



Program Application

Program Overview

Step 1 is a Men's 120-day Nevada State Certified Transitional Living with Level 1 Outpatient Substance Use Disorder (SUD), and Co-Occurring Disorder capable, treatment program. There are 20 beds in our facility located at 1015 North Sierra Street. We accept Medicaid for treatment services. If clients lose their insurance coverage after they become employed, or enter treatment services without benefits, SUD treatment fees are approximately \$185-\$205 a month. Clients are not required to pay clinical fees until after they have received their first paycheck.

- ❖ **Step 1 Outpatient Counseling is a 6-month-long program: Phase I (120 days): Clients reside in Transitional Living, attend Outpatient counseling group once a week, at least two individual counseling sessions** a month, and local recovery support meetings daily.
Phase II (2 months): After clients successfully complete Phase I and transition to independent living in the community, they are required to return for Outpatient treatment (one group session per week and one individual session per month) to successfully complete the Step 1 Outpatient Substance Use Disorder Treatment program.
- ❖ Clients who reside in the Transitional Living program (T.L.), do not pay rent at any time while they reside at Step 1. Residents of T.L. are required to start paying into their “savings” at the time of their first pay period after employment is obtained.
- ❖ Step 1 does NOT have a blackout period; clients are expected to find full-time employment within the first 2 weeks of intake. For those not coming to the program directly from incarceration, being currently employed is allowed as long as it fits with our schedule.
- ❖ Clients must be home by 5:30 pm every evening to check in. After-dinner curfew is at 10 pm. Clients are not permitted to work swing or graveyard shifts. Overtime is allowed, up to 8 hours per week.
- ❖ Applicants must be in stable physical/mental health in order to remain employed, participate in house chores, walk necessary distances, and attend meetings in the community.
- ❖ All clients residing in Transitional Living are randomly screened for substances by urinary analysis approximately once a month, or more often if deemed necessary by staff. We administer a daily breathalyzer when indicated.

Applicant Acknowledgment

I acknowledge that I have read and understand the program expectations above. I understand that any dishonesty or omission of information on this application will result in immediate refusal for admission to the Step 1 program.

Applicant Signature: _____ Date: _____

Applicant Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ SSN: _____ Offender ID#: _____

Referred by: _____

Race Description (Circle one):

- | | | |
|--------------------------------|--|------------------------|
| Alaskan Native(01) | Middle Eastern or North African (06) | Other Single race (20) |
| American Indian (02) | Native Hawaiian or Other Pacific Islander (23) | Two or more races (21) |
| Asian (13) | White (05) | Unknown (97) |
| Black or African American (04) | | |

Ethnicity: () Hispanic or Latino () Not Hispanic or Latino () Unknown

Gender Description: What sex were you assigned at birth, recorded on your original birth Certificate?

() Male 01 () Female 02 () Intersexual 13 () Prefer not to disclose 14

Gender Identity: How do you describe yourself? (Circle one)

- | | | |
|--------------------------------------|-----------------------------------|--|
| Male 1 | Transgender Man/Trans Male 9 | Different Identity 11:
Specify: _____ |
| Female 2 | Transgender Woman/Trans Female 10 | Prefer not to disclose 1 |
| Genderqueer/Gender Non-conforming 13 | | |

Sexual Orientation: Which of the following best represents your sexual orientation identity?

() Straight or Heterosexual 9 () Bisexual 3 () Gay 10 () Lesbian 11
() Not listed: Specify 12: _____ () Prefer not to disclose 13

Physical Address: _____

Mailing Address: _____

Phone (if applicable): _____ OK to Leave Message? ()Yes ()No

Emergency Contact: _____ Phone: _____ OK to Leave Message? ()Yes ()No

Children: _____ Ages: _____ Custody: Yes / No

DCFS Case Manager (if applicable): _____ Phone: _____

Answer the following questions with as much detail as possible. If it does not apply, then put N/A. Leaving questions blank or unanswered lowers your overall score. (Applicant Initial) _____

Are you a Veteran? ()Yes ()No If yes, which branch?: _____

LIVING STATUS (circle):

Independent Correctional Facility Sober Living Treatment Facility Medical Facility Homeless

Facility Name: _____

Admission Date: _____ Level of Care (if in treatment): _____

Admission Circumstances: _____

Note: If you are currently in a Department of Corrections, substance use treatment or medical facility, please sign the Request for Information (ROI) form attached to this application to allow Step 1, Inc. to coordinate your care.

Disability Status: Do you currently receive or plan to apply for disability benefits (such as Social Security Disability Insurance [SSDI] or Supplemental Security Income [SSI])? (Check which applies to you).

() Yes, I'm currently receiving. () In the process of applying () Plan to apply in the future () No

Legal History

Outstanding Warrants? ()Yes ()No If yes, explain: _____

Most recent Offense/Sentence: _____

Sentencing Date: _____ Next Parole Board: _____ Expected Release: _____

Parole/Probation Expires: _____ Parole/Probation Officer Name : _____

Diversion or Specialty Court: _____ Expected Graduation: _____

Criminal History

<u>Dates:</u>	<u>Charge(s):</u>	<u>Using/drinking at the time of offense?</u>

Have you ever been convicted of a violent offense? ()Yes ()No If yes, explain: _____

Have you ever been convicted of a sexual offense? ()Yes ()No If yes, explain tier rating: _____

During any period of incarceration, explain how many write-ups or disciplinary problems for which you were cited.: _____

Did you attend any programs or classes in jail or prison? ()Yes ()No

If yes, describe: _____

Employment and Education

Job Skills/Experience: _____

Last date of employment: _____

Highest level of Education: _____ College Classes ()Yes ()No If yes, explain? _____

Licenses/Certifications: _____

Substance Use History

Primary Drug (1st) of Choice: _____ Age of First Use: _____ Date of Last Use: _____

Method (Circle): Oral Smoking Nasal IV Amount used daily: _____

Secondary (2nd) Drug of Choice: _____ Age of First Use: _____ Date of Last Use: _____

Method (Circle): Oral Smoking Nasal IV Amount used daily: _____

Tertiary (3rd) Drug of Choice: _____ Age of First Use: _____ Date of Last Use: _____

Method (Circle): Oral Smoking Nasal IV Amount used daily: _____

Do you believe you have a problem with drug or alcohol use? _____

Have you ever injected drugs? ()Yes ()No If yes, when/how often? _____

Longest period of complete abstinence (not using any drugs or alcohol) outside or incarceration of treatment, and why do you think you remained drug and/or alcohol free? _____

Have you ever overdosed?()Yes ()No If yes, how many times and on which substances?:

Have you attended AA/NA or other recovery groups/meetings? ()Yes ()No Last attendance: _____

Substance Use Treatment History

How many times have you been admitted to substance use disorder treatment?: _____

List all prior treatment programs (Detox, Residential, PHP, Intensive Outpatient, Outpatient, MAT, Sober Living):

Program Name: _____ Dates: From: _____ To: _____

Revision Date: 12/15/2025

Completed ()Yes ()No Explain: _____

Program Name: _____ Dates: From: _____ To: _____

Completed ()Yes ()No Explain: _____

Program Name: _____ Dates: From: _____ To: _____

Completed ()Yes ()No Explain: _____

Medical Health History

Are you currently receiving care from a Medical Doctor or Practitioner, outside of incarceration? ()Yes () No

If Yes, Name: _____ Practice Name (Renown, St. Mary's, CHA, etc.): _____

Describe conditions for which you are being treated: _____

Have you ever been diagnosed with or treated for the following? (Check all that apply):

()Type 1 Diabetes ()Heart Attack ()Recent surgery or medical trauma

()Seizures ()Traumatic Brain Injury ()Stroke

()Any other previous medical condition not listed above: _____

Please provide more information for any condition you checked above (year diagnosed and last episode): _____

Date of last TB Test: _____ Results: _____

Please List all current medications:

<u>Medication Name</u>	<u>Dosage (Mg)</u>	<u>Frequency (Daily/2x Daily)</u>	<u>Prescribing Doctor</u>	<u>Reason/Condition</u>

Past medications prescribed that you are no longer taking: _____

Mental Health History

Have you ever been diagnosed with, or treated for, the following mental health disorders? (Check all that apply):

Borderline Personality Oppositional Defiance Obsessive Compulsive

Disruptive Mood
Dysregulation Antisocial Personality

Any other mental health issue or condition not listed above: _____

Please provide more information for any condition you checked above, including medications you are currently prescribed.: _____

Have you had a suicide attempt in the last 30 days? Yes No

I understand that providing any false or incomplete information on this application will result in denial of treatment, immediate discharge and/or return to legal custody.

I attest that all information above is true and correct. _____ (Initial).

Transitional Living Readiness

Are you physically able to walk to work if necessary and perform daily chores in T.L.? ()Yes ()No

Motivation for Step 1

1. Why are you considering the Step 1 program? _____

2. What is your concept of Spirituality? _____

3. What is your opinion regarding AA/NA meetings and the recovery support community ?

I attest that the above statements are true. _____ **(Initial).**

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ Date of Birth: _____
(Full Name)

Authorize: _____
(Name of current or most previous medical/mental health provider or substance use treatment center)

To disclose to: Step 1, Inc.

Purpose of Release: For coordination of continued care.

Information to be released: Medical evaluation/history, Substance use evaluation and treatment recommendations, Mental Health evaluation and treatment recommendations, Medication records

Acknowledgements

- I understand that my records are protected under Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (45 CFR Parts 160, 162 & 164 [HIPAA]), and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand that I may revoke this consent at any time in writing, except to the extent that action has already been taken in reliance on it.
- **This consent will expire one (1) year from the date of signature below, unless otherwise specified.**

Disclosure Type

() Single Disclosure (one-time release only) () Continuing Disclosure (ongoing release until expiration date specified above).

Required Federal Notice of Prohibition on Redisclosure

If information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIPAA Patient Rights Notice

- I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization, except in specific circumstances permitted by law.
- I understand that I am entitled to receive a copy of this signed authorization form.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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(Full Name)

Authorize: _____
(Name of current or most previous medical/mental health provider or substance use treatment center)

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