



# Shadow Mountain Recovery

## ADMISSIONS APPLICATION

*Shadow Mountain Recovery carefully reviews each Application for Admission. Please complete each section thoroughly and accurately.*

Shadow Mountain Recovery Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
Individual Completing Application/Relationship to Applicant: \_\_\_\_\_

### GENERAL INFORMATION Student (Applicant)

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_  
If Applicant is adopted, date/age of adoption: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

### Emergency Notification

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_

### Financial Sponsor (if difference than Student or Parent)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Agency/Organization (If Applicable): \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_

### FAMILY AND FRIENDS INFORMATION

Father Name: \_\_\_\_\_ Relationship: Natural / Adoptive \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Work Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Work Number(s): \_\_\_\_\_ Email: \_\_\_\_\_  
Fax Number: \_\_\_\_\_ Step-Mother's Name (If Applicable): \_\_\_\_\_  
Mother Name: \_\_\_\_\_ Relationship: Natural / Adoptive \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Step-Father's Name (If Applicable): \_\_\_\_\_  
Work Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Work Number(s): \_\_\_\_\_

Email: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Siblings**

List in chronological order (eldest first), all siblings. Include all step / half siblings, living or deceased (please indicate if deceased). Please describe each sibling's relationship with Applicant (i.e. healthy /friendly/hostile/estranged).

**Name Gender Age Birth date Relationship with student**

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_
- 5 \_\_\_\_\_
- 6 \_\_\_\_\_

**Peers**

Describe the Applicant's social interactions and relationships with friends: \_\_\_\_\_

Describe relationships with members of the opposite gender: \_\_\_\_\_

Does the Applicant have a history of abusive behaviors? If so, please explain: \_\_\_\_\_

Has the Applicant ever reported abuse by peers or adults? If so, please explain: \_\_\_\_\_

**RESIDENTIAL HISTORY**

Please list all previous placements where the Applicant has resided outside of his natural home. This should include boarding schools, foster homes, hospitals, detention facilities, etc.

**Name Address Phone Reason Dates of Residence**

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_

**EDUCATIONAL INFORMATION**

Shadow Mountain Academy requires copies of the Applicant's high school and college transcripts. These records are critical in designing a successful program for the student. Please request that the applicable institutions forward official transcripts to:

**Shadow Mountain Recovery Attn: Robb Holub – Executive Director /Owner**

**P.O. Box 65 Taos, NM 78571 Email: [rjholub2@mac.com](mailto:rjholub2@mac.com) Fax 505-212-0260**

Please List all the schools the applicant has attended from 9th grade thru college where applicable.

**Name of School – Location – Grade Level – Reason for Change**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

What are the Applicant's academic goals? (in his own words) \_\_\_\_\_

**Academics**

List any academic testing the Applicant has had \_\_\_\_\_

List any diagnosed learning disabilities or physical impairments e.g., Attention Deficit Disorder, Dyslexia, vision impairment):

Has the Applicant received any specific medical or therapeutic treatment for these disabilities?  
If so, what, by whom, and when?

\_\_\_\_\_

**BEHAVIORAL / EMOTIONAL INFORMATION**

Please describe any areas for concern in the following areas including, but not limited to, acts committed or contemplated by the Student:

Arson: \_\_\_\_\_

Delusional thoughts or experiences:

\_\_\_\_\_

Depression: \_\_\_\_\_

Eating disorders: \_\_\_\_\_

Excessive / inappropriate use of computer and or video games: \_\_\_\_\_

Lying: \_\_\_\_\_

Promiscuous behavior/sexual abuse: \_\_\_\_\_

Theft: \_\_\_\_\_

Self-mutilation: \_\_\_\_\_

Arrests/Convictions: \_\_\_\_\_

Violence / Aggressive behavior: \_\_\_\_\_

Other areas of concern: \_\_\_\_\_

**Emotional**

Please describe any traumatic experiences the Applicant has experienced:

\_\_\_\_\_

Has the Applicant been diagnosed with any mental disorder: \_\_\_\_ Yes / \_\_\_\_ No

If yes, please describe, including date of onset and diagnosis:

\_\_\_\_\_

Has the Applicant been hospitalized for any psychiatric / psychological reasons? \_\_\_\_ Yes / \_\_\_\_ No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

**SUBSTANCE ABUSE HISTORY**

Please list and indicate the frequency and intensity of any use/abuse of alcoholic beverages and/or drugs (including street narcotics or prescription medications) by the Applicant. For each drug and/or alcohol please state the age the use/abuse started, whether student used the substance socially or alone, frequency of use, quality?

\_\_\_\_\_

Please describe circumstances or stresses that prompted student's use/abuse of alcohol and/or drugs?

\_\_\_\_\_

Date of last known use and description of substance: \_\_\_\_\_

Are there any family members (parent, grandparent, sibling) who have a history of drug or alcohol use/abuse?

Explain: \_\_\_\_\_

**TREATMENT HISTORY**

Please list all professional and/or personal efforts that have been made by Applicant and/or Applicant's family members or friends to address the Applicant's emotional /behavioral / substance abuse problems (i.e. therapy, hospitalization, treatment programs, placement interventions, etc.). List the most current treatment first, along with the address and telephone number of the facility.

**Intervention 1**

Reason: \_\_\_\_\_

Professional/Therapist: \_\_\_\_\_

Address: \_\_\_\_\_

Frequency of visits: \_\_\_\_\_

Duration of treatment: \_\_\_\_\_

Psychological treatment: \_\_\_\_\_

Results: \_\_\_\_\_

**Intervention 2**

Reason: \_\_\_\_\_

Professional/Therapist: \_\_\_\_\_

Address: \_\_\_\_\_

Frequency of visits: \_\_\_\_\_

Duration of treatment: \_\_\_\_\_

Psychological treatment: \_\_\_\_\_

Results: \_\_\_\_\_

**OBJECTIVES**

Why is the Applicant seeking enrollment in this program? \_\_\_\_\_  
\_\_\_\_\_

What are your specific objectives for the Applicant while enrolled in this program? \_\_\_\_\_  
\_\_\_\_\_

What are your specific objectives for the Applicant upon completion of this program? \_\_\_\_\_  
\_\_\_\_\_

Religious Affiliations, if any: (optional): \_\_\_\_\_

**Applicant's Interests/Hobbies**

Does the Applicant have any experience/interest in: (please circle) Music Culinary Arts Physical Fitness Fly fishing  
Acting Woodworking/Construction Boxing Rafting Fine Arts Gardening/Greenhouse Baseball Hiking/Camping  
Business/Finance Skiing Any hobbies not listed? Please Identify: \_\_\_\_\_  
\_\_\_\_\_

**APPLICANT'S PERSONAL STATEMENT**

By truthfully and completely answering these questions, we hope to gain a better understanding of what you would like to achieve during your enrollment at Shadow Mountain Recovery. We also hope it will help you begin to reflect upon what you wish to gain for your future and what actions you need to take in order to achieve those goals.

What do you wish to accomplish in the next 4-5 years of your life? \_\_\_\_\_  
\_\_\_\_\_

What are some of the problems that you've had that could prevent you from achieving your goals?  
\_\_\_\_\_

What positive attributes will you bring to Shadow Mountain Recovery?  
\_\_\_\_\_

What do you need from Shadow Mountain Recovery that would help you to be successful?  
\_\_\_\_\_

Why did you decide to apply to Shadow Mountain Recovery?  
\_\_\_\_\_

**REFERRAL INFORMATION**

Educational Consultant - Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Other School or Program -Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Friend or Family Member -Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Previous Student / Family -Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Shadow Mountain Recovery Web Site \_\_\_\_\_ Internet -Search Engine(s) & key words:

Marketing Materials (i.e., Brochure \_\_\_\_\_  
Newsletter \_\_\_\_\_ Postcard \_\_\_\_\_ Email Message \_\_\_\_\_  
Other \_\_\_\_\_

Did you find our website easily? Yes \_\_\_\_\_ / No \_\_\_\_\_

**Shadow Mountain Recovery**  
**Attn: Robb Holub – Executive Director/Owner**  
**P.O. Box 65 Taos, NM 87571**  
**Admissions: Email: [rjholub2@mac.com](mailto:rjholub2@mac.com) - Fax 505-212-0260**

## **AUTHORIZATION, WAIVER AND RELEASE**

I, \_\_\_\_\_ (Applicant or Parent if Applicant is under the age of 18), hereby authorize all healthcare providers, or other covered entities to disclose to Shadow Mountain Recovery or its officers, agents, or employees, upon request, any information, oral or written, regarding the physical or mental health of \_\_\_\_\_ (Applicant), including, but not limited to, medical and hospital records, including what is otherwise private, privileged, protected or personal health information, including but not limited to, health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 100 Stat. 2024), as amended, the regulations promulgated thereunder and any other state or local laws and rules. Information disclosed by a healthcare provider or other covered entity may be redisclosed for treatment purposes and may no longer be subject to the privacy rules provided by 45 CFR § 164. In addition, I \_\_\_\_\_ (Applicant or Parent if Applicant is under the age of 18), hereby authorize the release of all records, information, files maintained for or about \_\_\_\_\_ (Applicant) by all institutions, including but not limited to schools, correctional facilities, disciplinary facilities, and treatment facilities, to Shadow Mountain Academy, or its officers, agents and employees, upon request, and I \_\_\_\_\_ (Applicant or Parent if Applicant is under the age of 18), hereby expressly waive any laws, regulations, rules of ethics and claims of confidentiality which might prevent any of my educators from releasing such information, as well as any all claims of liability against any person or entity providing information or records in accordance with this Authorization, Waiver and Release from any and all claims or liability for compliance thereto. Information provided to Shadow Mountain Recovery may be redisclosed by Shadow Mountain Recovery, its officers, agents or employees. Xeroxed or fax copies of this Authorization, Waiver and Release shall be deemed sufficient as an original.

(Signature) \_\_\_\_\_