Thank you for your interest in Vita Nova Residential Treatment, part of True North Recovery, Inc.

A completed packet is to include all documents listed on the Application Checklist.

**Application Checklist**

- Application (Client Profile 5 pages)
- Health Screening Form/Clearance to Participate (3 pages)
  
  **To be completed by a Health Care Provider within the past 45 days.
  
  Behavior Health Assessment (3.1 recommended level of care, and within the past 6 months)
- Release of Information (ROI)—for any referring providers OCS, Medical Doctors, Probation,
- Case Management etc. (please use our form)
- Contact Preference Form

Applications can be completed online at www.tnrak.org, faxed to (907) 357-8782, scanned and sent via email to vitanova@tnراك.org, or mailed to:

True North Recovery Inc.
591 S. Knik Goose Bay Road
Wasilla, AK 99654

Please contact (907) 313-1333 for questions regarding the application process.

No application will be processed without all required documents. After completing your online application, you will need to print the Vita Nova application packet, this will include the needed ROI’s, health screening form and your list of approved and not approved items. If you need assistance with completing the printable packet, please contact 907.313.1333 to schedule a meeting with one of our case managers.
Client Profile

To help guide your treatment in a manner that best meets your unique needs, please include the following information:

Identifying Data:
Full Legal Name: ___________________________________________ DOB: ____________ SSN: ________________
What is your Maiden Name? _______________________________________
□ Not Applicable
Physical Address: ________________________________________________
Mailing Address: ________________________________________________
Home Phone: ____________________ Cell Phone: ____________________

Miscellaneous:
List all medications/supplements/vitamins you are currently taking: __________________________________________
_________________________________________________________________________________________________
What date are you available to enter treatment? _________________________________________________________

Billing Information/Authorization

Expected Payment Source (check all that apply):
□ Insurance    □ Medicaid (includes Denali Kid Care)    □ Self-Pay    □ Other
Medicaid ID number: __________________________
CLIENT INFORMATION

Are you female (defined as having female reproductive organs)?  □ Yes  □ No
Are you male (defined as having male reproductive organs)?  □ Yes  □ No

Marital Status: (please circle) Married - Living as married - Widowed/Widower – Separated - Single (never married)
Divorced: how long? ____________

Race: (Please Circle) Aleut - American Indian – Asian – Athabascan - Black/African American – Caucasian – Hispanic –
Inupiat – Tsimshian - Native Hawaiian – Tlingit - Pacific Islander – Yupik –
Other Alaska Native ____________ Other ____________

Legal Status:
□ None/No involvement  □ Probation/Parole  □ Court Ordered for alcohol treatment
□ 30 Day Commitment  □ Informal Probation  □ Court Ordered for mental health treatment
□ 90 Day Commitment  □ Incarcerated  □ Court Ordered for observation and evaluation
□ 180 Day Commitment  □ Case Pending  □ Other ____________
□ Emergency Commitment  □ Deferred Prosecution
□ Office of Children Services  □ Community Sentencing

Military Status: (please circle) Never in Military- Active duty (combat)- Active duty (non-combat)- Reserves (combat)-
Reserves (non-combat)- Retired (combat)-Retired (non-combat)- Military Dependent

Have you ever been charged with a crime against a vulnerable person (child, elderly, or disabled)? ____________
If yes, please explain: ___________________________________________________________________________
__________________________________________________________________________________________

Are you required by state or federal authorities to register as a sexual offender? ____________
If yes, please explain: __________________________________________________________________________
__________________________________________________________________________________________

READINESS TO LEARN:
How do you like to learn?  □ Watching □ Reading □ Listening □ Doing
What language is spoken primarily in your home? ____________
Do you speak a second language?  □ Yes  □ No  If YES, what language? ____________
Do you need an interpreter?  □ Yes  □ No

Do you have special needs? (Check all that apply)
□ Diagnosed memory and/or learning disabilities  □ Severe Hearing Loss or Deaf
Do you need auditory aids? □ Hearing aids □ Other ____________
☐ Visual Impairment or Blind
Do you need visual aids? ☐ Magnifying glasses ☐ Large print material ☐ Braille ☐ Other ____________

☐ Major Difficulty in Ambulating; physical limitations ☐ Diagnosed chronic sleep problems
☐ Organic brain disorder ☐ Traumatic Brain Injury ☐ Other______________________________

What problem(s) brought you here today? (check all that apply)

☐ Alcohol problems ☐ Domestic violence ☐ Depression
☐ Drug problems ☐ Marital/Relationship Problems ☐ Psychological/emotional
☐ Alcohol/drug problems ☐ Family problems (non-marital) ☐ Suicide Attempt/Threat
☐ Legal problems ☐ Social/Interpersonal ☐ Victim of Child Abuse
☐ Victim of Sexual abuse ☐ Perpetrator of Sexual Abuse ☐ Perpetrator of Child Abuse
☐ Other: ______________________________

What goals would you like to achieve to improve your quality of living? (check all that apply)

☐ Regaining custody of children/parenting issues ☐ Lack of stress management skills
☐ Social network problem (i.e. drug using friends/acquaintances) ☐ Education issues
☐ Lack of sober, social support ☐ Poor communication skills and/or poor
☐ Lack of self-esteem, self-confidence, or positive identity ☐ Conflict management skills
☐ Lack of structure and time management skills ☐ Housing
☐ Financial concerns or unpaid bills ☐ Other: Please explain Below:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

FAMILY/SOCIAL HISTORY:
Where do you live currently? ____________________ Monthly household Income: ____________

Living Arrangements: ☐ Alone ☐ With Children ☐ With Spouse/Significant Other
☐ With Parents ☐ With Other Relatives ☐ With Non-Related Person
☐ Homeless ☐ Incarcerated ☐ Shelter

Where and with whom will you live after completing treatment?
Are you Pregnant? ☐ No ☐ Yes If YES, what is your due date? ______________

Do you Have Children? ☐ No ☐ Yes
Are you the primary caretaker of your children? ☐ No ☐ Yes
If YES, have you arranged for childcare while you participate in treatment? ☐ No ☐ Yes
SPIRITUALITY:
During the past month, how would you rate your sense of connectedness, spirituality or relationship with a higher power?
☐ Excellent  ☐ Good/Improving  ☐ Fair/Not Changing  ☐ Not Good  ☐ Very Bad  ☐ Other:

How important is spirituality in your life?
☐ Very important  ☐ Somewhat Important  ☐ Not Very Important  ☐ Not At All Important

How often do you spend time on regular spiritual practices?
☐ Every day or almost every day  ☐ Several times a month  ☐ Occasionally  ☐ Very rarely  ☐ Not at all

What is your religious affiliation, if any? ______________________________________

Is there anything else that you would like us to know about your religious/cultural/spiritual practices?
________________________________________________________________________________

SUBSTANCE USE:
What is your drug of choice? ____________________________________________________
When is the last time you used alcohol and/or other drugs? __________________________
Are you currently injecting drugs? ☐ No  ☐ Yes
Do you use Tobacco Products?  ☐ No  ☐ Cigarettes  ☐ Smokeless tobacco (chew)  ☐ Other

List your goal or goals for the future: ___________________________________________________________________
________________________________________________________________________________

Describe your personal challenges or things that make it difficult to reach your goals: __________________________________________________
________________________________________________________________________________

What would you like to gain from treatment that would support your recovery goals?
________________________________________________________________________________
________________________________________________________________________________

MENTAL HEALTH SUMMARY:
Prior mental health history: (Check all that apply)
☐ No history  ☐ Counseling  ☐ Medication management  ☐ Hospitalization
Are you currently involved in mental health services? ☐ No  ☐ Yes  If YES, with whom? ___________________________
During the past 12 months, did you take any medication that was prescribed to treat a mental health or emotional condition? ☐ No  ☐ Yes  If YES, please list medication and dosage:
________________________________________________________________________________
________________________________________________________________________________

Dates of prior mental health hospitalizations: __________________________________________

PHYSICAL HEALTH SUMMARY:
Have you undergone, or are you currently undergoing hormonal therapy for transgender surgery? _________
If yes, is this process completed (physical surgery, hormonal treatment, and emotional counseling components)?

__________________________ When was this process completed? ________________

Do you intend to undergo hormonal therapy for transgender surgery while admitted to this program? ______

In general, how would you describe your current health? □ Excellent □ Very Good □ Good □ Fair □ Poor

Have you had any unplanned weight changes in the last 12 months? □ No □ Yes If YES, please explain:

______________________________________________________________

Do you have nutritional concerns? □ No □ Yes If YES, please explain:

______________________________________________________________

Do you have a primary medical provider? □ No □ Yes If YES, Who?

______________________________________________________________

If you do not have health benefits, what is your financial plan for prescribed medications? _____________________________

Do you have allergies to foods or medications? □ No □ Yes If YES, please list:

______________________________________________________________

Do you have any chronic health or pain issues? □ No □ Yes If YES, please explain: _______________________

______________________________________________________________

SELF-ADMINISTRATION OF MEDICATION ATTESTATION

I, ____________________________, am able to self-administer the medication(s) prescribed to me, including if needed, the physician approved over-the-counter medications. It will be my responsibility to ask staff to retrieve my medication from the secure area when it is time for me to take my medication. I will assist in the documentation process by documenting each time I take medication on the “Self-Administration of Medication Form”.

SIGNATURE: ___________________________ DATE: ______________________
CONTACT PREFERENCES

I, _______________________, DOB: _______________, REQUEST/AUTHORIZE TRUE NORTH TO: _______ DISCLOSE INFORMATION TO AND/OR _____ OBTAIN INFORMATION REGARDING MYSELF USING THE FOLLOWING CONTACT INFORMATION:

NAME: ________________________________________________________________________________________________________________
MAILING ADDRESS: ____________________________________________________________________________________________________
CITY:__________________________________ STATE:_________________________________ ZIPCODE:______________________________
EMAIL: ________________________________________________________________________________________________________________
FAX NUMBER: (If applicable)_______________________________________________________________________________________________
MAIN PHONE:*____________________________________________________________ *TNR will leave a voice or text message at this number

(PLEASE LIST ALL OTHER NUMBERS THAT WE MAY USE TO CONTACT YOU)
1) #______________________________________RELATION_______________________ OK TO LEAVE MESSAGE? _____YES _____NO
2) #______________________________________RELATION_______________________ OK TO LEAVE MESSAGE? _____YES _____NO
3) #______________________________________RELATION_______________________ OK TO LEAVE MESSAGE? _____YES _____NO
4) #______________________________________RELATION_______________________ OK TO LEAVE MESSAGE? _____YES _____NO

INITIAL: ______________________________               ______________________________                ______________

CLIENT SIGNATURE PRINTED NAME DATE

SIGNATURE OF PARENT GUARDIAN/REPRESENTATIVE PRINTED NAME DATE

WITNESS SIGNATURE PRINTED NAME DATE

_____ I understand that the information in this correspondence may contain information relating to my substance use diagnosis and/or treatment, mental health diagnosis and/or treatment, and/or Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)

_____ I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that the agencies identified above may not condition my treatment on whether I sign a consent form, but that in certain circumstances I may be denied treatment if I do not sign a consent form.

_____ I understand and consent to the use of all electronic communication, text messaging and email and that they all have potential security risks.
DISCLOSURE OF ALCOHOL AND DRUG TREATMENT INFORMATION


I UNDERSTAND THAT I MAY BE DENIED SERVICES IF I REFUSE TO CONSENT TO A DISCLOSURE FOR THE PURPOSES OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS, IF ALLOWED BY STATE LAW. I WILL NOT BE DENIED SERVICES IF I REFUSE TO CONSENT TO A DISCLOSURE FOR OTHER PURPOSES.

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I HAVE A RIGHT TO RECEIVE A COPY OF THIS SIGNED AUTHORIZATION. I ALSO UNDERSTAND THAT UPON MY WRITTEN REQUEST, TNR MUST PROVIDE A RECORD OF DISCLOSURES MADE FOR LEGAL, ADMINISTRATIVE OR QUALITY ASSURANCE PURPOSES.

---

**NOTICE**

**PROHIBITING REDISCLOSURE OF ALCOHOL AND DRUG TREATMENT INFORMATION**

This 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 of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

---

SIGNATURE OF CLIENT                         PRINT NAME                         DATE
Thank you for your interest in Vita Nova Residential Treatment, part of True North Recovery, Inc.

A completed packet is to include all documents listed on the Application Checklist.

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Wasilla, AK 99654

Please contact (907) 313-1333 for questions regarding the application process.

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Health Screening and Clearance to Participate

The following form must be completed in full, by your health care provider, to participate in True North Recovery Inc.’s, Vita Nova Residential Treatment Program.

Does this patient require detoxification prior to entering treatment?  □ No  □ Yes
Does this patient have any physical impairments/limitations?  □ No  □ Yes  (If YES, please explain):

__________________________________________________________________________________________________
_____________________________________________________________________________________________

Are there any reportable communicable diseases?  □ No  □ Yes  (If YES, please explain):

Is the patient pregnant?  □ No  □ Yes  (If YES, Due Date):_______

Diphtheria/Tetanus Booster: Current immunization required date given: _____/___/___

List known food or environmental allergies: ______________________________________________________________

MEDICATION ALLERGIES: ____________________________________________________________

List all the patients’ current prescription medications: (please use reverse side if needed for additional meds)

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSAGE</th>
<th>FREQUENCY AND ROUTE</th>
<th>INDICATION</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

If the patient is prescribed, addictive or narcotic medications are there non-narcotic alternatives?  □ No  □ Yes
If YES, please list:

__________________________________________________________________________________________________

PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>SYSTEM</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
VITAL SIGNS

ABDOMEN

HEENT

EXTREM./MSK

NECK/THYROID

NEUROLOGICAL

CARDIOVASCULAR

SKIN

PULMONARY

OTHER:

HAV-Ab: Positive___ Negative___

HBV-sAB: Positive___ Negative___

HBV-sAg: Positive___ Negative___

HBV-cAb: Positive___ Negative___

HCV-Ab: Positive___ Negative___

True North Recovery Inc. is not rated as an assisted living facility. Therefore, potential clients must be able to perform the following activities without assistance: Daily living activities (such as cooking, cleaning, toileting, bathing/showering, dressing etc.), entering/exiting a building and general mobility (may use medical devices such as a wheelchair or walker.)

Is the patient able to perform these activities without assistance? □ No  □ Yes

LABORATORY/RADIOGRAPHY

REQUIRED FOR ADMISSION

Hepatitis panel date:  HIV date:

HAV- Ab:  Positive___ Negative___  HIV 1/2-Ab, Ag: □ (-)  □ (+)
HBV-sAB:  Positive___ Negative___
HBV-sAg:  Positive___ Negative___
HBV-cAb:  Positive___ Negative___
HCV-Ab:  Positive___ Negative___

*TB date:

Quantiferon Gold □ (-)  □ (+)  CXR if (+) Quantiferon (+) □ (wnl) □ (abnl)

ELECTIVE / NOT REQUIRED FOR ADMISSION

hCG date: □ (-)  □ (+)  CBC date: □ (wnl) □ (abnl)

UA date: □ (wnl) □ (abnl)

Approved Over the Counter Medications

**Provider**: Mark Yes or No for the following medication to indicate your approval status

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>APPROVED</th>
<th>NOT APPROVED</th>
<th>SAMPLE USES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol)</td>
<td>YES</td>
<td>NO</td>
<td>500 mg by mouth every 6 hours as needed for PAIN/HEADACHE/FEVER [Maximum 2000 mg/24hours]</td>
</tr>
<tr>
<td>Ibuprofen (Advil, Motrin) 400 mg</td>
<td>YES</td>
<td>NO</td>
<td>400 mg by mouth every 6 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS/FEVER [Maximum 1600 mg/24hours]</td>
</tr>
<tr>
<td>Naproxen(Aleve)</td>
<td>YES</td>
<td>NO</td>
<td>220 mg by mouth every 8 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS</td>
</tr>
<tr>
<td>Calcium Carbonate</td>
<td>YES</td>
<td>NO</td>
<td>1000 mg by mouth every 4 hours as needed for HEARTBURN</td>
</tr>
<tr>
<td>Drug and Description</td>
<td>YES</td>
<td>NO</td>
<td>Dose/Usage</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>-----</td>
<td>------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Bismuth Subsalicylate (Pepto-Bismol)</td>
<td>YES</td>
<td>NO</td>
<td>30 ml. or two 262 mg tablets by mouth every 4 hours as needed for HEARTBURN/INDIGESTION/DIARRHEA</td>
</tr>
<tr>
<td>Lactaid</td>
<td>YES</td>
<td>NO</td>
<td>1 tablet by mouth when eating dairy products as needed for LACTOSE INTOLERANCE</td>
</tr>
<tr>
<td>Multi-vitamin</td>
<td>YES</td>
<td>NO</td>
<td>1 tablet by mouth daily as needed for NUTRITIONAL SUPPLEMENT</td>
</tr>
<tr>
<td>Loratadine (Claritin)</td>
<td>YES</td>
<td>NO</td>
<td>10 mg by mouth daily as needed for SEASONAL ALLERGIES</td>
</tr>
<tr>
<td>(Halls, cough drop) 1 lozenge</td>
<td>YES</td>
<td>NO</td>
<td>Cough Suppressant - 1 lozenge by mouth every 1 hour as needed for COUGH/SORE THROAT</td>
</tr>
<tr>
<td>Diphenhydramine hydrochloride (Benadryl)</td>
<td>YES</td>
<td>NO</td>
<td>25 mg by mouth every 4 hours as needed for SEVERE ITCHING/NASAL CONGESTION</td>
</tr>
<tr>
<td>Benzocaine local anesthetics (Orajel)</td>
<td>YES</td>
<td>NO</td>
<td>apply gel directly to sore tooth or gum every 6 hours as needed for TOOTH/GUM PAIN</td>
</tr>
<tr>
<td>OTHER:</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

This patient has been medically evaluated and cleared to participate in residential treatment, which may include, groups and other activities for 8 or more hours per day. □ No □

This patient has been medically evaluated and cleared to live in a group atmosphere. □ No □

This patient has been medically cleared to participate in moderate aerobic and strength training exercises. □ No □

□ I have evaluated ___________________________________ and believe that this patient is capable and competent to self-administer his or her own medication, as prescribed.

PROVIDER SIGNATURE AND CREDENTIALS ________________________________  DATE ____________

PROVIDER NAME PRINTED ________________________________  PHONE NUMBER __________________

NAME OF CLINIC OR OFFICE ________________________________

---

True North Recovery
591 S. Knik Goose Bay Rd
Wasilla, AK 99654
CONSENT FOR DISCLOSURE OF INFORMATION

I, ______________________, DOB: ______________, REQUEST/AUTHORIZE TRUE NORTH TO: _______ DISCLOSE INFORMATION TO AND/OR _______ OBTAIN INFORMATION FROM:

NAME OF ORGANIZATION AND/OR INDIVIDUAL ____________________________

MAILING ADDRESS ______________________________________________________

PHONE: ___________________ FAX PHONE: _______________ EMAIL: ______________________________

I authorize the release and/or disclosure of the following clinical treatment records:

INITIAL ALL THAT APPLY.

____ ALL LISTED BELOW OR

____ UA RESULTS
____ ASSESSMENT/INTERPRETIVE SUMMARY
____ TREATMENT PLAN/CASE REVIEWS
____ LEAVE MSG FOR CLIENT TO CONTACT AGENCY
____ FINANCIAL INFORMATION AND ATTENDANCE

____ DISCHARGE SUMMARY
____ PROGRESS NOTES, TREATMENT/PLAN
____ NOTES, OR CLOSING SUMMARY

____ OTHER ______________________

____ ALL DATES OF SERVICES OR DATE or DATE RANGE of RECORDS TO BE RELEASED:

________________________________________

FOR THE PURPOSE OF: (INITIAL ALL THAT APPLY)

____ ALL LISTED BELOW OR

____ FURTHER TREATMENT/COORDINATION OF CARE
____ AT THE REQUEST OF THE CLIENT
____ LEGAL PURPOSES

____ OTHER ______________________

This ROI expires one year from the date is was signed, unless it is rescinded below.

INITIAL

______ I UNDERSTAND THAT THE INFORMATION IN THIS HEALTH RECORD MAY CONTAIN INFORMATION RELATING TO SUBSTANCE USE DIAGNOSIS AND/OR TREATMENT, MENTAL HEALTH DIAGNOSIS AND/OR TREATMENT AND/OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

I HAVE READ THE BACK OF THIS CONSENT AND HAVE BEEN PROVIDED WITH A COPY OF MY RIGHTS UNDER AND RESPONSIBILITIES AND UNDERSTAND THE PURPOSE OF THIS CONSENT

________________________________________

SIGNATURE OF CLIENT PRINT NAME DATE

________________________________________

SIGNATURE OF PARENT PRINT NAME DATE

GUARDIAN/REPRESENTATIVE

__________________________

SIGNATURE OF WITNESS PRINT NAME DATE

STOP. ONLY SIGN BELOW IF YOU ARE WANTING TO RESCIND YOUR ORIGINAL AUTHORIZATION FOR RELEASE OF INFORMATION. IF YOU WISH TO CHANGE THE INFORMATION TO BE RELEASE YOU WILL NEED TO SIGN A NEW ROI.

________________________________________

________________________________________

________________________________________

SIGNATURE OF CLIENT PRINT NAME DATE

SIGNATURE OF PARENT PRINT NAME DATE

GUARDIAN/REPRESENTATIVE

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APPROVED ITEMS TO BRING

Documents
• Photo I.D. (this is required)
• Calling card for long distance calls; local calls are free of charge.
• Stamps
• Social Security Card (if you have one)
• Medicaid Insurance Card (if you have one)
• Private Insurance Card
• Food Stamp Card (if you have one)
• Any important documentation you will need while in treatment (court documents etc.)
• Address book and phone numbers of sober support and loved ones

Clothing
Laundry facility and laundry detergent will be provided free of charge
• Warm Coat
• Light jacket
• Winter Gear
• 7 changes of clothing (No clothing with logos that depict alcohol, tobacco, violence, profanity, or sexual messages)
• 1 set of dress attire for church or special events
• 2 sets of exercise clothing
• 2 pajamas
• 7 pairs of socks
• 1 bathrobe
• 1 pair of indoor slippers
• 1 pair of everyday shoes
• 1 pair exercise shoes
• 1 pair of dress shoes
• 4 bras
• Underwear

Personal Toiletry Items
Alcohol MAY NOT be in the first 2 ingredients in these toiletries except for shampoo and conditioner and all toiletries must be brand new.
• Prescription glasses

**If you do not have the financial ability to purchase these items, your case manager can assist you in obtaining the community resources necessary to provide for your needs.

Page 1 of 2
PROHIBITED ITEMS

- Candles
- Air fresheners
- Febreeze
- Aerosol sprays of any kind
- Gum
- Unmarked hygiene items or powder
- Excessive amounts of money ($100) or expensive jewelry. The program is not responsible for lost or stolen items.
- Personal vehicle
- Electronic device such as laptops or tablets
- DVD movies
- Unapproved or previously opened over-the-counter medications
- Pornography or sex toys
- Mood altering substances of any kind, legal or illegal, i.e., marijuana, spice k2, bath salts, herbal incense, kratom
- Firearms or Ammunition
- Weapons or any items that could be used as a weapon, i.e., knives, needles
- Loose razor blades
- Illegal drugs
- Drug paraphernalia
- Alcoholic beverages
- Synthetic drugs including but not limited to synthetic cannabinoid

**A personal belongings container with limited space is available to secure valuable personal belongings such as excessive money or expensive jewelry. However, if possible, it may be best to arrange with a friend or family member to secure those items for you. If you have any additional questions or concerns, please call.**
REFFERAL FOR ADMISSION
To be completed by referring provider / agency

Applicant Name: ___________________________________________ Date of Birth: _____________     Age: ______

Physical Address (street/city/state/zip): _________________________________________________________________
Mailing address (if different from residence): ____________________________________________________________

Describe applicant’s motivation to commit treatment:

☐ Motivated (understands she/he needs help and willing to do what it takes to get it)
☐ Ambivalent (acknowledges that others see she/he has a problem, but not fully prepared to deal with it. Accepting of treatment only with strong external motivators)
☐ Denial (unwilling to accept that she has problem despite evidence to the contrary)
☐ Resistant (denies problem, actively refusing or fighting efforts to provide help)

Describe the main problem(s) for which the applicant is being referred. ______________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

What does the applicant describe as the main problem(s)? _________________________________________________
________________________________________________________________________________________________

Has the applicant ever been referred/received substance abuse/dependence treatment? ☐ No ☐ Yes If YES, briefly describe (when, where, and the outcome). ________________________________________________

Has there been a substance uses assessment in the last 90 days? ☐ No ☐ Yes If YES, Where?
Is the assessment attached to this referral? ☐ No ☐ Yes

Has applicant ever been referred/received mental health treatment? ☐ No ☐ Yes If YES, briefly describe when, where, and the outcome:

Is applicant receiving mental health treatment now? ☐ No ☐ Yes If YES, please name provider

Referral Information: (IF APPLICABLE)

Referring Individual Name: ___________________________ Relationship to applicant: ___________________________
Referring Agency Name (if applicable): _________________________________________________________________
Address: __________________________________________________________________________________________
Phone: ( ) _____________________       FAX# _____________________       Email: __________________________

Will the client be returning to you after treatment? ☐ No ☐ Yes
If NO, who will provide follow-up care: ________________________________________________________________

Referrer contact information (phone number/email address): ________________________________________________

Referral Agent Signature: ___________________________________________ Date: _____________