



The Salvation Army
Clitheroe Center
3630 East 20th Avenue, Anchorage, AK 99508
Phone: (907) 276-2898 Fax: (907) 770-8870

APPLICATION PACKET

Clitheroe Center

Updated: 2/9/2021

List of Contents

A. PLEASE READ FIRST -- Directions – How to Fill Out this Packet

- B. Welcome & Introduction.
- C. What services do you need?
- D. Intergy Demographics and Financial Registration Form.
- E. SAMPLE of Release of Information (ROI).
- F. Release of Information (Please use SAMPLE ROI as an example of how to correctly fill out this form – 2 pages). If you need more ROIs, they can be added. Do not put more than one agency or person on one form.
- G. Legal Data Questionnaire.
- H. Substance Abuse Treatment History Form.
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● **LOOK → Clitheroe Center is TOBACCO FREE – See Page ii**

For Questions or More Information:

Call Intake Coordinator at (907) 770-8812; Fax (907)770-8870.

PLEASE READ FIRST

Directions - How to Fill out this Packet

1) First Answer the Questions on Page 1 and 2 – What services do you need?

2) If you have already had a Substance Abuse Assessment in the last 6 months (or Integrated Assessment) then you only need to fill out the following:

- a. Pages 3-7 – Intergy Demographics and Financial Registration Form (5 pages).
- b. Page 9 – Release of Information Form to agency that did the assessment.
- c. Page 11 – Legal Questionnaire
- d. Pages 12-17 – Medical and Behavioral Health/Mental Health Questionnaires (5 pages).
- e. If your assessment recommends residential treatment, please submit medical/physical clearance (less than a month old) and a TB clearance (less than 6 months old).
- f. Then turn in your application to Clitheroe Intake Coordinator:

Intake Coordinator at (907) 770-8812; Fax (907)770-8870.

3) If you need a substance abuse assessment or if your last assessment is more than 6 months old, then you must fill out this entire packet and turn it in to Clitheroe Intake Coordinator.

For Questions or More Information:

Call Intake Coordinator at (907) 770-8812; Fax (907)770-8870.

● LOOK → Clitheroe Center is TOBACCO FREE ●

All Clitheroe Center campus Buildings and Property Are Tobacco Free.

Clitheroe affirms that tobacco/nicotine is a serious addictive drug, with research comparing the physiological pathways in the brain and the recovery from tobacco addiction to be similar to heroin. Also, the short- and long-term health hazards of using tobacco, and the fact that such use causes premature death, are well known and documented.

The Clitheroe Center's recovery philosophy and position includes recovery from all addictive substances, including nicotine. Tobacco/nicotine usage/relapse is viewed the same as relapse with any other addictive drug or alcohol. The goal of the Clitheroe Center treatment program is to assist clients to recover from all substance use disorders, including tobacco/nicotine.

Federal law prohibits tobacco use in any form inside any federally-supported treatment program. Prohibited are cigarettes, cigars, pipe tobacco, loose tobacco, chew, snuff, pinch, other forms of tobacco, and e-cigarettes.

For assistance with quitting smoking please contact the Alaska Tobacco Quitline at 1-800-QUIT-NOW or 1-800-784-8669.

Welcome & Introduction

Welcome to the Salvation Army Clitheroe Center! Thank you for considering us to help provide your healthcare.

The Clitheroe Center strives to provide excellent behavioral health treatment. We offer the following services:

- Assessment (Substance Abuse or Integrated Substance Abuse & Mental Health).
- Outpatient Treatment and Aftercare.
- Residential Treatment.

If you are interested in receiving services, please fill out this application packet and return it to the Intake Coordinator. Please take extra time to ensure that the ROIs (Releases of Information) are filled out correctly. We have inserted a SAMPLE ROI for you to follow as an example. If you have any questions or concerns, please feel free to contact the Intake Coordinator at (907) 770-8812; fax (907)770-8870.

Fees: Our services have fees, but services are provided even if you do not have the ability to pay. Our fees are also based on a sliding fee scale. You can pay fees using the following charge cards: Visa, MasterCard, or Discover, which may be billed over the phone, or you can mail a check/money order payable to: The Salvation Army Clitheroe Center. Cash is accepted also. If you have a friend/family member pay for your fee, make sure they specify whom they are paying for. Also, make sure to fill in the information for the family/friend payee section on the Discounted/Sliding Fee application in the packet. The current Medicaid sticker or payment voucher from your referral source will be accepted. Please be aware that Medicaid may not pay for all services.

Second Opinions: If you have received an assessment at another agency and you are looking for a second opinion, there is a fee.

Additional Requirements:

- **ASAP:** If you are referred to ASAP, you must contact ASAP to be assigned to Clitheroe prior to attending your assessment appointment. If you do not show for your assessment appointment, we are required to return your assignment to ASAP for non-compliance.
- **Probation/Parole:** If you are on probation or parole, your probation officer will need to fax over your pre-sentence investigation report, conditions of probation, or other legal documentation regarding your criminal history.
- **OCS, DMV, Employee Assistance Program, or other treatment agencies:** If any of these things apply to you, a letter of referral, discharge summary, or background information is helpful and may be required.
- **Psychiatric:** If you have a mental health provider, a current Release of Information (ROI) will be required from your mental health provider for collateral and for any prescription medications.

Assessment Appointments:

If you are here for an assessment, our assessment staff will not be able to continue with an assessment interview if you are under the influence of alcohol or non-prescribed mood/mind altering medications or substances, or if you bring children to the interview. You may reschedule your assessment appointment once. If you do not show up for your rescheduled appointment, you may have to wait up to 90 days.

For Questions or More Information:

Call Intake Coordinator at (907) 770-8812; Fax (907)770-8870.

NAME (PRINTED) _____ Date: _____ D.O.B. _____

What Services Do You Need ?

1) Do you need an Assessment? Yes No

If Yes, what kind of Assessment do you need?

- Substance Abuse Assessment.
- Integrated Assessment (includes both Substance Abuse and Mental Health.)
- Mental Health Assessment.
- You do not know what kind of Assessment you need.

2) Have you had an Assessment in the last 6 months? Yes No

If Yes, what kind of Assessment did you have? _____
What agency did the Assessment? _____ When? _____

3) Do you need Treatment? Yes No

If Yes, what kind of treatment do you need?

- Substance Abuse Outpatient Treatment.
- Substance Abuse Residential Treatment.
- Dual Diagnosis (Mental Health & Substance Abuse) Treatment.
- You do not know if you need treatment or do not know what kind of treatment.

Do you meet any of the following Priorities? (The State of Alaska partially funds Clitheroe Center and requires us to give priority to individuals who meet the following Priorities:)

- | | | |
|---|------------------------------|-----------------------------|
| Are you pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you used injection drugs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you a woman <u>and</u> have dependent children? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Where are you living today?

- You are living today in your own apartment or home.
- You are living today with friends or family.
- You are Homeless today.
- You are in a Hospital or Detox Facility today – Which hospital or Facility? _____.
- You are living today in a Halfway House.
- You are living today in a Correctional Center/Facility – Which facility? _____.

If you are living today in a Correctional Center or Halfway House

When is your scheduled release date? _____
Have you already been approved for Furlough? Yes No

SOME ADDITIONAL QUESTIONS:

I am related (by blood or marriage) to a current employee of The Salvation Army Clitheroe Center OR have personal involvement with a current employee. Yes No
If yes, their name is _____

I have attempted or considered suicide in the past 90 days. Yes No
If yes, I sought help from whom: _____ Their phone #: _____

I am currently being prescribed opiates, benzodiazepines or sleep aids. Yes No
If yes, the name of the medication is:

The medication is prescribed to me by: _____ Their phone #: _____

I intend to seek services at Clitheroe. Yes No
If no, I intend to seek services at: _____

Presenting Problem _____

Urgent Needs (Suicidal/homicidal ideation, personal safety concerns, withdrawal or other immediate medical concerns)

I understand that all Clitheroe Center treatment is Tobacco Free.

All Clitheroe Center campus Buildings and Property Are Tobacco Free.

Clitheroe affirms that tobacco/nicotine is a serious addictive drug, with research comparing the physiological pathways in the brain and the recovery from tobacco addiction to be similar to heroin. Also, the short- and long-term health hazards of using tobacco, and the fact that such use causes premature death, are well known and documented.

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Federal law prohibits tobacco use in any form inside any federally-supported treatment program. Prohibited are cigarettes, cigars, pipe tobacco, loose tobacco, chew, snuff, pinch, other forms of tobacco, and e-cigarettes.

For assistance with quitting smoking please contact the Alaska Tobacco Quitline at 1-800-QUIT-NOW or 1-800-784-8669.

I agree that all of the information I've provided is true and to the best of my knowledge. I understand that the information will be verified and that I need to provide releases of information, contact names/phone #'s, etc. I am also aware that if I intentionally provide false information it may delay my application for services and can possible disqualify me from receiving services from The Salvation Army Clitheroe Center.

My Signature: _____ Date: _____

My Printed Name: _____ Date: _____

INTERGY DEMOGRAPHICS AND FINANCIAL REGISTRATION FORM

PLEASE PRINT IN ALL AREAS

Please complete the following questionnaire as accurately as possible in order to assist in determining your treatment needs. Please indicate if you have difficulty with any of the following:

Reading Writing Understanding written or spoken English

DEMOGRAPHICS

SSN#: _____ First Name: _____ Middle Name: _____

Last Name: _____ Date of Birth: _____

Maiden Name: _____ Any Other Names You Have Used: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Place of Birth: _____

Gender Expression: Male Female Other: _____ Sexual Orientation: _____

Marital Status: _____ Race/ethnicity: _____ Culture: _____

Phone Number(s): _____

Employment Status: _____ Employers Name: _____

Referring provider: _____

REFERRAL SOURCE

DOC ASAP OCS FED/FBOP
 Doctor DVR Probation VA
 Institution Attorney OPA Other: _____

CHILDREN (under age 18):

Name	Age	Person child resides with

CONTACT INFORMATION

Emergency or collateral contact:

First Name: _____ Last Name: _____

Phone #: _____ Gender: Male or Female

PATIENT INSURANCE INFORMATION

Plan Code: _____ Group #: _____ Policy Class: _____ Start Date: _____

End Date: _____ Claim Member ID: _____ Eligibility ID: _____

Member Policy Type: _____ Member Note: _____ Member Copy: _____

ADDITIONAL INFORMATION REQUIRED FOR BILLING DEPARTMENT

Name of Insured, if not the client (First, Middle initial, Last): _____

SS# of Insured: _____ Medicaid #: _____

PAYEE

Conservator/Payee Information (Name): _____

Phone #: _____ Alternative phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

MISCELLANEOUS

Religious Preference (if any): _____ Attending services: Yes No

Any military service? Yes No

Highest grade level completed: _____; if GED, when obtained: _____

List any special classes or tutoring in school/ additional training:

Employment History including usual or last occupation/where and for how long:

SLIDING FEE APPLICATION FORM

It is the policy of The Salvation Army Clitheroe Center to provide essential services regardless of the client's ability to pay. Discounts are offered based upon family income and size. Please complete the following to determine if you are eligible for a discount.

CLIENT NAME		SOCIAL SECURITY #	
ADDRESS			
CITY		STATE / ZIP	
PHONE #		SOCIAL SECURITY #	
Email Address:			
EMPLOYED?	<input type="checkbox"/> Yes <input type="checkbox"/> No	CELL PHONE	
PLACE OF EMPLOYMENT			
HEALTH INSURANCE PLAN		Do you approve to bill Private Insurance:	<input type="checkbox"/> Yes <input type="checkbox"/> No
HEALTH INSURANCE POLICY #			
Do you have Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid #	
Are you a Veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you homeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you living in a shelter?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shelter Name:	

Please list self, spouse and dependent(s) under age 18

	NAME	DATE OF BIRTH
SELF		
SPOUSE		
DEPENDENT		
DEPENDENT		
DEPENDENT		
DEPENDENT		
DEPENDENT		
DEPENDENT		

FAMILY YEARLY INCOME

SOURCE	SELF	SPOUSE	OTHER	Sub-Total / Year
Gross wages, salaries, tips, etc.				
Social Security, pension, annuity, Veteran's benefits, unemployment				
Alimony, child support, military family allotments				
Income from business, self-employment, and dependents				
Other income: rent, interest, dividend, Native corporation (which one: _____)				
SUB-TOTAL of Income per person, per YEAR				
GRAND TOTAL for Household / Year				\$

REQUIRED DOCUMENTS

VERIFICATION CHECK LIST -- Please attach 1 copy for each of the following:	Please check if provided (✓)
Identification:	<input type="checkbox"/> Driver's license <input type="checkbox"/> Birth certificate <input type="checkbox"/> Employment ID <input type="checkbox"/> Passport
Proof of Address:	<input type="checkbox"/> Recent electric bill <input type="checkbox"/> Gas bill <input type="checkbox"/> Cable bill <input type="checkbox"/> Telephone bill <input type="checkbox"/> Self-addressed postmarked letter
Income:	<input type="checkbox"/> Most recent pay stub <input type="checkbox"/> SSI recipients - explanation of benefits <input type="checkbox"/> Statement from the Social Security office
Private Insurance:	<input type="checkbox"/> Copy of Insurance card(s) provided
Medicaid:	<input type="checkbox"/> Medicaid card/stamp <input type="checkbox"/> Application made or evidence of rejection (letter)
<input type="checkbox"/> No income verification	

I certify that the family size and income information shown is correct.

CLIENT NAME (print)		DATE	
SIGNATURE			

I agree to sign the SACC approved ROI 'Consent To Release Confidential Information' form to authorize the individual listed below to contact The Salvation Army on my behalf regarding financial payments ONLY. (PLEASE PRINT)

THEIR RELATIONSHIP TO ME (RELATIVE, PAYEE, ETC.)		
THEIR NAME		
THEIR ADDRESS		
THEIR PHONE NUMBER(S)		
MY NAME		DATE
MY SIGNATURE		

OFFICE USE ONLY

Provided by [Counselor Name]:			
Referred By:			
Program:			
Discount Approved:	%	APPROVED BY:	

DETERMINATION OF BASIS OF FEES

All clients of The Salvation Army Clitheroe Center’s Outpatient Program must complete a “financial intake” form before services begin. As a part of form completion, each client must provide backup information that verifies income. This backup can take a variety of forms, including pay stubs, income tax returns, statement from the Social Security office, or, for SSI recipients, an explanation of benefits. For income outside of wages and government benefits (such as alimony, child support, military family allotments, income from self-employment, rental income, and interest income), documentary evidence is also required.

The backup information must be presented at the time of intake or the first Outpatient counseling visit (individual or group). If a client is bringing the information to the first counseling visit, the client should arrive 20 minutes ahead of the scheduled appointment to complete financial intake paperwork.

No client who fails to bring backup information will be denied service. However, unless/until backup documentation is provided, the client will be charged at 100% of fees incurred rather than on a sliding scale. Clients who do submit backup information will be charged in accordance with their income, based on the Federal Poverty Income Guidelines for Alaska.

This form documents the client’s response to provision of backup documentation on income. Please check the correct box below:

- I have provided documentation of income, which is recorded on my “Financial Client Information Form.”
- I choose not to provide income documentation, with the understanding that failure to provide such documentation will result in my being charged 100% of fees incurred (no discounts).

Client Printed Name

Client Signature

Date

THE SALVATION ARMY CLITHEROE CENTER
CONSENT TO RELEASE INFORMATION TO A THIRD PARTY FROM THE SALVATION ARMY (“TSA”)
CONFIDENTIALITY STATEMENT

As a client or former client of a TSA program, you must give TSA written permission before it will discuss or otherwise exchange your information in writing with a third party (e.g., a probation/parole officer, lawyer, relative, agency, etc.), including the mere confirmation of whether you participated in a TSA program. You may request a review of your counseling or other records with a staff person at a reasonable time. However, the confidential information of other individuals may not be reviewed absent their written consent on a form like this one. In order to provide you the best service, TSA may internally exchange information between its different components on a need-to-know basis. Under all circumstances, your confidentiality will be respected and guarded.

This notice and consent-to-release form describes how mental-health, substance abuse-related, and other information about you may be used and disclosed and how you can obtain access to such information. Please review it carefully.

NOTICE TO AGENCY OR INDIVIDUAL RECEIVING CONFIDENTIAL INFORMATION: This information has been disclosed to you from records that may be protected by federal and state confidentiality rules (e.g., those codified at 42 C.F.R. part 2, those of the Health Insurance Portability and Accountability Act (“HIPAA”), or other applicable laws and regulations). Generally, the federal and state rules prohibit you from further disclosing this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by applicable laws and regulations. A general authorization for the release of medical or other information is NOT sufficient for that purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any patient being treated for alcohol or substance abuse.

CLIENT’S RELEASE OF CONFIDENTIAL INFORMATION

Your records are considered confidential and may be protected by federal law and regulations. They will not be released to other individuals or agencies without your written consent, which you are providing through this form. However, certain information protected by 42 C.F.R. part 2 may be released without your authorization under the following circumstances: 1) Upon TSA’s receipt of a legitimate court order; 2) to medical personnel in a medical emergency; 3) to qualified personnel for research, audit, or program evaluation; 4) if you threaten or commit a crime on the program premises or against TSA personnel; 5) if there is evidence to suggest child abuse or neglect, or risk of harm to a child; 6) if you pose a threat of serious harm to self or to others; 7) if necessary to provide a counseling-related service, TSA staff may internally share your information with other TSA staff, strictly on a need-to-know basis; and 8) if there is a Qualified Service Organization Agreement (“QSOA”) in effect for a specific service, e.g., laboratory or medical services. Violation of certain confidentiality rules is a crime and may be reported to TSA. Please ask TSA staff for help if you are concerned or need assistance understanding any part of this form.

EACH SECTION MUST BE COMPLETED

I. I, _____, hereby knowingly and voluntarily consent to and authorize the release of information from my records as specified below.

II. The information may be exchanged between the following persons/organizations:

Name of Facility: The Salvation Army Clitheroe Center

Address, City, State: Mailing Address: 3630 E 20th Ave., Anchorage, AK 99508 (p/ 276-2898, f/ 770-8870)

AND

Name of Individual, Agency, or Facility: _____

Address/phone #/fax #: _____

III. These persons/organizations may communicate regarding and disclose to each other the following information related to me:

- | | |
|---|--|
| <input type="checkbox"/> Program attendance and compliance | <input type="checkbox"/> Counseling records (except mental-health notes) |
| <input type="checkbox"/> Progress toward counseling goals | <input type="checkbox"/> Behavioral Health Assessment summary |
| <input type="checkbox"/> Recommendations for future case management | <input type="checkbox"/> Medical referral |
| <input type="checkbox"/> Contact information | <input type="checkbox"/> Other (be specific): _____ |

The information to be released may be released: in writing verbally electronically

IV. The purpose of or need for this disclosure is: _____

The Salvation Army is making an internal referral between its own units/components.

V. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it.

This authorization must be revoked in writing for data protected under HIPAA but may be revoked orally for data protected under 42 C.F.R. part 2. One of the persons/organizations to which information is being released can provide you with a form for revoking your consent, if applicable. If this authorization is not specifically revoked earlier, it will terminate after:

60 day’s 90 day’s one year from date of signature when my last program session is complete

VI. I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or healthcare operations, if permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

VII. I have reviewed the guidelines above regarding confidentiality and have received a copy of this document.

Printed Name

Signature

DOB

Date

THE SALVATION ARMY CLITHEROE CENTER
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VII. I have reviewed the guidelines above regarding confidentiality and have received a copy of this document.

Printed Name

Signature

DOB

Date

LEGAL QUESTIONNAIRE

NAME (PRINTED) _____ Date: _____ D.O.B. _____

Were you referred here by the Criminal Justice System due to a criminal offense Yes No

Check all of the following that apply to you:

- ALASKA DOC ASAP OCS OPA
 DVR ATTORNEY PUBLIC DEFENDER WELLNESS COURT
 VA FURLOUGH INSTITUTION EMPLOYER/EAP
 PROBATION (STATE) PROBATION/PAROLE (FED)
 OTHER: _____

Name and Contact Number for Probation/Parole Officer: _____

Name of Attorney or Public Defender: _____

Please list your current criminal offenses/charges?

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

- Offense(s) alcohol and or drug related? Yes No
Is this a probation/parole violation? Yes No
Are you under electronic monitoring? Yes No
Do you have a court date pending?
if yes, date _____ Yes No
Are you facing jail time? Yes No
surrender date: _____
Were you ever required to register as a Sexual Offender? Yes No
If yes, have you attended and have/will supply proof (via a letter or certificate of completion)
of the completion of a sex offender treatment program? Yes No
Have you ever been convicted of arson? Yes No
Have you ever been referred for Anger Management services? Yes No

IN ADDITION TO THE ABOVE OFFENSES, PLEASE LIST ANY OFFENSES FOR WHICH YOU HAVE BEEN EITHER ARRESTED, CONVICTED, OR SENTENCED. (INCLUDING JUVENILE OFFENSES):

Please check whether any of the identified offenses resulted in jail time and/or were alcohol or drug related.

- Offense: _____ Date: _____ Jail Alcohol Related Drug Related
Offense: _____ Date: _____ Jail Alcohol Related Drug Related
Offense: _____ Date: _____ Jail Alcohol Related Drug Related
Offense: _____ Date: _____ Jail Alcohol Related Drug Related
Offense: _____ Date: _____ Jail Alcohol Related Drug Related
Offense: _____ Date: _____ Jail Alcohol Related Drug Related

MEDICAL SCREENING FORM

NAME (PRINTED) _____ Date: _____ D.O.B. _____

DO YOU HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS? (CHECK ALL THAT APPLY)

Medical Screening (check all that apply)									
	Current	Past (yrs)	Chronic	Hospitalized		Current	Past (yrs)	Chronic	Hospitalized
Dental Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye/Ear/Throat/Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily Bruised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain/Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/chest pain/palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver/cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia/Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (If yes, Type <u>C</u>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea /Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones/Kidney infections/blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloody or black Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach: pain, ulcers, acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain all checked spaces; for example: resolved, healed, or under treatment?

Current Medications (including psychiatric medications):

Do you take them as prescribed? Yes No

Are the medications helpful? Yes No

If you needed meds, how would you pay for them? _____

Last TB Test: result and date _____ (If positive, proof of a negative chest x-ray is required.)

Alcohol – Drug Withdrawal: What kind of withdrawal symptoms have you had in the past:

Do you have a medical provider Yes No

Name/contact number: _____ Date of last appointment: _____

MEDICAL SCREENING FORM (continued)

NAME (PRINTED) _____ Date: _____ D.O.B. _____

Do you have a mental health provider Yes No

Name/contact number: _____ Date of last appointment: _____

Pending Medical or Dental Appointments: Yes No

If yes explain: _____

WOMEN ONLY: Last Menstrual Period: _____ If longer than 1 month explain why: _____

Are you pregnant Yes No

Pregnancy- If you have any reason to believe you may be pregnant **the following must be done:**

_____ Obtain a medical clearance from your medical provider.

(This must not be more than 72 hours old.)

_____ Your medical provider must indicate what medications you are permitted to take.

_____ Your provider must indicate your date of expected delivery.

All Applicants- please initial the following statements to indicate completion or compliance.

_____ I have accurately completed the Medical Screening Form.

_____ I understand that I am not to drink alcohol or use drugs 3 days prior to admission.

_____ All of my medical conditions have been addressed, treated or are under treatment by a medical provider.
I understand that it is my responsibility to continue appropriate treatment while in the Clitheroe Center.

_____ If I have medical equipment, I will need to have with a written prescription plus and in working order.

_____ If I am taking medication, I understand that I must have a 30-day supply of meds and a med order if diagnosed for residential treatment before I will be admitted. I must pay for and obtain my medication while in treatment.

_____ If I am prescribed any medication or medical equipment while at the Clitheroe Center, I understand it is my responsibility to pay for and obtain same.

_____ Elective medical procedures will only be allowed if they don't interfere with my treatment.

_____ I understand that if I am on furlough per DOC, I will receive medical/psychiatric care through DOC. Otherwise, I will assume personal responsibility for my own medical, dental, and mental health treatment.

I have read, understood and will comply with the above statements. I understand that not following medical and medication recommendations may result in discharge from treatment.

All other clients are responsible for arranging their medical, dental, and mental health treatment (exception for DOC furlough clients who will receive medical/psychiatric care through DOC.)

Client Printed Name: _____ Client Signature: _____

Date: _____

BEHAVIORAL HEALTH QUESTIONNAIRE

NAME (PRINTED) _____ **Date:** _____ **D.O.B.** _____

Family substance abuse

Family violence episodes

Family of origin issues

Family mental health history

Physical/sexual/emotional abuse

History of neglect

History of Trauma (Witnessed or experienced)

Relationship history

Current Relationships (include family, friends, community members etc)

Need for Social Support

Psychological and social adjustment to disabilities/disorders

Strengths

Needs

Abilities

Treatment Preferences

What issues are important to you in your treatment and what are your goals and expectations?

Mental Health Screening Form III

NAME (PRINTED) _____

Date: _____

D.O.B. _____

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history not just your current situation, this is why each question begins – “Have you ever...”

- 1) Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? Yes No
- 2) Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? Yes No
- 3) Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? Yes No
- 4) Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? Yes No
- 5) Have you ever heard voices no one else could hear or seen objects or things which others could not see? Yes No
- 6) A) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions or thought about killing yourself? Yes No
B) Did you ever attempt to kill yourself? Yes No
- 7) Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example: warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? Yes No
- 8) Have you ever experienced any strong fears? For example: of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? Yes No
- 9) Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to destruction of property? Yes No
- 10) Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? Yes No
- 11) Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? Yes No
- 12) Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example: by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? Yes No

- 13) Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep and believed you could do almost anything? Yes No
- 14) Have you ever had spells or attacks when you suddenly felt anxious, frightened, and uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? Yes No
- 15) Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work or your social relations? Examples would include: repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. Yes No
- 16) Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling? Yes No
- 17) Have you ever been told by teachers, guidance counselors or others that you have a special learning problem? Yes No

List of Mental Health Medications:

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 J.F.X. Carroll, Ph.D. & John J. McGinley, M.S., M.S.W., M.A.
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Primary Care PTSD Screen (PC-PTSD)

NAME (PRINTED) _____ Date: _____ D.O.B. _____

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introduction sentence to cue responders to traumatic events.

Scale

Instructions:

In your life, have you ever had any experience that was so frightening, horrible or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to? YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? YES NO
3. Were constantly on guard, watchful or easily startled? YES NO
4. Felt numb or detached from others, activities or your surroundings? YES NO

Prins, Ouimette, & Kimerling, 2003

SUBSTANCE USE HISTORY

NAME (PRINTED) _____ Date: _____ D.O.B. _____

	Age first Tried	Age of regular use	Age of heaviest use	Date of last use	Periods of abstinence	Quantity/ Frequency of Use	Method of Use (IV, smoking, Ingesting, snorting)
Alcohol							
Amphetamines (speed, methamphetamine)							
Cocaine/Crack							
Marijuana or Spice (K2)							
Heroin							
Methadone							
Other Opiates (codeine, Percocet)							
Tranquilizers (Valium, Xanax)							
Hallucinogens (LSD, DMT, PCP, Psilocybin, mescaline,							
Barbiturates (downers)							
Gas, Nitrates, aerosol, paint thinner							
Club Drugs-MDMA, GHB, Ketamine, rohypnol							
Cough suppressants, antihistamines							
Steroids							
Tobacco							
Other: _____							

SUBSTANCE ABUSE TREATMENT HISTORY

NAME (PRINTED) _____ Date: _____ D.O.B. _____

IF YOU WERE EVER IN TREATMENT FOR ALCOHOL OR DRUG RELATED PROBLEMS, PLEASE PROVIDE THE FOLLOWING INFORMATION:

of prior Residential Admissions: _____ #of prior Outpatient Admissions: _____

Start date: _____ End date: _____ Agency/State: _____

Event leading to treatment: _____

Discharge Status: Complete Left on own Agency discharge Other

Length of abstinence following discharge: _____

Event(s) Leading to Relapse: _____

Start date: _____ End date: _____ Agency/State: _____

Event leading to treatment: _____

Discharge Status: Complete Left on own Agency discharge Other

Length of abstinence following discharge: _____

Event(s) Leading to Relapse: _____

Start date: _____ End date: _____ Agency/State: _____

Event leading to treatment: _____

Discharge Status: Complete Left on own Agency discharge Other

Length of abstinence following discharge: _____

Event(s) Leading to Relapse: _____

Start date: _____ End date: _____ Agency/State: _____

Event leading to treatment: _____

Discharge Status: Complete Left on own Agency discharge Other

Length of abstinence following discharge: _____

Event(s) Leading to Relapse: _____