Application Checklist Page

- ☐ 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 (3.5 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

Women's Residential

- Completed applications can either be faxed to (907) 746-4750, or scan and email to the Office Administrator seana@setfreealaska.org, or mail to:

  Set Free Alaska
  P.O. Box 876741
  Wasilla AK 99687

  Please contact (907) 746-4748. Ext #4 for questions regarding the application process. All other questions please contact the Case Manager, Jennifer (907) 746-4748 ext. #3 or (907)315-6775.

Men's Residential

•Completed applications can either be faxed to (907) 235-3251, or scan and email to the victoria.w@setfreealaska.org, or mail to:

Set Free Alaska
1130 Ocean Drive Suite A
Homer, AK 99603

All other questions please contact the Case Manager, Michelle (907) 235-3250 ext. #3 or (907) 521-6056.

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: _____

Referral Information:

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: _____

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 ☐ Self-pay ☐ Medicaid (includes Denali Kid Care) ☐ Other

Medicaid ID number: _____Medicare ID Number: _____

CLIENT INFORMATION

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

Marital Status: ☐ Married ☐ Living as married ☐ Widowed/Widower
☐ Separated ☐ Single (never married) ☐ Divorced: how long?_____

Race: (Please Check)

☐ Aleut	☐ Haida	☐ Tsimshian
☐ American Indian	☐ Hispanic	☐ Yupik
☐ Asian	☐ Native Hawaiian	☐ Other Alaska Native _____
☐ Athabascan	☐ Inupiat	☐ Other _____
☐ Black/African American	☐ Pacific Islander	
☐ Caucasian	☐ Tlingit	

Ethnicity:

☐ Chicano/Other Hispanic	☐ Mexican American	☐ Not Spanish/Hispanic/Latino
☐ Cuban	☐ Puerto Rican	
☐ Hispanic-origin not specified	☐ Spanish/Hispanic Latino	

Military:

☐ Active duty; Combat	☐ Active Duty; No Combat	☐ Military Dependent
☐ **Never** in Military	☐ Retired from Military	☐ Reserves/National Guard; Combat
☐ Reserves/National Guard; No Combat		☐ Other _____

Legal Status:

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

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 primarily spoken in your home? _____

Do you speak a second language? ☐ No ☐ Yes If YES, what language? _____

Do you need an interpreter? ☐ No ☐ Yes

Do you have special needs? (**Check all that apply**)

☐ Diagnosed memory and/or learning disabilities ☐ Severe Hearing Loss or Deaf

Do you need auditory aides? ☐ 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 problems
☐ 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
☐ Shame and guilt about hurting family or need to make amends
☐ 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
☐ Lack of motivation
☐ Housing
☐ Other: Please explain_____
_____

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 Persons
☐ 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

Please list all your children:

Name	Date of Birth	Where does your child live?

Are you the primary caretaker for any of your children? ☐ No ☐ Yes

If YES, have you made arrangements for childcare? ☐ No ☐ Yes

Are you requesting to bring your child (children) to the center? ☐ 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 used 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 prescription 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? ☐ Yes ☐ No If yes, please explain: _____

_____

SIGNATURE: _____ DATE: _____

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Emergency Contact: _____

Health Screening and Clearance to Participate

The following information form must be <u>completed in full</u> by your health care provider to participate in a Set Free Alaska 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

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:		

Set Free Alaska Residential Treatment facility 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:	☐ (-)	☐ (+)	HIV 1/2-Ab, Ag:	☐ (-)	☐ (+)
HBV-sAb:	☐ (-)	☐ (+)			
HBV-sAg:	☐ (-)	☐ (+)	*TB date:		
HBV-cAb:	☐ (-)	☐ (+)	Quantiferon Gold	☐ (-)	☐ (+)
HCV-Ab:	☐ (-)	☐ (+)	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**
☐YES ☐ NO	Acetaminophen (Tylenol) 500mg by mouth every 6 hours as needed for PAIN/HEADACHE/FEVER MENSTRUAL CRAMPS [Maximum 2000 mg/24hours]
☐YES ☐NO	Ibuprofen (Advil, Motrin) 400 mg by mouth every 4 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS/FEVER
☐YES ☐NO	Naproxen(Aleve) 220mg by mouth every 8 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS/MUSCLE ACHE/FEVER
☐YES ☐NO	Calcium Carbonate (Tums) 1000 mg by mouth every 4 hours as needed for HEARTBURN
☐YES ☐NO	Bismuth Subsalicylate (Pepto-Bismol) 30 ml. or two 262 mg tablets by mouth every 4 hours as needed for HEARTBURN/INDIGESTION/DIARRHEA
☐YES ☐NO	Docusate Sodium (Colace) 100 mg by mouth two times daily as needed for CONSTIPATION
☐YES ☐NO	Anti-gas tablets (Beano) 2 tablets by mouth before meals as needed for FLATULENCE/GAS
☐YES ☐NO	Lactaid 1 tablet by mouth when eating dairy products as needed for LACTOSE INTOLERANCE
☐YES ☐NO	Multi-vitamin take 1 tablet by mouth daily as needed for NUTRITIONAL SUPPLEMENT
☐YES ☐NO	Magnesium Supplement - take 1 tablet by mouth daily as needed for NUTRITIONAL SUPPLEMENT
☐YES ☐NO	Loratadine (Claritin) 10 mg by mouth daily as needed for SEASONAL ALLERGIES
☐YES ☐NO	Oxymetazoline 0.05% solution nasal spray (Afrin) 2 sprays each nostril 2 times a day as needed for NASAL CONGESTION
☐YES ☐NO	Cough Suppressant (Halls, cough drop) 1 lozenge by mouth every 1 hour as needed for COUGH/SORE THROAT

☐YES ☐NO	Diphenhydramine hydrochloride (Benadryl) 25 mg by mouth every 4 hours as needed for SEVERE ITCHING/NASAL CONGESTION. Consult health care provider if symptoms worsen or persist
☐YES ☐NO	Nicotine Patch one 14 mg nicotine patch applied once per day for TOBACCO/CIGARETTE CRAVINGS
☐YES ☐NO	FOR THOSE ALLERGIC TO NICOTINE PATCHES: Nicotine Lozenges one 2-4 mg lozenge by mouth every 2-4 hours
☐YES ☐NO	Benzocaine local anesthetics (Orajel) apply gel directly to sore tooth or gum every 6 hours as needed for TOOTH/GUM PAIN
☐YES ☐NO	Topical antibiotic ointment (Neosporin) apply thin layer to affected skin area 3 times daily as needed for ITCHING/SKIN IRRITATION
☐YES ☐NO	Hydrocortisone acetate 1% cream apply thin layer to affected skin area 3 times daily as needed for ITCHING/SKIN IRRITATION
☐YES ☐NO	Clotrimazole 1% (Lotrimin) apply thin layer to affected skin are 2 times daily as needed for ATHLETE'S FOOT/JOCK ITCH/RINGWORM

PATIENT NAME: _____ DATE OF BIRTH: _____

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 their own medication, as prescribed.

_____ _____
PROVIDER SIGNATURE AND CREDENTIALS DATE

_____ _____
PROVIDER NAME PRINTED PHONE NUMBER

_____
NAME OF CLINIC OR OFFICE

FOR PATIENT TO COMPLETE

I, _____, am able to self-administer the medication(s) prescribed to me, including if needed the physician approved over-the-counter medications listed above. I will be responsible 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 the medication I take at the time I take it on the "Self-Administration of Documentation form."

_____ _____
PATIENT SIGNATURE DATE

CONTACT PREFERENCES

I, _____ (CLIENT NAME), DOB: _____, REQUEST/AUTHORIZE SET FREE ALASKA TO: _____ (INITIAL) DISCLOSE INFORMATION TO AND/OR _____ (INITIAL) OBTAIN INFORMATION FROM MYSELF USING THE FOLLOWING CONTACT INFORMATION:

NAME: _____

MAILING ADDRESS: _____

CITY:_____ STATE:_____ ZIPCODE:_____

EMAIL: _____

FAX NUMBER: (If applicable)_____

MAIN PHONE:*_____ *SFA 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.

_____	_____	_____
SIGNATURE OF CLIENT	PRINT NAME	DATE
_____	_____	_____
SIGNATURE OF PARENT, GUARDIAN OR REPRESENTATIVE	RELATIONSHIP TO CLIENT	DATE
_____	_____	_____
WITNESS SIGNATURE	PRINTED NAME OF WITNESS	DATE

PO BOX 876741
WASILLA, AK 99687
907-373-4732 MAT-SU OFFICE
907-235-4732 HOMER OFFICE

****EXAMPLE****

CONSENT FOR DISCLOSURE OF INFORMATION

I, Jane Doe DOB: 6-2-80, REQUEST/AUTHORIZE **SET FREE ALASKA** AND

NAME OF ORGANIZATION **AND** INDIVIDUAL, OR THIRD PARTY PAYER: Agency Name and/or Contact Person

MAILING ADDRESS: 4567 Made up Ln. Wasilla, Ak 99654

PHONE: (907)891-2345 FAX: (907)678-9123 EMAIL: first.last@agency.com

TO COMMUNICATE WITH AND DISCLOSE TO ONE ANOTHER THE FOLLOWING INFORMATION:

SPECIFIC INFORMATION TO BE RELEASED: (INITIAL ALL THAT APPLY)

JD ALL LISTED BELOW OR:

* Please fill one of these forms out for any agency or person tha we may need to contact, such as the agency that did your assessments, your OCS case worker, or probation officer.*

_____ ASSESSMENT/INTERPRETIVE SUMMARY
_____ TREATMENT PLAN
_____ TREATMENT REVIEWS/PROGRESS
_____ PSYCHOLOGICAL EVALUATION
_____ OTHER:_____

_____ UA/DRUG TEST RESULTS
_____ ATTENDENCE
_____ DISCHARGE SUMMARY
_____ FINANCIAL/PAYMENT INFORMATION

JD ALL DATES of SERVICE OR: DATE or DATE RANGE of RECORD(S) to be released: _____

FOR THE PURPOSE OF: (INITIAL ALL THAT APPLY)

JD ALL LISTED BELOW OR:

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

_____ FINANCIAL
_____ PAYMENT & HEALTH CARE OPERATIONS
_____ OTHER _____

INITIAL

JD 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.

THIS CONSENT AUTOMATICALLY EXPIRES ONE YEAR FROM LAST DATE OF SERVICE WITH SFA (or upon completion of financial obligation, whichever is later) UNLESS OTHERWISE SPECIFIED. OTHER DATE/EVENT:_____

Jane Doe	Jane Doe	6/9/20
SIGNATURE OF CLIENT	PRINT NAME	DATE
SIGNATURE OF PARENT, GUARDIAN OR REPRESENTATIVE	RELATIONSHIP TO CLIENT	DATE
Witness	Witness	6/9/20
WITNESS SIGNATURE	PRINTED NAME OF WITNESS	DATE

Recipients: If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

THIS ROI IS REVOKED _____ INITIAL

**** DO NOT INITIAL THIS LINE****
Initialing this line will void consent.

P.O. Box 870911
Wasilla, AK 99687
907-373-4732 Mat-Su (FAX 907-746-4749)
907-235-4732 Homer (FAX 907-235-4733)

CONSENT FOR DISCLOSURE OF INFORMATION

I, _____DOB: _____, REQUEST/AUTHORIZE **SET FREE ALASKA** AND

NAME OF ORGANIZATION **AND** INDIVIDUAL, OR THIRD PARTY PAYER: _____

MAILING ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

TO COMMUNICATE WITH AND DISCLOSE TO ONE ANOTHER THE FOLLOWING INFORMATION:

SPECIFIC INFORMATION TO BE RELEASED: (INITIAL ALL THAT APPLY)

____ ALL LISTED BELOW OR:

_____ ASSESSMENT/INTERPRETIVE SUMMARY
_____ TREATMENT PLAN
_____ TREATMENT REVIEWS/PROGRESS
_____ PSYCHOLOGICAL EVALUATION
_____ OTHER:_____

_____ UA/DRUG TEST RESULTS
_____ ATTENDENCE
_____ DISCHARGE SUMMARY
_____ FINANCIAL/PAYMENT INFORMATION

_____ ALL DATES of SERVICE OR: DATE or DATE RANGE of RECORD(S) to be released: _____

FOR THE PURPOSE OF: (INITIAL ALL THAT APPLY)

____ ALL LISTED BELOW OR:

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

____ FINANCIAL
____ PAYMENT & HEALTH CARE OPERATIONS
____ OTHER _____

INITIAL
_____ 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.

THIS CONSENT AUTOMATICALLY EXPIRES ONE YEAR FROM LAST DATE OF SERVICE WITH SFA (or upon completion of financial obligation, whichever is later) UNLESS OTHERWISE SPECIFIED. OTHER DATE/EVENT:_____

_____	_____	_____
SIGNATURE OF CLIENT	PRINT NAME	DATE
_____	_____	_____
SIGNATURE OF PARENT, GUARDIAN OR REPRESENTATIVE	RELATIONSHIP TO CLIENT	DATE
_____	_____	_____
WITNESS SIGNATURE	PRINTED NAME OF WITNESS	DATE

Recipients: If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

THIS ROI IS REVOKED _____ INITIAL

PO Box 876741
Wasilla, AK 99687
907-373-4732 Mat-Su(FAX 907-746-4749)
907-235-4732 Homer(FAX907-235-4733)

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, SFA 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, SFA 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

PO Box 876741
Wasilla, AK 99687
907-373-4732 Mat-Su(FAX 907-746-4749)
907-235-4732 Homer(FAX907-235-4733)

SNAP Acknowledgement

As an FNS (Food and Nutrition Services) certified drug and alcohol treatment center, Valley Oaks Residential is qualified to use SNAP benefits for any eligible resident's food needs while they reside in a facility. The amount of benefits a facility can use and the date the facility can receive the benefits depends on the following:
-The date the resident entered and leaves the facility
-The monthly SNAP benefit amount, and if the monthly benefit amount was issued for the individual or household.

The facility is held financially responsible for any loss of benefits to the resident due to misuse or theft of the an EBT card while in possession of the facility; therefore, Set Free Alaska will retain all cards which will be kept and secured for safekeeping.

For clients who are currently receiving benefits a change form will be submitted to the DPA office notifying them the individual is now residing at our facility, along with a request to have an alternate card issued with Set Free Alaska Inc. listed as the authorized representative. Clients who are not receiving benefits will be required to submit an application to the DPA office for food assistance, along with a request to have an alternate card issued with Set Free Alaska as the authorized representative.

Upon discharge Set Free Alaska Inc. will relinquish the card back to the client, and a change notice will be sent to the DPA office notifying them the client is no longer residing at our facility. Any alternate cards issued to Set Free Alaska Inc. will then be destroyed, and any final benefits for the month will be paid to the agency if applicable.

By signing below, I acknowledge understanding of, and agree to abide by the SNAP benefit policy.

_____ _____

Signature Date

REFFERAL FOR ADMISSION

** To be completed by referring provider/agency (if any)

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 needs help and willing to do what it takes to get it)
- ☐ Ambivalent (acknowledges others sees she has problem, but not fully prepared to deal with it or accepting treatment only with strong external pressure)
- ☐ 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 completed by: _____ Relationship to applicant: _____

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

Referral Agent Signature: _____ 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

- Seven Changes of Clothing
    - **No clothing with logos that depict alcohol, tobacco, violence, profanity, or sexual messages**
- Warm Coat
- Light jacket
- Winter Gear
- 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
- Women's Residential
    - 4 Bras
    - Underwear
- Men's Residential
    - Underwear/Boxers

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 hairs styling product (aerosol free)
- 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 office)
- 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
- Water bottle
- Women's Residential
    - 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" 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
- Febreze
- Aerosol sprays of any kind
- Nicotine products of any kind, including chew, cigars, electronic cigarettes, vapes, etc.
- 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
- Matches or lighters
- Mood altering substances of any kind, legal or illegal, i.e., marijuana, spice 2k, bath salts, herbal incense
- 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 in the office to secure valuable personal belongings such as excessive money or expensive jewelry. However, if possible, it may be best to make arrangements with a friend or family member to secure those items for you. If you have any additional questions or concerns, please call.

**Children: Men and Women are responsible for all their child's needs while in treatment; diapers, formula, clothing, health care, monitors, car seat, etc.