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) 235-4733, or scan and email to the Office Receptionist caitlin@setfreealaska.org, or mail to:

  Set Free Alaska

  1130 Ocean Drive Suite A

  Homer, AK 99603

  Please contact (907) 235-4732 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) 235-4733, or scan and email to the caitlin@setfreealaska.org, or mail to:

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

  All other questions please contact the Case Manager, Zeb Perkins (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
☐ American Indian
☐ Asian
☐ Athabascan
☐ Black/African American
☐ Caucasian
☐ Haida
☐ Hispanic
☐ Native Hawaiian
☐ Inupiat
☐ Pacific Islander
☐ Tlingit
☐ Tsimshian
☐ Yupik
☐ Other Alaska Native ________________
☐ Other ___________________________

Ethnicity:

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

Military:

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

Legal Status:

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

☐ 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 problems

☐ 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

☐ 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 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

Is the patient currently under a doctor's care for medical conditions? ☐ No ☐ Yes

If yes, please provide more information: ______________________________________

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 ☐ (-) ☐ (+) CXR if (+) Quantiferon (+) ☐ (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

****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.

EXAMPLE

CONTACT PREFERENCES

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

(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.

Bruce Wayne	Bruce Wayne	9/23/2020
SIGNATURE OF CLIENT	PRINT NAME	DATE
____	____	____
SIGNATURE OF PARENT, GUARDIAN OR REPRESENTATIVE	RELATIONSHIP TO CLIENT	DATE
____	____	____
WITNESS SIGNATURE	PRINTED NAME OF WITNESS	DATE

CONTACT PREFERENCES

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

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: Gotham Correctional Facility and/ or PO Jim Gordon

MAILING ADDRESS: 1234 Gotham Police Plaza, Gotham, NY 12345

PHONE: 1(234)567-8910 FAX: 1(234)567-1112 EMAIL: Jim.gordon@gothampd.gov

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

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

BW 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

FOR THE PURPOSE OF: (INITIAL ALL THAT APPLY)

BW ALL LISTED BELOW OR:

EXAMPLE

____ FURTHER TREATMENT/COORDINATION OF CARE
____ AT THE REQUEST OF CLIENT
____ LEGAL PURPOSES
____ FINANCIAL
____ PAYMENT & HEALTH CARE OPERATIONS
____ 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.

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	Bruce Wayne	9/23/2020
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

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

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

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	Print Name	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: ___________________

Rev: 5.12.2021

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.