Serenity House Application Checklist

Please ensure all forms are completely filled out, signed and dated.

- ☐ New Tobacco Free Policy
- ☐ Personal Response Form (Assessment Application)
- ☐ Family Involvement Questionnaire
- ☐ Personal Goals (Please Assist Client if Needed)
- ☐ Client Bill of Rights
- ☐ Confidentiality of Records
- ☐ Confidentiality of Information Acknowledgement
- ☐ Patient Rules and Regulations
- ☐ Financial Policy
- ☐ Proof of Income Checklist
- ☐ Notice of New Serenity House Residential Policy

Consent of Release of Confidential Information:

_____

_____

_____

_____

CPH Behavioral Health
245 North Binkley St. Suite 202, Soldotna, AK 99669
Intake office: (907) 714-4521 Fax Number: (907) 260-4063

ATTENTION

New tobacco free policy for Behavioral Health Department locations, including the Behavioral Health Intake Office, Serenity House, Care Transitions and Diamond Willow buildings.

As of June 1st, 2017, the Behavioral Health department took an important step in supporting the health of individuals with substance addictions by adopting a tobacco free policy to protect the rights of clients, employees and visitors to breathe clean air. Individuals with a substance addictions smoke at rates two to four times higher than the general population and experience increased mortality and morbidity rates related to smoking. Recent research indicates that quitting smoking while in recovery can increase the chance of long term sobriety by 25%. Additionally, a large proportion of employees in substance abuse treatment facilities are smokers and therefore are less likely to discuss the benefits of tobacco cessation with clients during treatment. The commonality of smoking in this population and community exposes many individuals to secondhand smoke. On average, tobacco free workplace policies effectively reduce secondhand smoke exposure by 72%.

The overall goal of tobacco free policy on our campus is to protect the health of our clients, employees and visitors while reducing health care costs and increasing employee productivity. This is an important step in protecting the health of individuals who are heavily impacted by smoking related illness and exposed to dangerous secondhand smoke. The policy includes **NO** E-cigarettes, vapes, cigarettes, loose or chewing tobacco and cigars.

For more information on and help with quitting tobacco products, please speak with nursing staff, your medical provider, or contact the Alaska Tobacco Quit Line at 1-800-QUIT-NOW (1-800-784-8669) 24 hours a day, 7 days a week. Alaska Tobacco Quit Line free services include telephone coaching, free nicotine replacement therapy, self-guided materials, a secure website, information for those concerned about a tobacco user, referrals and expanded services for pregnant and nursing women.

I have read and understand NO TOBACCO POLCY.

Client signature:_____ Date:_____

Staff witness signature:_____

(Original copy to clients chart, second copy for client records)

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Personal Response Form – Assessment Application

Dear prospective client: The information that you share with us in this document is considered sensitive and will be kept confidential. It will be reviewed by your assessing counselor, along with meeting for a personal interview, in order to best understand your needs and find the right treatment fit for you. Thank you for taking time to provide us with honest answers.

Full Legal Name:		**Date:**	
Home Phone:		Cell Phone:	
Date of Birth:		City/State/Country of Birth:	
Current Mailing Address:			
Former/Maiden Names *(if any):*			
Current Legal Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed			
If a Minor, Current Legal Guardian/Parent:			
Social Security Number:			
Preferred name that you would like to be called (nickname, middle name, etc.) If any:			
Who referred you to our agency?			

Insurance or Payment Source: *(please circle all applicable answers):*

SELF-PAY MEDICAID INSURANCE VETERAN ANMC OTHER

If insured:
Primary Insurance Company Name:_____
Name of Insured:_____
Policy #:_____

Persons to Notify in Case of Emergency

Name:		Address:		Phone:	
Name:		Address:		Phone:	
Name:		Address:		Phone:	

Brief description of the problem that you hope we can help you with: Brief description of the improvements you want to see in your life:

Your Social History and Current Status

Age:	
Sexual Orientation:	
Identified Gender:	
Race or Ethnic Identification:	
Cultural/Ethnical Preferences If Any:	
Preferred Language:	
Other Languages Spoken, if any:	
Do you have any Military Service History: If yes, when?	
Do you have a specific religion or spiritual Belief that is important to you, if any?	
Leisure, Hobbies and recreation. (What do you like to do for fun?):	
Number of pregnancies, if any:	
Number of live births, if any:	
Children/Minors in your care or home (Currently): *provide first names and ages*	
Children/Minors **Not** in your care (Currently): *provide first names and ages*	

Are you in a romantic or committed relationship or marriage with anyone right now? If yes, tell us a little bit about this relationship (*partner's name, length of time together, are you happy or unhappy?)* If no, how long have you been single?

Where do you live right now?	
How long have you been living there?	
Are you happy with your current living arrangement?	
If you have children, what are the parenting arrangements right now? (*Who has custody, how is it going, etc.)*	

Do you have any issues related to parenting that you would like counseling with? If yes, please briefly explain:
Have you been sexually active in the past 12 months? If yes, how many sexual partners have you had in the past year? Gender(s) of partners: Safe sex, unsafe sex, or both:
Do you have any sexual concerns or problesm that you would like counseling help with? If yes, please briefly explain:
Have you had any abuse in your adult relationships? Physical: Sexual: Emotional/Verbal: Other:
Did you have any abuse or neglect in your childhood? Physical: Sexual: Emotional/Verbal: Other:
Have you ever been abusive to someone else? Physical: Sexual: Emotional/Verbal: Other:
Are there any immediate serious family problems going on right now? If yes, please briefly explain:
Have you lost anyone in your family (or close friends) due to death or suicide? If so, when?

Current Financial Status

Have you worked in this past year?	
What was your yearly income this past year?	
How much money do you make right now, monthly?	
Are you able to meet your basic needs?	
Do you have any other sources of financial support/help? *(Food stamps, family, unemployment, child support, etc.)*	
What are your main financial concerns right now?	
Do you want to work?	
Would you like to learn about a program that helps people return to work?	Yes No

Who are your friends right now, if any? What are they like? Are they supportive of your desire to enter treatment or get counseling? Describe: Please Provide names of supportive family members, if any: Do you have any family members or close friends that you would like to be a part of the counseling or treatment process? Please provide names, if so: Do you have any family members or friends that you do **NOT** want to be involved right now? Please provide names, if so:
Share some of your personal strengths, talents, and abilities:
What are some of the biggest obstacles or challenges that might stand in the way of your success?

Developmental History

History from your childhood and teenage years (ages 0-18)

Did you have normal physical development as a child or were there any delays (such as walking, talking or puberty):	
Do you feel like your emotional development was normal or were there areas that you struggled with?	
Were you able to make friends as a child or was it difficult for you?	
Did you behave and follow rules normally, or was it difficult for you to follow rules at school or at home?	
Were you able to learn at a normal rate, or were there any learning disabilities or challenges?	
Did you have any problems with speech, hearing, or vision? Please describe if yes:	
Did you have enough to eat when you were a child? Would you say that your average meal was healthy and nutritious, poor nutrition, or a mixture?	
Is there any possibility that your mother might have used alcohol or drugs when she was pregnant with you? Did anyone tell you that you had FASD?	
Did you ever have injury to your brain or get knocked unconscious as a child? If yes, did it cause any problems for you after?	

Biophysical and Medical: Current Status and History

Your past medical history (surgeries, major medical problems or issues):	
Your medical health conditions right now:	
Who is your medical provider?	
How often do you see a medical provider?	
How many times have you been to the Emergency Room in the past 12 months?	
Are there any medical concerns right now that you haven't seen a doctor about?	
When was your last Physical Exam: Findings of last Physical Exam:	
What is your biological family's health history? *(such as cancer, heart problems, diabetes, blood pressure, etc.)*	
What is your family's attitude towards getting medical care?	

Current Prescription Medicines that you are taking:

Do you take any vitamins or supplements? If yes, what?

Do you have any allergies to any medications? If yes, what?

Allergies: any other non-food allergies? *(Such as bees, detergent, latex, etc.)*
If so, describe:
What do you do if you have a reaction?

Nutrition/Diet:
Have you had any significant weight gain or loss in the past couple months? Describe:

Do you have any food allergies? If yes, describe:

Do you have any special diet needs? *(diabetic, religious, vegan):*
If yes, please describe how you manage this:

Do you have a nationalist, dietician, or person that you work with on food related issues?

Do you have problems with eating, such as binging or restricting calories? If yes, please describe:

Would you like any help with food related issues while you are in counseling?

Physical Pain:
Are you currently in pain?
On a scale from 0-10 *(0 none, 10 unbearable)* please rate your pain today:
If yes, where is the location of the pain?
What makes it worse?
What makes it better?
Are you seeing someone for pain?
If yes, please describe who and what the treatment is for:

Physical Activity:
How physically active are you right now?
What kind of physical shape would you like to be in?
Do you have any restrictions or disabilities that keep you from participating in certain physical fitness activities?
If yes, please describe:

Do you have any goals for your physical health?

Sexual Health:
Birth control used:
Date of last pelvic exam:
Would you like to be tested for sexually transmitted infections
while you are in treatment?

Dental/Oral Health:
How often do you see a dentist?
Regular dental provider:
Date of last Dental Exam:
Do you have any dental concerns or needs right now?
If yes, please describe:

Withdrawal Symptoms:
If you are addicted to drugs or alcohol, what are you typical withdrawal symptoms:

If you are entering treatment with us soon, what withdrawal symptoms do you expect to have?

How do you typically manage these?

How would you describe the quality of sleep in this past month?

Would you like help on learning good sleep practices?

Do you use nicotine?
If yes, please describe how *(cigarettes, vape, chewing tobacco, etc.)*

Have much do you use each day?

Have you ever had a brain injury, concussion?
If yes, were there any changes in your thinking or personality after the brain injury?

Did your mother consume alcohol or drugs while she was pregnant with you?
Where you ever diagnosed FASD?

Any Additional Health Comments or Concerns:

Educational and Vocational Status and History

What is your highest grade you have completed in school?	
What was school like for you overall?	
Did you have any learning disorders or problems with learning? If yes, please describe:	
What is the best way for you to learn things? *(Visual, audio, hands on, etc.)*	
What were your favorite classes or subjects?	
Did you care about doing well in school?	
Do you have any interest in going on in school or college? If yes, please describe:	
Have you had any vocational training or attended a trade school? *(Electrical, construction, welding, chef, beautician, medical coding, etc.)* If yes, please describe:	
Do you have any interest in furthering your vocational training? If yes, please describe:	
Would you want to learn about a program? Return to school?	
Current Employer/Employment: How long have you been at this job?	
Brief Work History:	
What are your long-term career goals, if any?	
What are your immediate employment needs, if any?	

Legal Status and History

Number of arrests in the past 12 months:	
Total amount of lifetime spent in jail or incarcerated:	
Legal issues in past 12 months:	
What is your present legal status?	
Probation officer? *(if on probation)*	
Do you have OCS involvement? If yes, provide name of OCS caseworker:	
Current/Pending future court date? If yes, provide date:	
Do you have an attorney? If yes, provide name:	
Please briefly describe your legal history:	

Mental Health Status and History

Have you ever been to counseling for help with your mental health? If so, briefly explain:	
Have you ever been hospitalized for your mental health? If so, briefly explain:	

Have you ever been given a mental health diagnosis? If so, please describe:	
If you have had had counseling or mental health services, did you find them helpful? Please briefly explain:	
Please describe what your daily mental health is like right now? *(Thoughts, emotions, etc.)*	
Depression symptoms can sometimes include feelings of hopelessness, problems with sleep, low self-worth, low energy, low motivation and more. If you are experiencing some depression please describe your symptoms:	
Anxiety symptoms can sometimes include feeling afraid, irritable, panicky, nervousness, having problems with sleep, problems concentrating and more. If you are experiencing some anxiety, please describe your symptoms:	
When you feel emotionally overwhelmed, how do you cope?	
Have you ever self-harmed? Do you currently self-harm? Please briefly explain?	
Have you ever tried to end your life? If yes, please briefly explain: Are you currently feeling suicidal? If yes, do you have a plan? Please briefly describe:	
Do you hear voices? Do you hear or see things that other people say aren't there?	
Have you ever been diagnosed with ADD or ADHD? Do you have problems paying attention? Do you have problems sitting still?	
Do you have problems controlling your temper when you get angry? Have you ever hurt someone or damaged property because you were angry? Please briefly explain:	
Do you have big mood swings up and down? *(Over a short or long period of time)* Do you have periods of time where you feel like you are on top of the world, spend too much money, feel very sexual, talk really fast or need hardly any sleep? If so, please briefly explain:	

Do you have any obsessive or compulsive behaviors? *(Handwashing, skin picking, persistent urges or thoughts, etc.)* Do you have any addictions to non-drug related things? *(Sex, gambling, video games, etc.)*	
Do you binge on food sometimes? *(Eating more than you wanted to and then feeling bad about it later)* Do you restrict food or calories in a way that others say is to excessive? If you struggle with food related issues, what are your beliefs about food? If you have any concerns about food related behaviors, please explain:	
Do you have any grief or loss about the death of a loved one(s) or changes in your life or family structure? Please explain: Do you have a past history of trauma or abuse that you hope counseling will help you with? Briefly explain:	
Do you think that counseling will be able to help? Please explain:	
Do you have any mental health issues in your biological family? *(Include schizophrenia, bipolar disorder, ADHD, depression, anxiety, PTSD, mental health hospitalizations, etc.)* How does your family feel about people who go to counseling?	
What is something that you hope will get better within a month of starting counseling?	
What is something you hope will get better within a year of starting counseling?	

***Please Briefly Describe The Consequences that Addiction has had on You in these Areas:**

Intimate Relationships/Marriage:

Family/Children

Employment/Educational:

Social/Friends/Community:

Emotional:

Physical/Body:

Legal:

Have you ever had treatment for alcohol or drug use before?
If yes, please describe when and where:

In what ways was it helpful?

Have you tried 12 step meetings before?
If yes, how often do you attend meetings right now?

If you have tried to quit drugs or alcohol on your own, please briefly describe how often you have tried and what the results were:

Does your biological family have any problems with drugs or alcohol? Please describe:

Do you have any family members who have ever gone to treatment, rehab or addiction counseling?

What is your family's view of you entering addiction treatment?

Where are you at in terms of motivation to make changes?

- o I'm not really sure if change is even possible for me.
- o I'm thinking about changing...but I will need some help to actually do it.
- o I'm starting to take some steps towards making changes, but I could use some help.
- o I'm already taking active steps towards change and it's going well.
- o I've made complete changes and it's been working really well for months!

Please share what *immediate* changes you hope will happen as a result of getting into addiction treatment:

Please share what *long-term* changes you hope will happen for you as a result of getting into addiction treatment:

Thank you so much for your thoughtful and honest answers!

Family Involvement Questionnaire

The following questions are wonderful things to ask an involved family member or close friend. You can have them fill this part out or you can talk to them and write down their answers yourself. (If you don't have an involved person right now, that's okay. Write "not right now" below.

Family member/guardian/friend's name:

Family member/guardian/friend's contact phone number:

Family member/guardian/friend's perception of the individuals strengths, talents and abilities:

Family member/guardian/friend's comments or concerns about individual's current problem or issue:

Additional thoughts or comments:

Services that the family/guardian/friend wants for the individual:
(please circle the service that you think will best fit your loved ones immediate needs)

- ☐ Intensive Residential Treatment (for at least 1-2 months)
- ☐ Long-term Residential Treatment (over 3 months, up to 1 year)
- ☐ Intensive Outpatient Treatment (1-4 hours daily attendance, M-F)
- ☐ Outpatient Treatment (2-6 hours per week)
- ☐ Individual Counseling **Only** (1x per week or less)
- ☐ Family/Couples Counseling **Only** (1x per week or less)
- ☐ Other:

What is **your** desired involvement level in your loved one's treatment or services:

- ☐ I want to come to family day group at residential treatment every week (1x per week)
- ☐ I want to be involved in some kind of counseling services on a weekly or bi weekly basis
- ☐ I would like to check in regularly, once every month or two, with a counselor
- ☐ I want to be supportive but I don' need to be a part of the counseling process
- ☐ I want to be a part of the counseling process if there is an emergency
- ☐ Other:

Family/Guardian/Friend thank you for your help completing this part of the application packet!

Please complete the following by filling in every single field or cell. An answer to each question is required.

	Age Started	Last Use	Method *(smoke, snort, IV, etc.)*	Acquired *(streets, doctor, family, internet, etc.)*	Frequency of use	Amount
Alcohol						
Heroin						
Other opiates/pills						
Methamphetamine						
Amphetamines/Speed						
Cocaine/Crack						
Xanax/Anxiolytics/Benzos						
MDMA/Molly/Ecstasy						
Cannabis/Marijuana						
Spice						
Bath salts/designer drugs						
Inhalants						
Hallucinogens/LSD						
Other						
Do you us tobacco?		If yes, what kind?		How much?		

Have you ever been arrested?	
Legal issues in the last 12 months?	
Do you have a probation officer? (name/number if yes)	
Do you have an attorney? (name/number if yes)	
Do you have any children?	
Do you have any custody concerns?	
Do you have any OCS involvement? (name/number if yes)	

Brief description of the problem that you hope we can help you with:	

My Personal Goals for One Year in Treatment
We want to work with you as we create a Treatment Plan for you. By learning more about what you hope your life will look like AFTER a successful treatment experience, we can better understand how to help you reach your goals. Please provide a brief response to the following questions so that we can better work together in creating the kind of life you want to live.

1. MY SOBRIETY GOAL: What is your goal for drug and alcohol related use? Do you want to stop use entirely? Would you like to learn how to stay clean and sober? Please explain what you hope to see change in your life in this area by the time you graduate from treatment:

2. MY MEDICAL CARE GOAL: What is your goal for medical care? Would you like to start (continue) working with a doctor and dentist to take better care of your physical health? Do you have a medical diagnosis that you want to manage in better ways? Please explain:

3. MY EXERCISE AND NUTRITION GOAL: What is your goal for exercise and nutrition? Would you be willing to start some basic and gentle exercise? Would you like to have better nutrition? Would you like to take care of your physical health needs? Please explain:

4. MY EMOTIONAL HEALTH GOAL: What is your goal for you own emotional health? Are there specific emotions that are problems for you? (*such as anger, depression, grief, anxiety, etc.)* Do you know how to identify your emotions? Do you know what to do with difficult emotions? Please share with us what you hope to get out of treatment when it comes to having better emotional health:

5. MY THINKING AND BEHAVIORS GOAL: What is your goal regarding the ways that you think and behave? Would you like to learn some healthier ways of thinking? Would you like to have help learning to make better behavioral choices? Please explain what you hope to see change by the time you are completely done with treatment here:

6. MY MENTAL HEALTH GOAL: Do you have a mental health diagnosis or are you concerned about some of your mental health symptoms? What is your diagnosis *(if any)*? Would you like to have help learning to manage mental health issues in healthy ways? Are you willing to consider medication help as well? If you have mental health needs, please explain what you hope to see change as a result of treatment help:

7. MY MOTIVATION GOAL: How is your current motivation for making changes in your life? What do you want your motivation level to look like on year from now? Are you willing to work hard in treatment?

8. MY LEGAL ISSUES GOAL: Do you have current legal issues *(court sentencing, parole or probation officer, OCS, ASAP, etc.)*. If you do, do you hope that these will be resolved or bettered by participating in treatment? What do you hope happens with these legal issues as a result of your participation in treatment? Please explain:

9. MY RELAPSE PREVENTION GOAL: When you are done with a full year of treatment with us, how would you like to be able to handle relapse temptations? What do you hope your recovery will look like? Please explain:

10. MY FAMILY AND FRIENDS GOAL: What kinds of things do you hope to learn that will help you have better relationships with friends and/or family? Are there any relationships that are especially important to you? How can treatment help you improve those relationships? Do you find yourself in "bad relationships" often and want to work on that area? Do you need help with marital or parenting issues? Please share your thoughts with us:

11. MY HOUSING AND JOB GOAL: Do you need help finding safe housing? Do you need help getting (or keeping) good employment? What about transportation? What do you hope your "work life" will look like one year from now? What do you hope your living environment will be like one year from now? Please share:

12. Are there any other important goals that we missed? Please share them here:

Serenity House Treatment Center
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CLIENT BILL OF RIGHTS

Serenity House supports and protects the fundamental human, civil, constitutional, and statutory rights of each client.

Serenity House's Treatment program has been designed with the intention of meeting the client's individual "needs" that may be conductive to their recovery. We view the client's individual needs as a priority of this program. The client has a voice in the modification of their treatment services. Client program evaluation forms and suggestion boxes are available. Completed evaluation forms may be given to a staff member.

A. YOU HAVE THE RIGHT to quality care and to treatment with dignity and respect as a person.

B. YOU HAVE THE RIGHT reasonably expect to obtain from your counselor complete and current information about your evaluation, treatment, and recovery in terms and language that you can understand.
C. YOU HAVE THE RIGHT to know by name and responsibility, the staff member(s) involved in your treatment.
D. YOU HAVE THE RIGHT to consideration of your privacy and individuality as it relates to their physical, social, religious and psychological well-being within the constraints of the program setting.
E. YOU HAVE THE RIGHT to expect the program staff to make reasonable response to your requests within the framework of the therapeutic policies of the treatment program.
F. YOU HAVE THE RIGHT to information about the relationship to other health care institutions and agencies so far as your care or referral are concerned.
G. YOU HAVE THE RIGHT to expect reasonable continuity of care in your treatment, which shall include, but not be limited to, the appointment times that staff is available.
H. YOU HAVE THE RIGHT to confidentiality as it relates to your treatment program. Case consultation and treatment issues may be reviewed within the staff and will be discussed discretely and confidentially.
I. YOU HAVE THE RIGHT to the confidentiality of your treatment record. Information from the treatment record can be released to other persons and agencies only when you complete a "Release of Information" form (ROI) specifying the person or agency.
J. YOU HAVE THE RIGHT when significant alternatives for your care and treatment exist, to information concerning alternatives, such information shall be provided without violating your confidentiality.
K. YOU HAVE THE RIGHT to discuss any non-disciplinary discharge planning.

L. YOU HAVE THE RIGHT to inspect the Program's Policy and Procedure Manual by requesting, in writing, and appointment with the counselor.

M. YOU HAVE THE RIGHT to refuse treatment to the extent permitted by law and to be informed of the consequences of their actions.

N. YOU HAVE THE RIGHT to examine and receive an explanation of your bill regardless of sources of the payment.

O. YOU HAVE THE RIGHT to express a grievance or a complaint that you may have relating to your treatment. Every effort will be made to resolve complaints with the person with whom they occur.

It is recognized that some grievances are unmanageable. If you have a grievance with the Program, the first step is to thoroughly discuss it with your counselor. If no resolution is obtainable, the second step is for you to put your grievance in writing to the supervisor with the request for a meeting appointment. If no resolution is forthcoming from this meeting with the supervisor, you may contact Central Peninsula Hospital's Administrator at (907) 714-4404. If resolution is still outstanding, you may contact the State of Alaska Division of Behavioral Health at (907) 269-3600.

CLIENT RESPONSIBILITIES

A. YOU HAVE THE RESPONSIBILITY to provide information about present complaints, past and current functioning, hospitalizations, medications, and other matters related to their behavioral and physical health.

B. YOU HAVE THE RESPONSIBILITY to share expectations of and satisfaction with the program.

C. YOU HAVE THE RESPONSIBILITY to ask questions when you do not understand your care, treatment, or services or what you are expected to do.

D. YOU HAVE THE RESPONSIBILITY to follow instructions for your plan of care, treatment, or services and expressing concerns about your ability to follow the proposed plan of care, treatment, or services.

E. YOU HAVE THE RESPONSIBILITY to accept consequences for the outcomes of care, treatment, or services if you do not follow the planned care, treatment, or services.

F. YOU HAVE THE RESPONSIBILITY to follow the programs policies and procedures.

G. YOU HAVE THE RESPONSIBILITY to show respect and consideration of program's staff and property, as well as other individuals and their property.

H. YOU HAVE THE RESPONSIBILITY to meet financial commitments.

I. YOU HAVE THE RESPONSIBILITY to provide the program the signed written acknowledgment confirming that your responsibilities were explained.

Client Signature:_____ **Date:**_____

Staff Signature:_____

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CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal Law and Regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing; or,
2. The disclosure is allowed by a court order; or,
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or,
4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program.

Violation of the Federal Law and Regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal Law and Regulations do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate state or local authorities. (see 42 U.S.C, 290 EE-3 for Federal Laws and 42 CFR Part 2 for Federal Regulations.)

I have read and understand <u>The Client Bill or Rights.</u>

Client Name:_____ Client Signature:_____

Witness:_____ Date:_____

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FINANCIAL POLICY

Thank you for choosing us as your treatment provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Services will be billed and submitted to insurances as appropriate. We will offer an extended payment plan if need is documented. All changes are your responsibility.

Insurance

We may accept assignment of insurance benefits at the time of your assessment or intake appointment. The balance is your responsibility, whether the insurance company pays or not. We can only bill your insurance company only if you give us your insurance information, a copy of your insurance card and/or an original claim form are requested when you are admitted.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our Utilization Review Team will comply with all necessary clinical reviews as required by your insurance company. If however, your insurance company has not paid your account within 45 days, the balance will become your responsibility. Our agency is committed to providing the best treatment for our clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination or usual and customary rates. Please let us know if you have any questions or concerns regarding our Financial Policy.

I have read, understand and agree to this Financial Policy.

Client Name:_____ Client Number:_____

Client Signature:_____ Date:_____

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CONFIDENTIALITY OF INFORMATION ACKNOWLEDGEMENT

I, _____, understand that any information which is disclosed regarding other clients, while I am a client at Serenity House Treatment Center (SHTC), is confidential.

The group is to provide a safe environment for disclosing personal information. This is a problem-solving group, and information shared in the group should stay in the group. This information is to be confidential and is my responsibility, as well as that of the other group members.

This confidentiality is protected by Federal Law (42 CFR Part 2). I understand that I cannot make any disclosure of such information without the written consent of the person to whom the information pertains.

I have read, or have had read to me, the foregoing rules and agree to abide by this statement.

Client Name:_____ Date:_____

Client Signature:_____

Witness:_____

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Intake Office: *(907) 714-4521*
Fax Number: *(907) 260-4063*

PATIENT RULES AND REGULATIONS

1. No phone contact privileges for your first week in treatment.
2. Telephone time is from 5:30 p.m. until 10:00 p.m. daily, unless it's a treatment task, but may not interfere with regularly scheduled groups and/or activities. Please restrict your calls to 10 minutes. We will only accept emergency incoming calls.
3. There are no pass privileges for the first two weeks in treatment. Passes may be issued Saturdays for 4 hours. Pass can be submitted to treatment team on Tuesday prior to pass date for treatment team approval.
4. **No smoking, vaping, or chewing; Tobacco products are prohibited on all CPH property.**
5. Male patients may not visit in a female patient's room. Female patients may not visit in a male's room.
6. Patients must be fully and appropriately dressed when in common area including footwear.
7. No hats are to be worn in the house.
8. Meals and treatment activities must be attended on time. Even if you do not eat, you need to spend 10 minutes at the table with you peers and participate in prayer.
9. Patients are responsible for cleaning their room and doing their own laundry during **their free time, not during group time.** Rooms will be inspected by team members, should a room not pass inspection, and the entire group will lose phone privileges from 3-5 days.
10. A urinalysis test may be done when returning from passes and outside meetings. **Compliance is mandatory.** Non-compliance will result in discharge immediately.
11. Lights out is 10:30 p.m. everyone must retire to their room and **shut off lights.**
12. No use of mood-altering chemicals will be permitted while in treatment.
13. When at the gym, patients may not leave the premises for any reason, patients must work out. Patients may not use the phone or the tanning bed when at the gym.
14. Patients are not allowed to bring outside reading material including newspapers.
15. No CD's, tapes, headphones, MP3 players, or unrelated treatment materials will be allowed on premises. No television, radio, or cell phones. If patient plans to make long distance phone calls, bring a phone card or charge card.
16. No cussing or intimidation of counselors or peers.
17. Sexually harassing behavior will not be tolerated. This includes but is not limited to: touching, sexual innuendos, sexual humor and stories of sexual content.
18. Clothing must cover entire stomach, buttocks, and shoulders at all times. You will be asked to change if attire is deemed inappropriate by staff.
19. No food or beverages outside of the kitchen area. Water is allowed in covered water bottle. Absolutely NO CANDY, SNACK FOODS, OR SODAS IN BEDROOMS.

FAILURE TO COMPLY WITH RULES AND REGULATIONS

MAY RESULT IN EARLY DISCHARGE.

I have read and understand the above Rules and Regulations.

Patients Signature:_____ Date:_____

Staff Signature:_____ Date:_____

Serenity House Treatment Center
Central Peninsula General Hospital
Intake Office: *(907) 714-4521*
Fax Number: *(907) 260-4063*

PROOF OF INCOME CHECKLIST

At this time, Serenity House Treatment Center accepts all major insurance, Medicaid and self-pay clients.

If you require financial arrangements for your treatment payments, you will need to bring in proof of your family's gross income.

The following is a list of items that could help provide that proof:

1. If employed, bring in most current pay stub for yourself and spouse, if married.
2. Most recent W-2 or copy of last year's tax return.
3. If you are receiving any of the following, you must also bring proof in the form of your most recent pay stub:

    - Unemployment
    - Social Security Income
    - Retirement pension
    - Public Assistance
    - Native corporation dividends
    - Permanent fund dividend (proof of filing with batch card)

If you have no income, you must provide other documentation and inform your evaluator.

I have read, understand, and agree to the Proof of Income Requirements.

Client Name:_____ Date:_____

Client Signature:_____

Notice of New Serenity House Residential Policies

Medical Provider Policy

All clients will be required to see our in house medical provider for all medical needs while enrolled in Serenity House Residential Treatment Center. Outside medical provider visits (including dental and vision appointments) will not be permitted unless deemed medically necessary by our in house provider. Serenity House provides exemplary quality of care and does everything possible to meet all clients' medical needs and help clients reach and maintain optimal health.

Legal Obligations Policy

Attorneys, Probation Officers, OCS Case Workers, etc. must be contacted prior to admission and made aware that client will be unavailable to appear in person for court hearings, meetings with attorneys, probation appointments, and other legal obligations. Serenity House will provide a letter for clients to give to all legal liaisons verifying their admission and unavailability for meetings. Clients are required to sign a release of information for any of the aforementioned liaisons. Attorneys can reschedule court dates to accommodate clients' residential treatment admission. If a court date cannot be rescheduled, clients will be allowed to attend telephonically. Scheduled OCS visits with children will be permitted one time per week only and must be scheduled one week in advance. Clients must arrange their own safe transportation for their scheduled visitation.

When arranging transportation, OCS may be available to arrange and fund transportation. If they do not, if transportation is provided by family, the family member must attend family group and be approved by primary clinician prior to appointment. If transportation is not provided by family, it may be a safe member or the recovery community with a minimum of 6 months sobriety.

I have read and understand MEDICAL PROVIDER AND LEGAL OBLIGATIONS POLICY.

Client Signature:_____ Date:_____

Staff Witness Signature:_____

central peninsula behavioral health

serenity house | diamond willow | outpatient services

245 North Binkley St Suite 202 Soldotna, AK 99669
Intake office: 907-714-4521 Fax number: 907-260-4063

Consent for Release of Confidential Information

Client Name: _____ Date of Birth: _____

I authorize the mutual exchange of information and communication between Central Peninsula Behavioral Health and _____
Phone number _____ fax number _____ and I authorize the information to be exchanged verbally, in writing, and/or by fax.

I am aware that disclosure information may include alcohol/drug abuse information, and/or psychological/psychiatric information. I authorize the following information to be exchanged.

(Please Initial which information will be released)

_____ Acknowledge presence in treatment/attendance
_____ History pertinent to this referral
_____ Diagnosis
_____ Urinalysis results
_____ Treatment plan
_____ Treatment records
_____ Discharge summary, status
_____ Treatment recommendations
_____ Substance abuse assessment
_____ Program compliance
_____ Prognosis
_____ Psychological/psychiatric assessment
_____ Psychological/psychiatric reports
_____ Medical records
_____ Other: _____

The above information is to be exchanged for the purpose of: _____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my verbal consent unless otherwise provided for in the regulations. I also understand that I may revoke this content at any time except to the extent that action has been taken in reliance on its previous written revocation of this document and that in any event this consent expires: _____
(Specify event, date(s), or condition).
If left blank, this specific authorization will expire 6 months from the date of my signature.

Signature of Client: _____ Date: _____

Signature of Witness: _____ Date: _____

Records from which this information has been disclosed are confidential and protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom the information pertains or as permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for release of alcohol and drug abuse client records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

(Revised June 2012)

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(Revised June 2012)

What to Bring

Please follow this list carefully. Due to space limitations, additional items are not allowed.

Suitcase, wallets, purses and all other belongings will be searched upon arrival for treatment.

4-5 Pairs of Pants*

This includes Jeans, slacks, skirts, yoga and sweat pants.

Very revealing clothing items such as mini-skirts are not allowed.

6 Shirts*

This includes t-shirts, sweaters, button up shirts, hoodies and sweatshirts.

Clothing with pro-drug, alcohol, violence, gang-related or demeaning /disrespectful statements are not allowed.

Revealing clothing, including spaghetti-strap tank tops, are also not allowed.

4-7 Pairs of Socks

4-7 Pairs of Underwear

(Women: include 3-5 bra's)

1 Bathrobe *(optional)*

2 Pajama Sets/Gowns

1 Slippers/Indoor Shoes

The House has an "Indoor Shoes Only" policy,

So bring something clean and comfortable to wear on your feet that you will designate as your "House" shoes during your stay.

1-2 Outdoor Shoes

Boots during winter, plus 3 pair of tennis shoes for gym/hikes.

1 Warm Coat, 1 Hat

There will be times when you will be outside. Bring weather appropriate coat or jacket as well as one weather appropriate hat.

Personal-Hygiene Items, 1 of each:

- Bath Soap
- Comb/Hairbrush
- Hand/Body Lotion (optional)
- Razor & Shaving Cream (optional)
- Toothpaste and Toothbrush
- Non-alcohol Mouthwash (optional)
- Shampoo & Conditioner
- Deodorant
- Hair Spray (optional)
- Curling Iron/Hot Curlers (optional-no frayed wires allowed)
- For Women: Feminine hygiene products (1-month supply)
- Perfume or cologne (optional)
  if you choose to bring one, this will not be allowed in bedrooms but will be kept in a locked area (due to high alcohol content) and available for use once per day.

Make up*

*Limit make-up to the bare minimum. 1 mascara, 1 eye-liner, 1 eyebrow liner, 1-2 lipsticks/gloss, 1 blush, 1-3 eye shadow colors, 1-2 foundation products, 1 facial wash, 1 moisturizer, and 1-2 additional products if needed. *Additional make-up items will not be allowed to be brought into treatment*

Linens Provided-Towels and hand-towels are provided, as are sheets, pillows and blankets. If you have a special bedspread, pillow or towel you wish to bring, you may do so.

Tobacco Products-

NOT ALLOWED AT SERENITY HOUSE AS OF JUNE 1ST, 2017.

Laundry Soaps-Laundry machines and basic laundry soap products are made available free of charge at the House.

Spending Money-Serenity House residents may have up to $20.00 cash on their person. Any additional money, including bank debit cards, will be kept in a locked container for safety. You may get your debit card and additional cash prior to a trip to the store.

Cell Phone-Cell phones are turned off during the entire Serenity House stay, however, you may bring your cell phone if needed in order to access contact numbers. Your phone will be kept in a safe locked area (along with your wallet and any medications you may bring).

Books-Other than a favorite religious text (Bible, Book of Mormon, Tao Te Ch'ing, etc.) please do not bring any books to treatment. You will be provided with ample reading materials while you are here. If you have a new blank journal that is special to you, you may bring one, as you will be doing a lot of journaling during your stay. (Simple notebook journals will be provided).

Reading Glasses or Contacts-If you wear reading glasses or wear contacts, please bring as you will be engaging with a variety of reading materials during your stay.

iPods/iPads/Laptops-No tech/computer devices allowed during your treatment stay in order to provide you with a quiet and distraction-free healing experience.

Photos/Pictures-You may bring 1-2 pictures of your children and/or a safe and supportive loved one to set or hang on your desk while in treatment, if that would be helpful to you.

Valuables-Please **do not** bring any valuables with you to residential treatment.

Special Foods-Delicious home-cooked meals are served three times a day at Serenity House. The kitchen is also open for snacks during various times of the day, a variety of snack foods also provided as part of your stay. If you have a special diet that will need to be accommodated (such as vegetarian), please let our staff know as soon as possible.