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) 357-8781, scanned and sent via email to vitanova@tnrak.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
☐ 30 Day Commitment
☐ 90 Day Commitment
☐ 180 Day Commitment
☐ Emergency Commitment
☐ Office of Children Services
☐ Probation/Parole
☐ Informal Probation
☐ Incarcerated
☐ Case Pending
☐ Deferred Prosecution
☐ Community Sentencing
☐ Court Ordered for alcohol treatment
☐ Court Ordered for mental health treatment
☐ Court Ordered for observation and evaluation
☐ Other ________________________________

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

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

☐ Regaining custody of children/parenting issues
☐ Social network problem (I.e. drug using friends/acquaintances)
☐ Lack of sober, social support
☐ Lack of self-esteem, self-confidence, or positive identity
☐ Lack of structure and time management skills
☐ Financial concerns or unpaid bills
☐ Lack of stress management skills
☐ Education issues
☐ Poor communication skills and/or poor
☐ Conflict management skills
☐ Housing
☐ 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-ADMINISTATRATION 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
(CLIENT NAME) (INITIAL)
INFORMATION TO AND/OR _______ OBTAIN INFORMATION REGARDING MYSELF USING THE FOLLOWING CONTACT
(INITIAL)
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:

_____ 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.

____________________________	______________________________	________________
CLIENT SIGNATURE	PRINTED NAME	DATE
____________________________	______________________________	________________
SIGNATURE OF PARENT GUARDIAN/REPRESENTATIVE	PRINTED NAME	DATE
____________________________	______________________________	________________
WITNESS SIGNATURE	PRINTED NAME	DATE

DISCLOSURE OF ALCOHOL AND DRUG TREATMENT INFORMATION

I UNDERSTAND THAT MY ALCOHOL AND/OR DRUG TREATMENT RECORDS ARE PROTECTED UNDER THE FEDERAL REGULATIONS GOVERNING CONFIDENTIALITY AND DRUG ABUSE 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 AND 164, AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED FOR BY THE REGULATIONS.

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 UNDERSTAND THAT I MAY REVOKE A CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION BASED ON THIS CONSENT HAS ALREADY BEEN TAKEN. SEE RECEPTION FOR INSTRUCTIONS TO REVOKE A CONSENT. IF TREATMENT IS MANDATED AS PART OF PROBATION REQUIREMENTS, A CONSENT MAY NOT BE REVOKED UNTIL CONDITIONS OF PROBATION ARE MET OR PROBATION ENDS.

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

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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.

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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.

Patient Name: ____

Date of Birth: ____

Phone Number: ____

Emergency Contact: ___________________________________

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)

MEDICATION	DOSAGE	FREQUENCY AND ROUTE	INDICATION

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

____

PHYSICAL EXAMINATION

SYSTEM	NORMAL	ABNORMAL	SYSTEM	NORMAL	ABNORMAL
VITAL SIGNS			ABDOMEN		
HEENT			EXTREM./MSK		
NECK/THYROID			NEUROLOGICAL		
CARDIOVASCULAR			SKIN		
PULMONARY			OTHER:		

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___ HBV-sAB: Positive___ Negative___ HBV-sAg: Positive___ Negative___ HBV-cAb: Positive___ Negative___ HCV-Ab: Positive___ Negative___	HIV 1/2-Ab, Ag: ☐ (-) ☐ (+)
	*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

MEDICATION	APPROVED	NOT APPROVED	SAMPLE USES
Acetaminophen (Tylenol)	YES	NO	500 mg by mouth every 6 hours as needed for PAIN/HEADACHE/FEVER [Maximum 2000 mg/24hours]
Ibuprofen (Advil, Motrin) 400 mg	YES	NO	400 mg by mouth every 6 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS/FEVER [Maximum 1600 mg/24hours]
Naproxen(Aleve)	YES	NO	220 mg by mouth every 8 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS

Calcium Carbonate (Tums)	YES	NO	1000 mg by mouth every 4 hours as needed for HEARTBURN
Bismuth Subsalicylate (Pepto-Bismol)	YES	NO	30 ml. or two 262 mg tablets by mouth every 4 hours as needed for HEARTBURN/INDIGESTION/DIARRHEA
Lactaid	YES	NO	1 tablet by mouth when eating dairy products as needed for LACTOSE INTOLERANCE
Multi-vitamin	YES	NO	1 tablet by mouth daily as needed for NUTRITIONAL SUPPLEMENT
Loratadine (Claritin)	YES	NO	10 mg by mouth daily as needed for SEASONAL ALLERGIES
(Halls, cough drop) 1 lozenge	YES	NO	Cough Suppressant - 1 lozenge by mouth every 1 hour as needed for COUGH/SORE THROAT
Diphenhydramine hydrochloride (Benadryl)	YES	NO	25 mg by mouth every 4 hours as needed for SEVERE ITCHING/NASAL CONGESTION
Benzocaine local anesthetics (Orajel)	YES	NO	apply gel directly to sore tooth or gum every 6 hours as needed for TOOTH/GUM PAIN
OTHER: _______________	YES	NO	
OTHER: _______________	YES	NO	

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 ☐ Yes

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

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

☐ 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
Phone (907) 313 1333 Fax (907) 357-8781

CONSENT FOR DISCLOSURE OF INFORMATION

I, ______________________, DOB: _____________, REQUEST/AUTHORIZE TRUE NORTH TO: _______ DISCLOSE
(CLIENT NAME) (INITIAL)
INFORMATION TO AND/OR _______ OBTAIN INFORMATION FROM:
(INITIAL)
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 AGENCT
____ FINANCIAL INFORMATION AND ATTENDENCE
____ 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
____ FINANCIAL
____ PAYMENT HEALTH CARE OPERATIONS
____

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 HELTH DIAGNOSIS AND/OR TREATMENT AND/OR HUMAN IMMUNODEFICIENCY VIRIUS (HIV) AND AQUIRED IMMUNE DEFICIENCT 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 GUARDIAN/REPRESENTATIVE PRINT NAME DATE

______________________________ ______________________________ ______________
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.

______________________________ ______________________________ ______________
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SIGNATURE OF CLIENT	PRINT NAME	DATE

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
- Contact lenses (if wearing contacts)
- 1 contact solution (if wearing contacts)
- 1 shampoo
- 1 conditioner
- 1 hair styling product (kept in locker)
- 1 body wash or soap bar
- 1 face wash
- 1 face moisturizer
- 1 pack Q-tips
- 1 deodorant
- 1 shave cream (optional)
- 4 razors (kept in the locker)
- 1 lotion
- 1 nail clipper for toes/ 1 for nails
- 1 nail file
- 1 set of dentures/cleaner/glue (if you have dentures)
- 1 toothbrush
- 1 toothpaste
- 1 water bottle
- 1 travel size hairspray (will be kept in the office)
- 1 body spray (aerosol free)
- 1 box of tampons or 1 bag of pads
- 1-quart size Ziploc bag of makeup

Optional Items

- 1 large priority box 12 ¼” x 12 ¼ x 6” of approved reading materials—recovery related literature, daily devotions, spiritual, self-help, educational etc.
- 1 large priority box 12 ¼” x 12 ¼ x 6” of coping materials—sewing knitting, beading, scrapbooking etc.
- Cell phone may be used only while out on pass

**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.

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:** _____________