



## 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](mailto:ValleyOaksAdmin@SetFreeAlaska.org) or mail to:

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

Please contact 907-205-5958 for questions regarding the application process. **DOC** can also call the same number. 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](mailto:CompassAdmin@SetFreeAlaska.org) or mail to:

Compass Residential  
C/O Set Free Alaska  
3964 Bartlett St., Unit 2  
Homer, AK 99603

Please contact 907-677-6426 for questions regarding the application process or if you are calling from **DOC**. All other questions, please contact the Case Managers at 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     | Athabaskan      | 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)**

- |   |  |  |                                      |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Assisted Living                            | <input type="checkbox"/> Correction Detention Facility | <input type="checkbox"/> Crisis Residence                              | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> Group Home                                 | <input type="checkbox"/> Halfway House                 | <input type="checkbox"/> Homeless                                      | <input type="checkbox"/> Shelter     |
| <input type="checkbox"/> Residential Treatment                      | <input type="checkbox"/> Therapeutic Foster Care       | <input type="checkbox"/> Transitional Housing                          | <input type="checkbox"/> Unknown     |
| <input type="checkbox"/> Hospital for Psychiatric Purposes          |  | <input type="checkbox"/> Nursing Home                                  | <input type="checkbox"/> Other       |
| <input type="checkbox"/> Private Residence with supportive services |  | <input type="checkbox"/> Private Residence without supportive services |                                      |

13. Marital Status:  Married  Divorced  Widowed  Cohabiting  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 Sales	Service/Household Laborer/Not farm	Crafts/Operatives	Farm Owner/Laborer
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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	60,000-74,499	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 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	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 completed in full by your health care provider to participate in a Set Free Alaska Residential Treatment Program.**

Does this patient require detoxification prior to entering treatment?  No  Yes  
 Does this patient have any physical impairments/limitations?  No  Yes (If YES, please explain):

\_\_\_\_\_

Are there any reportable communicable diseases?  No  Yes (If YES, please explain):

Is the patient pregnant? (Women's Residential ONLY)  No  Yes

List known food or environmental allergies: \_\_\_\_\_

MEDICATION ALLERGIES: \_\_\_\_\_

List all the patients' current prescription medications: (please use reverse side if needed for additional meds)

MEDICATION	DOSAGE	FREQUENCY AND ROUTE	INDICATION

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	<input type="checkbox"/> (-) <input type="checkbox"/> (+)
CXR if (+) Quantiferon (+)	<input type="checkbox"/> (wnl) <input type="checkbox"/> (abnl)_____

## Approved Over the Counter Medications

	<b>**Provider**</b> : Mark Yes or No for the following medication to indicate your approval status
<input type="checkbox"/> YES <input type="checkbox"/> NO	Acetaminophen (Tylenol) 500mg by mouth every 6 hours as needed for PAIN/HEADACHE/FEVER MENSTRUAL CRAMPS [Maximum 2000 mg/24hours]
<input type="checkbox"/> YES <input type="checkbox"/> NO	Ibuprofen (Advil, Motrin) 400 mg by mouth every 4 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS/FEVER
<input type="checkbox"/> YES <input type="checkbox"/> NO	Naproxen(Aleve) 220mg by mouth every 8 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS/MUSCLE ACHE/FEVER
<input type="checkbox"/> YES <input type="checkbox"/> NO	Calcium Carbonate (Tums) 1000 mg by mouth every 4 hours as needed for HEARTBURN
<input type="checkbox"/> YES <input type="checkbox"/> NO	Bismuth Subsalicylate (Pepto-Bismol) 30 ml. or two 262 mg tablets by mouth every 4 hours as needed for HEARTBURN/INDIGESTION/DIARRHEA
<input type="checkbox"/> YES <input type="checkbox"/> NO	Docusate Sodium (Colace) 100 mg by mouth two times daily as needed for CONSTIPATION
<input type="checkbox"/> YES <input type="checkbox"/> NO	Anti-gas tablets (Beano) 2 tablets by mouth before meals as needed for FLATULENCE/GAS
<input type="checkbox"/> YES <input type="checkbox"/> NO	Lactaid 1 tablet by mouth when eating dairy products as needed for LACTOSE INTOLERANCE
<input type="checkbox"/> YES <input type="checkbox"/> NO	Multi-vitamin take 1 tablet by mouth daily as needed for NUTRITIONAL SUPPLEMENT
<input type="checkbox"/> YES <input type="checkbox"/> NO	Magnesium Supplement - take 1 tablet by mouth daily as needed for NUTRITIONAL SUPPLEMENT
<input type="checkbox"/> YES <input type="checkbox"/> NO	Loratadine (Claritin) 10 mg by mouth daily as needed for SEASONAL ALLERGIES
<input type="checkbox"/> YES <input type="checkbox"/> NO	Oxymetazoline 0.05% solution nasal spray (Afrin) 2 sprays each nostril 2 times a day as needed for NASAL CONGESTION
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cough Suppressant (Halls, cough drop) 1 lozenge by mouth every 1 hour as needed for COUGH/SORE THROAT
<input type="checkbox"/> YES <input type="checkbox"/> NO	Diphenhydramine hydrochloride (Benadryl) 25 mg by mouth every 4 hours as needed for SEVERE ITCHING/NASAL CONGESTION. Consult health care provider if symptoms worsen or persist
<input type="checkbox"/> YES <input type="checkbox"/> NO	Nicotine Patch one 14 mg nicotine patch applied once per day for TOBACCO/CIGARETTE CRAVINGS
<input type="checkbox"/> YES <input type="checkbox"/> NO	FOR THOSE ALLERGIC TO NICOTINE PATCHES: Nicotine Lozenges are not allowed at our residential programs however other forms of nicotine replacement may be considered.

<input type="checkbox"/> YES <input type="checkbox"/> NO	Benzocaine local anesthetics (Orajel) apply gel directly to sore tooth or gum every 6 hours as needed for TOOTH/GUM PAIN
<input type="checkbox"/> YES <input type="checkbox"/> NO	Topical antibiotic ointment (Neosporin) apply thin layer to affected skin area 3 times daily as needed for ITCHING/SKIN IRRITATION
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hydrocortisone acetate 1% cream apply thin layer to affected skin area 3 times daily as needed for ITCHING/SKIN IRRITATION
<input type="checkbox"/> YES <input type="checkbox"/> NO	Clotrimazole 1% (Lotrimin) apply thin layer to affected skin are 2 times daily as needed for ATHLETE'S FOOT/JOCK ITCH/RINGWORM
<input type="checkbox"/> YES <input type="checkbox"/> NO	Melatonin
<input type="checkbox"/> YES <input type="checkbox"/> NO	Vitamins: Clearly List Below
Please indicate if cleared to take Vitamin C, Zinc, Magnesium, Multivitamin or other specified vitamins.	_____
	_____
	_____

**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.



CONSENT FOR DISCLOSURE OF INFORMATION

I, [redacted] DOB: [redacted], 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: (Guardians/minors over 10 yrs receiving SUD services)

BW INITIAL FOR ALL LISTED BELOW OR: INITIAL ONLY WHAT APPLIES

- ASSESSMENT/INTERPRETIVE SUMMARY
TREATMENT PLAN
TREATMENT REVIEWS/PROGRESS
PSYCHOLOGICAL EVALUATION
VERBAL AND WRITTEN PROGRESS AND GENERAL COMPLIANCE
MEDICAL RECORDS
OTHER:
UA/DRUG TEST RESULTS
ATTENDANCE
DISCHARGE SUMMARY
FINANCIAL/PAYMENT INFORMATION

FOR THE PURPOSE OF: (Guardians/minors over 10 yrs receiving SUD services)

BW INITIAL FOR ALL LISTED BELOW OR: INITIAL ONLY WHAT APPLIES

- 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.

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

Bruce Wayne SIGNATURE OF CLIENT (10YRS & ABOVE RECEIVING SUD SERVICES) 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.

THIS ROI IS REVOKED - CLIENT OR STAFF INITIAL, DATE AND TIME: \_\_\_\_\_



CONSENT FOR DISCLOSURE OF INFORMATION

I, [redacted] DOB: [redacted], 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: (Guardians/minors over 10 yrs receiving SUD services)

INITIAL FOR ALL LISTED BELOW OR: INITIAL ONLY WHAT APPLIES

- ASSESSMENT/INTERPRETIVE SUMMARY, TREATMENT PLAN, TREATMENT REVIEWS/PROGRESS, PSYCHOLOGICAL EVALUATION, VERBAL AND WRITTEN PROGRESS AND GENERAL COMPLIANCE, MEDICAL RECORDS, OTHER:
UA/DRUG TEST RESULTS, ATTENDENCE, DISCHARGE SUMMARY, FINANCIAL/PAYMENT INFORMATION

FOR THE PURPOSE OF: (Guardians/minors over 10 yrs receiving SUD services)

INITIAL FOR ALL LISTED BELOW OR: INTITAL ONLY WHAT APPLIES

- 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 (10YRS & ABOVE RECEIVING SUD SERVICES) 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

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

\_\_\_\_\_  
DATE

PO Box 876741  
Wasilla, AK 99687

907-373-4732 – Mat-SU, 907-746-4749 Fax  
907-416-7569 – Homer, 907-226-5906 - Fax



REFERRAL FOR ADMISSION

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

Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Physical Address (street/city/state/zip): \_\_\_\_\_

Mailing address (if different from residence): \_\_\_\_\_

Describe applicant's motivation to commit treatment:

- Motivated (understands she needs help and willing to do what it takes to get it)
Ambivalent (acknowledges others sees she has problem, but not fully prepared to deal with it or accepting treatment only with strong external pressure)
Denial (unwilling to accept that she has problem despite evidence to the contrary)
Resistant (denies problem, actively refusing or fighting efforts to provide help)

Describe the main problem(s) for which the applicant is being referred. \_\_\_\_\_

What does the applicant describe as the main problem(s)? \_\_\_\_\_

Has the applicant ever been referred/received substance abuse/dependence treatment? [ ] No [ ] Yes IF YES, briefly describe (when, where, and the outcome). \_\_\_\_\_

Has there been a substance uses assessment in the last 90 days? [ ] No [ ] Yes If YES, Where? \_\_\_\_\_

Is the assessment attached to this referral? [ ] No [ ] Yes

Has applicant ever been referred/received mental health treatment? [ ] No [ ] Yes If YES, briefly describe when,

where, and the outcome \_\_\_\_\_

Is applicant receiving mental health treatment now? [ ] No [ ] Yes If YES, please name provider \_\_\_\_\_

Referral completed by: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

Referrer contact information (phone number/email address): \_\_\_\_\_

Referral Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## SNAP Acknowledgement

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

- The date the resident entered and leaves the facility
- The monthly SNAP benefit amount, and if the monthly benefit amount was issued for the individual or household.

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

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

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

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

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Signature

---

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
  - 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.

