



## 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](mailto: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](mailto: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)

<input type="checkbox"/> Aleut	<input type="checkbox"/> Haida	<input type="checkbox"/> Tsimshian
<input type="checkbox"/> American Indian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Yupik
<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Alaska Native _____
<input type="checkbox"/> Athabascan	<input type="checkbox"/> Inupiat	<input type="checkbox"/> Other _____
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Pacific Islander	
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Tlingit	

**Ethnicity:**

<input type="checkbox"/> Chicano/Other Hispanic	<input type="checkbox"/> Mexican American	<input type="checkbox"/> Not Spanish/Hispanic/Latino
<input type="checkbox"/> Cuban	<input type="checkbox"/> Puerto Rican	
<input type="checkbox"/> Hispanic-origin not specified	<input type="checkbox"/> Spanish/Hispanic Latino	

**Military:**

<input type="checkbox"/> Active duty; Combat	<input type="checkbox"/> Active Duty; No Combat	<input type="checkbox"/> Military Dependent
<input type="checkbox"/> <b>Never</b> in Military	<input type="checkbox"/> Retired from Military	<input type="checkbox"/> Reserves/National Guard; Combat
<input type="checkbox"/> Reserves/National Guard; No Combat		<input type="checkbox"/> Other _____

**Legal Status:**

<input type="checkbox"/> None/No involvement	<input type="checkbox"/> 180 Day Commitment	<input type="checkbox"/> 30 Day Commitment
<input type="checkbox"/> 90 Day Commitment	<input type="checkbox"/> Case Pending	<input type="checkbox"/> Community Sentencing
<input type="checkbox"/> Deferred Prosecution	<input type="checkbox"/> Informal Probation	<input type="checkbox"/> Emergency Commitment
<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Office of Children Services	<input type="checkbox"/> Probation/Parole
<input type="checkbox"/> Court Ordered for observation and evaluation		<input type="checkbox"/> Court Ordered for alcohol treatment
<input type="checkbox"/> Court Ordered for mental health treatment		<input type="checkbox"/> 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)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alcohol problems       | <input type="checkbox"/> Domestic violence             | <input type="checkbox"/> Depression                       |
| <input type="checkbox"/> Drug problems          | <input type="checkbox"/> Marital/Relationship Problems | <input type="checkbox"/> Psychological/emotional problems |
| <input type="checkbox"/> Alcohol/drug problems  | <input type="checkbox"/> Family problems (non-marital) | <input type="checkbox"/> Suicide Attempt/Threat           |
| <input type="checkbox"/> Legal problems         | <input type="checkbox"/> Social/Interpersonal          | <input type="checkbox"/> Victim of Child Abuse            |
| <input type="checkbox"/> Victim of Sexual abuse | <input type="checkbox"/> Perpetrator of Sexual Abuse   | <input type="checkbox"/> Perpetrator of Child Abuse       |
| <input type="checkbox"/> Other: _____           |  |   |

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

- |   |  |
|---|--|
| <input type="checkbox"/> Regaining custody of children/parenting issues                 | <input type="checkbox"/> Lack of stress management skills      |
| <input type="checkbox"/> Social network problem (I.e. drug using friends/acquaintances) | <input type="checkbox"/> Education issues                      |
| <input type="checkbox"/> Lack of sober, social support                                  | <input type="checkbox"/> Poor communication skills and/or poor |
| <input type="checkbox"/> Lack of self-esteem, self-confidence, or positive identity     | <input type="checkbox"/> Conflict management skills            |
| <input type="checkbox"/> Shame and guilt about hurting family or need to make amends    | <input type="checkbox"/> Lack of motivation                    |
| <input type="checkbox"/> Lack of structure and time management skills                   | <input type="checkbox"/> Housing                               |
| <input type="checkbox"/> Financial concerns or unpaid bills                             | <input type="checkbox"/> 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 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 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 **completed in full** 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? (Women's Residential ONLY) ☐ No ☐ Yes

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	
*TB date:	
Quantiferon Gold	<input type="checkbox"/> (-) <input type="checkbox"/> (+)
CXR if (+) Quantiferon (+)	<input type="checkbox"/> (wnl) <input type="checkbox"/> (abnl)_____

## Approved Over the Counter Medications

	<b>**Provider**: Mark Yes or No for the following medication to indicate your approval status</b>
<input type="checkbox"/> YES <input type="checkbox"/> NO	Acetaminophen (Tylenol) 500mg by mouth every 6 hours as needed for PAIN/HEADACHE/FEVER MENSTRUAL CRAMPS [Maximum 2000 mg/24hours]
<input type="checkbox"/> YES <input type="checkbox"/> NO	Ibuprofen (Advil, Motrin) 400 mg by mouth every 4 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS/FEVER
<input type="checkbox"/> YES <input type="checkbox"/> NO	Naproxen(Aleve) 220mg by mouth every 8 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS/MUSCLE ACHE/FEVER
<input type="checkbox"/> YES <input type="checkbox"/> NO	Calcium Carbonate (Tums) 1000 mg by mouth every 4 hours as needed for HEARTBURN
<input type="checkbox"/> YES <input type="checkbox"/> NO	Bismuth Subsalicylate (Pepto-Bismol) 30 ml. or two 262 mg tablets by mouth every 4 hours as needed for HEARTBURN/INDIGESTION/DIARRHEA
<input type="checkbox"/> YES <input type="checkbox"/> NO	Docusate Sodium (Colace) 100 mg by mouth two times daily as needed for CONSTIPATION
<input type="checkbox"/> YES <input type="checkbox"/> NO	Anti-gas tablets (Beano) 2 tablets by mouth before meals as needed for FLATULENCE/GAS
<input type="checkbox"/> YES <input type="checkbox"/> NO	Lactaid 1 tablet by mouth when eating dairy products as needed for LACTOSE INTOLERANCE
<input type="checkbox"/> YES <input type="checkbox"/> NO	Multi-vitamin take 1 tablet by mouth daily as needed for NUTRITIONAL SUPPLEMENT
<input type="checkbox"/> YES <input type="checkbox"/> NO	Magnesium Supplement - take 1 tablet by mouth daily as needed for NUTRITIONAL SUPPLEMENT
<input type="checkbox"/> YES <input type="checkbox"/> NO	Loratadine (Claritin) 10 mg by mouth daily as needed for SEASONAL ALLERGIES
<input type="checkbox"/> YES <input type="checkbox"/> NO	Oxymetazoline 0.05% solution nasal spray (Afrin) 2 sprays each nostril 2 times a day as needed for NASAL CONGESTION
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cough Suppressant (Halls, cough drop) 1 lozenge by mouth every 1 hour as needed for COUGH/SORE THROAT
<input type="checkbox"/> YES <input type="checkbox"/> 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
<input type="checkbox"/> YES <input type="checkbox"/> NO	Nicotine Patch one 14 mg nicotine patch applied once per day for TOBACCO/CIGARETTE CRAVINGS
<input type="checkbox"/> YES <input type="checkbox"/> NO	FOR THOSE ALLERGIC TO NICOTINE PATCHES: Nicotine Lozenges one 2-4 mg lozenge by mouth every 2-4 hours
<input type="checkbox"/> YES <input type="checkbox"/> NO	Benzocaine local anesthetics (Orajel) apply gel directly to sore tooth or gum every 6 hours as needed for TOOTH/GUM PAIN



<input type="checkbox"/> YES <input type="checkbox"/> NO	Topical antibiotic ointment (Neosporin) apply thin layer to affected skin area 3 times daily as needed for ITCHING/SKIN IRRITATION
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hydrocortisone acetate 1% cream apply thin layer to affected skin area 3 times daily as needed for ITCHING/SKIN IRRITATION
<input type="checkbox"/> YES <input type="checkbox"/> 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

**\*\*REQUIRED 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



# This is the section for Releases of Information (ROIs).

*Please read the ROIs carefully and  
make sure to write **clearly**.*

We have included our disclosure of information; this is a notification of your rights and protections for your records at Set Free Alaska. Please sign, print, and date clearly.

We have included a contact preference; this is so that Set Free Alaska can talk to you about you. This is always helpful.

We have also included a blank general ROI. Please fill this out in case anyone needs to be aware of your treatment.

We have included examples on how to fill out all our ROIs. We do not need these forms back.

If any of these ROIs do not apply to you, please **do not** fill them out.

## 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 AND OR LEGAL GAURDIAN

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
DATE



\*\*\*EXAMPLE\*\*\*

### CONTACT PREFERENCES

I, **Bruce Wayne**, DOB: **04-28-85**, REQUEST/AUTHORIZE SET FREE ALASKA TO: **BW** DISCLOSE  
(CLIENT NAME) (INITIAL)  
INFORMATION TO AND/OR **BW** OBTAIN INFORMATION FROM MYSELF USING THE FOLLOWING CONTACT  
(INITIAL)  
INFORMATION:

**NAME:** **Bruce Wayne**

**MAILING ADDRESS:** **1234 Wayne Manor Lane**

**CITY:** **Gotham** **STATE:** **NY** **ZIPCODE:** **12345**

**EMAIL:** **bruce@wayneent.org**

**FAX NUMBER:** (If applicable) \_\_\_\_\_

**MAIN PHONE:\*** **1(234)567-8910** \*SFA will leave a voice or text message at this number

\*\*\*EXAMPLE\*\*\*

(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 |

\*\*\*EXAMPLE\*\*\*

**INITIAL:**

**BW** 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)

**BW** 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.

**BW** I understand and consent to the use of all electronic communication, text messaging and email and that they all have potential security risks.

\*\*\*EXAMPLE\*\*\*

**Bruce Wayne**  
**SIGNATURE OF CLIENT**

**Bruce Wayne**  
**PRINT NAME**

**09.23.2020**  
**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

Revised 5/4/2020





**\*\*EXAMPLE\*\***

## CONSENT FOR DISCLOSURE OF INFORMATION

I, **Bruce Wayne** DOB: **04.28.85** REQUEST/AUTHORIZE **SET FREE ALASKA** AND  
NAME OF ORGANIZATION **AND** INDIVIDUAL, OR THIRD PARTY PAYER: **PO Jim Gordon**  
MAILING ADDRESS: **1234 Police Plaza, Gotham, NY 12345**  
PHONE: **1(234)567-1112** FAX: **1(234)567-1113** EMAIL: **jim.gordon@gothampd.com**

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

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

**BW**  
INITIAL

ALL LISTED BELOW

OR: **\*\*EXAMPLE\*\***

<input type="checkbox"/> ASSESSMENT/INTERPRETIVE SUMMARY	<input type="checkbox"/> UA/DRUG TEST RESULTS
<input type="checkbox"/> TREATMENT PLAN	<input type="checkbox"/> ATTENDENCE
<input type="checkbox"/> TREATMENT REVIEWS/PROGRESS	<input type="checkbox"/> DISCHARGE SUMMARY
<input type="checkbox"/> PSYCHOLOGICAL EVALUATION	<input type="checkbox"/> FINANCIAL/PAYMENT INFORMATION
<input type="checkbox"/> OTHER: _____	

**BW**  
INITIAL

ALL DATES of SERVICE

OR: DATE or DATE RANGE of RECORD(S) to be released: \_\_\_\_\_

FOR THE PURPOSE OF: (INITIAL ALL THAT APPLY)

**BW**  
INITIAL

ALL LISTED BELOW

OR: **\*\*EXAMPLE\*\***

<input type="checkbox"/> FURTHER TREATMENT/COORDINATION OF CARE	<input type="checkbox"/> FINANCIAL
<input type="checkbox"/> AT THE REQUEST OF CLIENT	<input type="checkbox"/> PAYMENT & HEALTH CARE OPERATIONS
<input type="checkbox"/> LEGAL PURPOSES	<input type="checkbox"/> OTHER _____

INITIAL

**BW** 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.

**\*\*EXAMPLE\*\***

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: \_\_\_\_\_

**Bruce Wayne**  
**SIGNATURE OF CLIENT**

**Bruce Wayne**  
**PRINT NAME**

**09.23.2020**  
**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.

**\*\*EXAMPLE\*\***

THIS ROI IS REVOKED \_\_\_\_\_ INITIAL





## 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.

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Signature

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Print Name

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Date





## REFERRAL 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.**