Application Checklist Page

- ☐ Application
- ☐ **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)

Women's Residential - Valley Oaks

- Completed applications can be faxed to 907-746-4750 or scanned and email to ValleyOaksAdmin@SetFreeAlaska.org or mail to:

Valley Oaks Residential
C/O Set Free Alaska
PO Box 876741
Wasilla, AK 99687

Please contact 907-746-4748 ext. #6 for questions regarding the application process. All other questions or if calling from **DOC** please call 907-205-5958. This phone will be available Monday through Thursday from 7:00 AM to 5:00 PM ONLY!

Men's Residential - Compass

- Completed applications can be faxed to 907-235-3251 or scanned and email to CompassAdmin@SetFreeAlaska.org or mail to:

Compass Residential
C/O Set Free Alaska
1130 Ocean Drive, Suite A
Homer, AK 99603

Please contact 907-235-3250 ext. #1 for questions regarding the application process. All other questions please contact the Case Managers at 907-235-3250 ext. #3 or if calling from **DOC** please call 907-521-6056 or 907-982-3233.

- I understand I must have valid ID before the day of my assessment, or I will be rescheduled. _____ Initial
- **Please Note**: Set Free Alaska, Inc. does not offer any services to sex offenders at this time. _____ I understand: Initial

Client Profile

1. Client Name (First and Last): _____

IF FEMALE MAIDEN NAME IS REQUIRED _____

Parent or guardian Name (If Applicable) _____

2. Date of Birth: _____

3. Social Security Number: ___ ___ ___ -- ___ ___-- ___ ___ ___ _

4. Phone Number: _____

5. Email: _____

6. Physical Address: Street, Apartment _____

City, State, Zip _____

7. Mailing Address: Street, Apartment _____

City, State, Zip _____

8. Client Gender **Male OR Female**
(Defined as having the respective reproductive organ)

9. ***Required if Female:*** Pregnant: **YES OR NO** **If yes: DUE DATE _____/ _____/ _____**

9.5. Injection Drug User (In Past 12 Months): CIRCLE ONE **YES OR NO**

10. Race: (*Please circle all that apply*)

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

11. Ethnicity: (*Circle One*)

Spanish/Hispanic/Latino/Mexican	Chicano/Other Hispanic	Cuban	Not Hispanic Specific Origin	Mexican American
Spanish/Hispanic Latino	Puerto Rican	Not Specified		

12. Living Arrangements: (*Check One*)

☐ Assisted Living	☐ Correction Detention Facility	☐ Crisis Residence	☐ Foster Care
☐ Group Home	☐ Halfway House	☐ Homeless	☐ Shelter
☐ Residential Treatment	☐ Therapeutic Foster Care	☐ Transitional Housing	☐ Unknown
☐ Hospital for Psychiatric Purposes		☐ Nursing Home	☐ Other
☐ Private Residence with supportive services		☐ Private Residence without supportive services	

13. Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabitating ☐ Separated ☐ Single

14. Do you use tobacco? ☐ Yes ☐ No What type? (Cigarettes/ Cigars/ Smokeless/ Pipe)

15. English Fluency: ☐ Excellent ☐ Good ☐ Moderate ☐ Poor ☐ None

16. Interpreter Needed? ☐ Yes ☐ No

17. Military Status: ☐ Never in Military ☐ Reserves/National Guard ☐ Active Duty ☐ Retired ☐ Veteran ☐ Combat

18. Referral Source: _____

19. Employment Status: (Circle one)

Employed Full Time	Not in Labor Force, Inmate	Retired	Student
Employed Part Time	Not in Labor Force, Not Seeking Work	Seasonal in Season	Disabled
Homemaker	Not in Labor Force, Subsistence	Seasonal, Out of Season	

Unemployed, Seeking Work Unemployed, not Seeking Work Not in Labor Force: Other:_____

List your Profession/Work/Experience/Skills/Trade:

Professional/Managerial	Service/Household	Crafts/Operatives	Farm Owner/Laborer
Sales	Laborer/Not farm		

20. Education: ☐ HS Diploma ☐ GED ☐ BA/BS Degree ☐ AA Degree ☐ Masters Degree

21. Household Composition: (*Circle One*)

Lives Alone	Lives with Adolescents	Lives with Children	Lives with Non-Relatives
Lives with Relatives	Lives with Significant Other	Lives with Significant Other and Children	
Other			

Number of People Living with You: _____Number of Children: _____

Number of Children in Residential Setting Receiving Services: _____

Number of Legal Dependents: _____

22. Annual Household Income: (Circle One)

0-999	1,000-4,999	5, 000- 9,999	10,000-19,999	20,000-29,000
20,000-29,000	30,000-39,000	40,000-49,000	50,000-59,000	60,000+

23. Legal Status: (*Circle one*)

None/No Involvement	180 Day Commitment	30 Day Commitment	90 Commitment
Case Pending	Community Sentencing	Deferred Prosecution	Informal Probation
Emergency Commitment	Incarcerated	Office of Children's Services	Probation/Parole
Court Ordered for Observation and Evaluation		Court Ordered for Mental Health Treatment	
Court Ordered Juvenile (INT) Parents Retain Custody		Court Ordered Juvenile (INT), DJJ Custody	
Court Ordered for Alcohol Treatment		Title 12-Not Guilty by Reason of Insanity	

Number of Arrests in the past 30 days: _____

24. ***Presenting Problem(s) in clients own words (Why are you seeking our services?):***

_____

25. Please identify your primary source of income: (*Circle One*)

None	Tribal Assistance Program	AK Native Corporation Dividend	Public Assistance/Welfare
Alimony	Alaska PFD	Child Support	Parent's Income
Employment	Interest and Other	Other	Social Security
Social Security Disability	Self Employed	Railroad Retirement	Unemployment Compensation
Spouse/Significant other	Retirement/Survivor/Disability Pension	Supplemental Security Insurance	

26. Please identify your expected payment Source : (*Circle One*)

Aetna
AK Native Health Care
Blue Cross/Blue Shield
CIGNA
Client Self Pay
HMO
Indian Health Services
Medicaid
Medicare
No Charge
Other Government Grant Other Native Health Care
Other Private
Sliding Scale; client partial payment
Sliding Scale, No Charge Other Public
Other: _____

In case of emergency Set Free Alaska Staff has my permission to notify any of the following persons:

Name: _____

Phone# _____ Cell# _____

Relationship: _____

Name: _____

Phone# _____ Cell# _____

Relationship: _____

By signing and submitting this form, I am giving consent to Set Free Alaska to enter my identifying information into the appropriate electronic health recording system(s).

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.

_____I consent for Set Free Alaska, Inc. to verify my health insurance coverage.

SIGNATURE OF CLIENT	**PRINT NAME**	**DATE**
SIGNATURE OF PARENT, GUARDIAN OR REPRESENTATIVE	**RELATIONSHIP TO CLIENT**	**DATE**

What date are you available to enter treatment? _____

Have you ever been charged with a crime against a vulnerable person (child, elderly, or disabled)?
If yes, please explain: _____

_____

_____

READINESS TO LEARN:

How do you like to learn? ☐ Watching ☐ Reading ☐ Listening ☐ Doing

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 _____

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?

_____

Where and with whom will you live after completing treatment? _____

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

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?

☐ No ☐ Yes

If yes, is this process completed (physical surgery, hormonal treatment, and emotional counseling components)?

_____

When was this process completed?

_____

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: _____

_____

Have you ever been diagnosed with an eating disorder? _____

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:** _____

CHILD PROFILE PAGE:

THIS PAGE IS ONLY APPLICABLE IF YOU ARE WANTING TO BRING YOUR CHILD INTO THE TREATMENT CENTER. PLEASE BE AWARE THAT THIS IS NOT A GUARANTEE THAT THE CHILD WILL BE ACCEPTED INTO THE PROGRAM.

Any child that enters the residential program may be subjected to get an assessment from our children's program. Please also be aware that the child may not be able to join you for the first 30 days of treatment.

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

Is there OCS involvement? ☐ No ☐ Yes

If YES, Who is your caseworker?_____

Are you requesting to bring your child(children) to the center?

☐ No ☐ Yes

I understand that this program has limited availability for the child to enter the program with me.

SIGNATURE OF CLIENT _____ PRINT NAME _____ 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? (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

Is patient due for any refills for any of the above listed medication? ____No ___Yes

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
☐ YES ☐ NO	Melatonin
☐ YES ☐ NO	Vitamins: Clearly List Below _____ _____ _____ _____ _____ _____

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/Client Signature Print Name 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 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

CONSENT FOR DISCLOSURE OF INFORMATION

I, Bruce Wayne DOB: 07-07-1967 , REQUEST/AUTHORIZE **SET FREE ALASKA** AND

NAME OF ORGANIZATION **AND** INDIVIDUAL, OR THIRD-PARTY PAYER: Family Health Center

MAILING ADDRESS: 1258 Happy Health Way , Wasilla AK 99654

PHONE: 907-654-1234 FAX: 907-654-4567 EMAIL: Familyhealthcenter@gmail.com

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

FOR THE PURPOSE OF: INITIAL ALL THAT APPLY)

BW ALL LISTED BELOW OR:

EXAMPLE

- ____ FURTHER TREATMENT/COORDINATION OF CARE
- ____ PAYMENT & HEALTH CARE OPERATIONS
- ____ LEGAL PURPOSES
- ____ FINANCIAL
- ____ 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. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

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

I consent to my records to be released ☒ **Electronically** ☒ **Hard Copy**

Bruce Wayne	Bruce Wayne	8.23.2023
SIGNATURE OF CLIENT	PRINT NAME	DATE
SIGNATURE OF PARENT, GUARDIAN OR REPRESENTATIVE	RELATIONSHIP TO CLIENT	DATE
WITNESS SIGNUTRE	PRINT NAME OF WITNESS	DATE

EXAMPLE

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 CLIENT OR STAFF INITIAL, DATE AND TIME: _____

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

FOR THE PURPOSE OF: (INITIAL ALL THAT APPLY)

____ ALL LISTED BELOW OR:

____ FURTHER TREATMENT/COORDINATION OF CARE
____ PAYMENT & HEALTH CARE OPERATIONS
____ LEGAL PURPOSES

____ FINANCIAL

____ 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. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it.

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:_____

I consent to my records to be released □ Electronically □ Hard Copy

_____	_____	_____
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 CLIENT OR STAFF INITIAL, DATE AND TIME: _____

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

SET FREE ALASKA 907-373-4732 FAX: 907-746-4749
VALLEY OAKS RESIDENTIAL 907-746-4748 EXT. #4 FAX: 907-746-4750
COMPASS RESIDENTIAL 907-235-3250 EXT. #1 FAX: 907-235-3251

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: _____

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

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 perfume.

- 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

- Candles
- Air fresheners
- Febreze
- Aerosol sprays- except for hair products and/or deodorant (must be kept in front office)
- Nicotine products including chew, cigars, e-cigarettes, vapes
    - Except nicotine patches that must be kept in the front office
- Gum
- Energy drinks
- Fermented drinks of any kind
- Unmarked hygiene items or powder
- Cash over $100
    - This program is not responsible for lost and/or stolen items
- Personal vehicle
    - Except for in phase 4
- DVDs unless approved
- 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, spike 2k, bath salts, herbal license
- Firearms or ammunition
- Weapons or any items that could be used as a weapon
    - i.e., knives or 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 front 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, clothing, health care, monitors, car seat, etc.