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 Childre | |
| 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 – 74,499 | above 75K |

**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 Insan | |

Number of Arrests in the past 30 days: _____

**24.** ***Presenting Problem(s) in client's 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 | Medicaid |
| AK Native Health Care | Medicare |
| Blue Cross/Blue Shield | No Charge |
| CIGNA | Other Government Grant Other Native Health Care |
| Client Self Pay | Other Private |
| HMO | Sliding Scale; client partial payment |
| Indian Health Services | 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:<br>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<br>_____ _____ _____<br>_____ _____ _____ |

**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
- ____ 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
- ____ 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 |
| | EXAMPLE | |
| WITNESS SIGNUTRE | PRINT 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: _____



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

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"), 45C.F.R. PTS 160 AND 164, AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT UNLESSOTHERWISE 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. #6 FAX: 907-746-4750
COMPASS RESIDENTIAL 907-235-3250 EXT. #1 FAX: 907-235-325

**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

# Prohibited Items

- 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 (Phase 4 only) (Not allowed at Compass)
- 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.