump VA Medical Center, Prescott, AZ. The primary goal at the DRRTP is to address recovery related issues of addiction, mental health, vocational rehabilitation, and/or psychosocial treatment by daily attendance with at least 4 hours in psychoeducational classes and therapy. Veterans usually stay in treatment an average of 45-90 days with length of stay individualized depending on progress in the program. Treatment consists of two Phases. During Phase I (the first 45 days) there are no overnight passes or employment that interferes with treatment program. During Phase II, overnight passes are approved based on therapeutic value. Vocational rehabilitation is emphasized and strongly supported. Prescott is a rural community and securing employment can present a challenge as there are limited job opportunities and limited public transportation.

1. Complete the attached NAVAHCS Application for Admission to the DRRTP.

2. Read attached Medical Care Agreement; attached Statement of Acknowledgement; attached Domiciliary Resident Personal Belonging Guidelines; and Admission Criteria. Veteran will be required to complete and sign these forms if admitted to the Domiciliary.

Send or bring the application packet to:
NAVAHCS, DRRTP Building 151
Domiciliary Screening Team
500 North Highway 89
Prescott, AZ 86313

After the application has been received and eligibility is confirmed, the application will be evaluated by our Screening Team to determine if Veteran meets admission criteria. Notification will be made of the acceptance or denial of the application. Thank you for your inquiry and submission of this application. If you have questions, call 1-800-949-1005 Ext. 6863, between 8 AM and 4:00 PM, Monday through Friday.
Application for Admission to the Domiciliary (RRTP)

VETERAN DESCRIPTION

Veteran's Name (last name, name, middle initial) (please print) _________________________

Social Security Number …………………… _ _ _ - _ _ _ - _ _ _

Address: ______________________________________________________________________

Date of Birth (mm, dd, yy) ………………………._ _ / _ _ / _ _ Age ___________

Sex

☐ 1. Male

☐ 2. Female

What is your marital status (check only one)?

☐ 1. Married

☐ 2. Remarried

☐ 3. Widowed

☐ 4. Separated

☐ 5. Divorced

☐ 6. Never Married

Do you have a contact phone?

☐ No

☐ Yes

MILITARY HISTORY

Period of Service (check longest one)

☐ 1. Korean War (7/50-1/55)

☐ 2. Between Korean and Vietnam Eras (1/55-7/64)

☐ 3. Vietnam Era (8/64-4/75)

☐ 4. Post-Vietnam (5/75-7/90)


☐ 6. Persian Gulf Era (8/90 to present)

Branch of Service: ________________________ Date Entered: ________________________

Date of Discharge: ________________________ Type of Discharge: ________________________

PSYCHIATRIC/MENTAL HEALTH EVALUATION

Have you ever been hospitalized for a psychiatric problem (do not include substance abuse treatment)?

☐ No ☐ Yes

Have you used the VA medical system for medical and/or psychiatric care in the past?

☐ No ☐ yes

You can just say "yes" or no" for these. During the past 30 days, have you had a period (that was not the
direct result of alcohol or drug use) in which you …
(Check one answer for each item; blank responses will not be considered a "no" response).

a. experienced a serious depression ........................................ [ ] No [ ] Yes
b. experienced serious anxiety or tension ............................... [ ] No [ ] Yes
c. experienced hallucinations ............................................... [ ] No [ ] Yes
d. experienced trouble understanding, concentrating or remembering … [ ] No [ ] Yes
e. had trouble controlling violent behavior ................................ [ ] No [ ] Yes
f. took prescribed medication for a psychological/emotional problem … [ ] No [ ] Yes

If you have ever been treated for a mental health condition, what kind of condition was it?

________________________

When was your condition diagnosed? __________________________________________

If you ever spent time in the hospital because of your mental health condition, list the place and dates of hospital admissions.

_____________________________________________________

_____________________________________________________

Are currently taking psychiatric medications?   [ ] No   [ ] Yes

If yes, please list current medications: ____________________________________________

If you no longer take them, please describe why: _____________________________________

_____________________________________________________

Are you currently participating in outpatient MH or Substance Abuse treatment? ____Yes  ____No

If no, explain why? ________________________________________________________________

_____________________________________________________

SUBSTANCE ABUSE HISTORY

Do you have a problem with alcohol dependency now (veteran's perception)? ............ [ ] No [ ] Yes

How often do you drink? __________________________________________________________

Have you had a problem with alcohol dependency in the past? ................................. [ ] No [ ] Yes

Have you ever been in a residential treatment program or hospitalized for treatment of alcoholism?

[ ] No   [ ] yes

Do you have a problem with drug dependency now? _________________________________  ____No  ____Yes

Drugs of choice: __________________________________________________________________

Have you had a problem with drug dependency in the past? _____________________________ [ ] No [ ] Yes
Have you ever been in a residential treatment program or hospitalized for treatment of a drug dependency?  
☐ No  ☐ Yes  
If so, when and where ________________________________________________________________

Desired goals for participating in the Domiciliary treatment program: (goals must be listed for screening)  
__________________________________________________________________________________
__________________________________________________________________________________

LEGAL HISTORY

Have you ever been charged/convicted of a crime?  
☐ No  ☐ Yes  
If yes, explain:
__________________________________________________________________________________
__________________________________________________________________________________

Have you ever served time in county jail or prison?  
☐ No  ☐ Yes  
If yes, explain (dates):
__________________________________________________________________________________

Do you have any warrants for your arrest?  
☐ No  ☐ Yes
Do you have any pending court dates?  
☐ No  ☐ Yes
If yes, explain:
__________________________________________________________________________________

Do you have a Probation Officer or Parole Officer?  
☐ No  ☐ Yes
Probation/Parole Officer Name: ___________________ Telephone Number: __________

I have to report (circle one) Weekly / Monthly / Mail in Reports /

EMPLOYMENT STATUS/INCOME/HOUSING

Are you currently homeless:  ____Yes  ____No  
If so, Where are you staying?
__________________________________________________________________________________

Have you received HUD/VASH or HCHV services?  ____Yes  ____No  
Do you receive any of the following kinds of financial support (check one box for each question)
  Service Connected/Psychiatry .... % _____  ☐ No  ☐ Yes
  Service Connected/Other ........ % _____  ☐ No  ☐ Yes
Receives NSC pension .......... $ ______ □ No □ Yes
Non-VA disability (e.g. SSDI) ...... $ ______ □ No □ Yes

What was your last job and when did it end?

__________________________________________________________________________

MEDICAL INFORMATION

Do you feel you have any serious medical problems? □ No □ Yes

If yes, please explain:

__________________________________________________________________________

Disabling injuries? .......................................................... □ No □ Yes
Are you planning on having surgery in the next 6 months? ...................... □ No □ Yes
Are you taking any medications/prescriptions on a regular basis for medical conditions? □ No □ Yes

Please list any medications:

__________________________________________________________________________

Any physical or medical limitations (list/explain):

__________________________________________________________________________

Do you have any mental impairment (for example, stroke, head injury, or any problems with making decisions for yourself)? □ No □ Yes

I am willing to participate in treatment programs as recommended. I certify that all of the above information is true and correct.

DATE: ____________________ SIGNED: ________________________________
NAVAHCS Domiciliary Medical Care Agreement

**Medical Care**

1) I understand that the **main purpose** for my admission to the Domiciliary is to actively participate in a treatment program designed to address my vocational rehabilitation, addiction, mental health, lifestyle changes, medical rehabilitation, and my psychosocial treatment issues.
2) I understand that the medical care provided by the domiciliary staff will be limited in scope and will focus on achievable goals that will not interfere with the main purpose of my admission.
3) I understand that chronic medical issues that I may have, such as chronic pain, will need to be stable at the time of admission. We are not able to aggressively treat you for chronic pain and that is not the focus of your treatment.

**Medication Policy and Narcotics**

1) I understand that newly initiated or increased narcotic medications for conditions such as chronic pain will **NOT** be available during my stay in the Domiciliary. If your pain increases and you are requesting additional addictive medications from Dom Medical or other non-Dom providers, such as the Emergency Department or fee-basis providers, then this is not the program for you. If narcotic use starts to escalate, we can gradually reduce the narcotic medication to prevent withdrawal and reduce your tolerance level.
2) For some Dom residents, as you withdraw from alcohol or street drugs, your emotional and physical pain may increase, and we do not want to initiate another dependency.
3) I understand that I report all medications that I am taking, including over the counter medications, to Dom Medical personnel at admission. I also understand that I bring in all medications, including prescribed narcotic and benzodiazepine medications, and give them to Dom Medical personnel at all times during my domiciliation.
4) I agree to give informed consent for the domiciliary staff to communicate with any agency or clinic from which I am receiving such medications. Such communications would be in an effort to coordinate the medical care provided for me.
5) I understand that I can only take medications, either prescribed or over-the-counter, that are prescribed or approved by Dom Medical Clinic while I am a resident of the Dom.

**Domiciliary Participation and Chronic Pain**

1) I understand that, if I have chronic pain issues that make it difficult for me to adequately participate in either groups or classes or to focus on my treatment issues, I may be asked to discharge from the Dom until the pain issues are resolved and I can concentrate on my recovery program.
2) If I am discharged for that reason, I understand that I should further pursue my medical issues with a primary health care provider in an effort to stabilize my medical conditions.

**Dental and Eye Care**

1) I understand VA dental resources are limited; services provided are on the basis of priorities and emergent in nature.
2) I understand that VA eye care resources are limited; services are provided on basis of priorities.
3) I understand that if I am 10% or greater "Service Connected" or have a medical condition or eye disease that needs monitoring, I may be provided with a routine eye examination and corrective eye wear while in the Domiciliary.

Patient Signature_________________________________________Date_____________________________

DRRTP Statement of Acknowledgement

As an applicant for the Northern Arizona VA Health Care System Domiciliary (DRRTP), I am aware of and acknowledge the following:

1) My application will be reviewed by the Domiciliary Screening Team. My acceptance into the Domiciliary will be determined on multiple factors which may include but are not limited to my previous treatment experiences, my medical and/or psychiatric needs, my ability to perform my own “activities of daily living” (ADLs), my ability to live in a group setting, my goals for employment and/or training, and the availability of beds.

2) If accepted, I will, upon request, agree to a urine drug screen and breathalyzer prior to admission and whenever requested by Domiciliary staff.

3) Any use of drugs and/or alcohol AFTER I have been accepted into the Domiciliary and BEFORE I have been admitted will be evaluated. If relapse does occur, admission will be dependent upon medical consideration and my admission may be delayed or denied.

4) I understand that during my stay in the Domiciliary, I may be subject to a co-payment. Co-pay is determined by information you provide on Form 10-10EC and is based on factors such as your income, financial status and Veteran rating.

5) If it is determined I have any fugitive felony warrants I may be declared ineligible for VA health care and I may be billed retroactively for services rendered while I was in warrant status.

6) Should it be determined the Domiciliary cannot provide all the care I need, I will have additional referral options explored by the referral source and/or the Domiciliary Admission Coordinator. In service of my best interests, I will fully cooperate in this process.

7) If accepted, I will follow my treatment plan and abide by the rules and regulations of the Domiciliary. My continued stay in the Domiciliary will be based on my performance.

_________________________________________  ______________________
Signature of Veteran                        Date
DRRTP Vehicle Guidelines

1. Purpose: To provide guidelines for Personally Owned Vehicles (POVs) for DRRTP residents for their convenience during their stay.

2. POVs belonging to the DRRTP residents are as follows:

   All vehicles must be registered with the VA police.
   All vehicles must be parked in Lot “T” and meet Arizona State requirements.
   No vehicles will have “For Sale” signs posted.
   No maintenance is allowed in the lot.
   If a vehicle has been tagged as “subject to tow”, the owner of the vehicle will have three (3) days to respond to the VA Police.

3. The VA will not be held liable for theft or damage of personal vehicles.

I have read and understand these requirements and will abide by them.

Veteran Signature: ____________________________ Date: _______________

Staff Signature: ____________________________ Date: _______________
Domiciliary Admission Criteria

Per the VA Handbook 1162.02, a Veteran must meet the following admission criteria:

(1) Be assessed as not meeting criteria for acute psychiatric or medical admission.

(2) Have tried a less restrictive treatment alternative, or one was unavailable.

(3) Be assessed as requiring the structure and support of a residential treatment environment.

(4) Be assessed as not a significant risk of harm to self or others.

(5) Be lacking a stable lifestyle or living arrangement that is conducive to recovery.

(6) Be capable of self preservation and basic self care.

(7) Have identified treatment and rehabilitation needs, which can be met by the program.

Additionally, we are not an appropriate level of care to provide acute medically-managed or medically-monitored detoxification to Veterans at moderate to severe risk.