

Thank you for your interest in 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, completed within the past 6 months and inclusive of ASAM)
 |
| * 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 Court Ordered for alcohol treatment  Informal Probation Court Ordered for mental health treatment  Incarcerated Court Ordered for observation and evaluation  Case Pending Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Deferred Prosecution  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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been charged with arson? ­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you required by state or federal authorities to register as a sexual offender? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 PRINTED NAME DATE

GUARDIAN/REPRESENTATIVE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

I HAVE HAD EXPLAINED TO ME AND FULLY UNDERSTAND THIS REQUEST/AUTHORIZATION TO RELEASE AND/OR OBTAIN RECORDS AND INFORMATION, INCLUDING THE NATURE OF THE RECORDS, THEIR CONTENTS, AND THE CONSEQUENCES AND IMPLICATIONS OF THEIR RELEASE. I UNDERSTAND THAT ONCE MY INFORMATION IS RELEASED, TNR CANNOT PREVENT THE REDISCLOSURE OF THAT INFORMATION, HOWEVER DOES PROVIDE A STATEMENT OF PROHIBITION AGAINST REDISCLOSURE OF PROTECTED HEALTH INFORMATION WITH DISCLOSURES MADE.

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

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**.

**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.

|  |
| --- |
| 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  |
|  | \*TB date: Quantiferon Gold (-) (+)    |   |
|  | CXR if (+) Quantiferon (+) (wnl)     |
|  |  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 forPAIN/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 \_\_\_\_ ATTENDANCE

 \_\_\_\_ ASSESSMENT/INTERPRETIVE SUMMARY \_\_\_\_ DISCHARGE SUMMARY

 \_\_\_\_ TREATMENT PLAN/CASE REVIEWS \_\_\_\_ PROGRESS NOTES, TREATMENT/PLAN \_\_\_\_ LEAVE MSG FOR CLIENT TO CONTACT AGENCT \_\_\_\_ NOTES, OR CLOSING SUMMARY

\_\_\_\_ FINANCIAL INFORMATION AND ATTENDENCE \_\_\_\_ 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 \_\_\_\_ FINANCIAL

\_\_\_\_ AT THE REQUEST OF THE CLIENT \_\_\_\_ PAYMENT HEALTH CARE OPERATIONS

\_\_\_\_ 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 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 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

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.

I HAVE HAD EXPLAINED TO ME AND FULLY UNDERSTAND THIS REQUEST/AUTHORIZATION TO RELEASE AND/OR OBTAIN RECORDS AND INFORMATION, INCLUDING THE NATURE OF THE RECORDS, THEIR CONTENTS, AND THE CONSEQUENCES AND IMPLICATIONS OF THEIR RELEASE. I UNDERSTAND THAT ONCE MY INFORMATION IS RELEASED, TNR CANNOT PREVENT THE REDISCLOSURE OF THAT INFORMATION, HOWEVER DOES PROVIDE A STATEMENT OF PROHIBITION AGAINST REDISCLOSURE OF PROTECTED HEALTH INFORMATION WITH DISCLOSURES MADE.

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

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

 Page 1 of 1

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.

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: \_\_\_\_\_\_\_\_\_\_\_\_\_**