

Care Transitions Intake Application Packet

Instructions: Please answer each question as completely as possible. If a question does not apply, write N/A.
Information provided is confidential and will be used to help determine appropriate services and payment options.

1. APPLICANT INFORMATION

Full Legal Name:	Date Completed:
Preferred Name / Nickname:	Nickname / Maiden / Other Names Used:
Date of Birth:	Age:
Place of Birth (City / State / Country):	Social Security Number (if required):
Current Phone Number:	Email Address:

Current Physical Address:

City:	State:	ZIP Code:
-------	--------	-----------

Current Mailing Address (if different from physical address):

City:	State:	ZIP Code:
Current Legal Marital Status:	Spouse / Partner Name (optional):	

2. IDENTITY AND BACKGROUND

Sex Assigned at Birth:	Gender Identity (optional):
Race (optional):	Ethnicity (optional):
Primary Language:	Interpreter Needed? ☐ Yes ☐ No

Cultural, spiritual, religious, or community considerations important to your care:

3. REFERRAL AND PAYMENT SOURCE

Who referred you to CPH Behavioral Health?

Have you received services from CPH Behavioral Health before? ☐ Yes ☐ No ☐ Unsure

Insurance or payment source (check all that apply): ☐ Medicaid ☐ Medicare ☐ Private Insurance
☐ VA / TRICARE ☐ Self-Pay ☐ Grant ☐ Other

4. INSURANCE COVERAGE

Do you currently have health insurance? ☐ Yes ☐ No ☐ Unsure

Primary Insurance Company Name:	Primary Insurance Phone Number:
Primary Insurance Company Address:	City / State / ZIP:
Primary Policy Holder:	Policy Holder Date of Birth:
Primary Policy Number:	Primary Group Number:

Secondary insurance (complete if applicable):

Secondary Insurance Company Name:	Secondary Insurance Phone Number:
Secondary Insurance Company Address:	City / State / ZIP:
Secondary Policy Holder:	Policy Holder Date of Birth:
Secondary Policy Number:	Secondary Group Number:

5. EMERGENCY CONTACTS

Name	Relationship	Phone	Address
Primary Emergency Contact Name:		Emergency Contact Phone Number:	

Emergency Contact Address:	City / State / ZIP:
-----------------------------------	----------------------------

6. MEDICAL HISTORY

Current Health Care Provider:	Provider Phone Number:
Date Last Seen:	ER Visits During the Past 12 Months:

Medication allergies (list medication and reaction):

Current medical conditions or health concerns:

MEDICAL HISTORY CONTINUED

Non-Treatment Substance-Related Hospitalizations in the Past 6 Months:	Prior Mental Health Treatment Admissions:
Prior Mental Health Hospitalizations:	Prior Substance Use Treatment Admissions:

7. CURRENT HOUSEHOLD AND SOCIAL HISTORY

Applicant lives with (check one): ☐ Relatives ☐ Children ☐ Non-Relatives ☐ Significant Other ☐ Alone ☐ Significant Other and Children ☐ Other

Current living arrangement (check one): ☐ Private Residence Without Supportive Services ☐ Supportive Housing ☐ Residential Program ☐ Homeless ☐ Other

Current marital status (check one): ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Cohabiting

If other living arrangement, please specify:

List children/minors in the home (name or initials, age, and relationship to applicant):

Describe your current social situation, relationships, and available support system:

Are you currently experiencing housing instability or homelessness? ☐ Yes ☐ No

If yes, please explain:

Do you feel safe in your current home and relationships? ☐ Yes ☐ No ☐ Unsure

Are you a caregiver for another person? ☐ Yes ☐ No

Current transportation needs or barriers:

8. EDUCATION AND EMPLOYMENT

Highest Grade Completed:	Diploma / Degree / Certificate:
Current Employment Status:	Employer:
Job Title / Occupation:	Length of Employment:

Learning needs, literacy concerns, or accommodations that may help you participate in services:

9. CURRENT FINANCIAL STATUS AND BASIC NEEDS

Current sources of income (check all that apply): ☐ Employment ☐ SSI ☐ SSDI ☐ VA Benefits
☐ Retirement ☐ Public Assistance ☐ Child Support ☐ None ☐ Other

Approximate Current Monthly Household Income:	Yearly Income for the Most Recent Year:
Primary Income Source:	Receiving Disability Benefits? ☐ Yes ☐ No

Are you currently able to meet your basic needs? ☐ Yes ☐ No ☐ Sometimes

Check any basic needs with which you need assistance: ☐ Food ☐ Housing ☐ Utilities ☐ Clothing
☐ Transportation ☐ Medical Care ☐ Medication ☐ Childcare ☐ Safety ☐ Other

Please describe current financial concerns or urgent basic-needs assistance requested:

10. MILITARY SERVICE

Have you ever served in the U.S. Armed Forces, National Guard, or Reserves? ☐ Yes ☐ No

Branch of Service:	Dates of Service:
Discharge Status:	Combat / Deployment History (optional):

Eligible for or Receiving VA Services? ☐ Yes ☐ No ☐ Unsure	VA Facility / Provider:
--	-------------------------

Military-service experiences or needs you would like the treatment team to be aware of:

11. LEGAL STATUS AND HISTORY

Have you had any legal issues during the past 12 months? ☐ Yes ☐ No

If yes, describe the charge, court, date, and current status:

Present legal status (check all that apply): ☐ None ☐ Pending Charges ☐ Probation ☐ Parole ☐ Pretrial Supervision ☐ Court-Ordered Treatment ☐ Protective Order ☐ Other

Number of Arrests in the Past 30 Days:	Nights Spent in Jail in the Past 30 Days:
Drug-Related Arrests in the Past 30 Days:	Crimes Committed in the Past 30 Days:
Awaiting Charges, Trial, or Sentencing? ☐ Yes ☐ No	Currently on Probation or Parole? ☐ Yes ☐ No
Probation / Parole Officer:	Officer Phone:
Attorney / Public Defender:	Attorney Phone:
Next Court Date:	Court Location / Case Number:

Past legal history or legal obligations that may affect treatment attendance or planning:

12. SERVICE NEEDS AND ADDITIONAL INFORMATION

What services are you requesting or interested in? ☐ Mental Health ☐ Substance Use ☐ Medication Management ☐ Peer Support ☐ Case Management ☐ Crisis Services ☐ Other

Briefly describe the primary reason you are seeking services now:

What do you hope to gain from treatment or services?

Are there barriers that may affect your ability to participate in services? ☐ Yes ☐ No

If yes, please describe (work schedule, childcare, transportation, accessibility, technology, or other):

Is there anything else you would like CPH Behavioral Health to know?

13. APPLICANT ACKNOWLEDGMENT

I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that completing this application does not guarantee admission or establish a provider-patient relationship. CPH Behavioral Health may contact me using the preferences listed in this packet to coordinate screening, eligibility, scheduling, or services.

Applicant Signature:	Date:
Parent / Guardian Signature (if applicable):	Date:
Staff Receiving Application:	Date / Time Received:

14. FOR OFFICE USE ONLY

Date Contacted:	Contacted By:
Screening Date:	Screened By:
Program / Level of Care Referred To:	Appointment Date / Time:
Disposition:	Follow-Up Needed By:

BEHAVIORAL HEALTH: CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

CPH Behavioral Health supports and protects the fundamental human, civil, constitutional, and statutory rights of each client.

CPH Care Transitions detox program has been designed with the intention of meeting the client's individual needs that may be conducive to their recovery process. We view the client's individual needs as 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 any staff member.

- **YOU HAVE THE RIGHT** to quality care and to treatment with dignity and respect as a person.
- **YOU HAVE THE RIGHT** to reasonably expect to obtain from nursing staff your complete and current information about your assessment, treatment and detox process in terms and language that you can understand.
- **YOU HAVE THE RIGHT** to know by name and responsibility, the staff member(s) involved in your treatment process.
- **YOU HAVE THE RIGHT** to consideration of your privacy and individuality as it relates to physical, social, religious, and psychological well-being within the constraints of the program setting.
- **YOU HAVE THE RIGHT** to expect nursing staff to make reasonable response to your requests within the framework of the therapeutic policies of the treatment program.
- **YOU HAVE THE RIGHT** to information about the relationship to other health care institutions and agencies so far as your care or referral is concerned.
- **YOU HAVE THE RIGHT** to expect reasonable continuity of care in your treatment, which shall include, but not limited to, the appointment times that staff is available.
- **YOU HAVE THE RIGHT** to confidentiality as it relates to your treatment program. Case consultation and treatment issues may be reviewed with the staff and will be discussed discretely.
- **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 specifying the person or agency.
- **YOU HAVE THE RIGHT**, when significant alternatives for your care and treatment exist, to information concerning alternatives, such information shall be provided without risk to your confidentiality.
- **YOU HAVE THE RIGHT** to discuss any non-disciplinary discharge planning.
- **YOU HAVE THE RIGHT** to refuse treatment to the extent permitted by law and to be informed of the potential consequences of this treatment refusal.
- **YOU HAVE THE RIGHT** to examine and receive an explanation of your bill regardless of sources of the payment.
- **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.

CPH Care Transitions detox program has been designed with the intention of meeting the client's individual needs that may be conducive to their recovery process. 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 any staff member.

CLIENT RESPONSIBILITIES

- **YOU HAVE THE RESPONSIBILITY** provide information about present complaints, past and current functioning, hospitalizations, medications, and other matters related to their behavioral and physical health.
- **YOU HAVE THE RESPONSIBILITY** to share expectations of and satisfaction with the program.
- **YOU HAVE THE RESPONSIBILITY** to ask questions when you do not understand your care, treatment, or services or what you are expected to do.
- **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.

- **YOU HAVE THE RESPONSIBILITY** to accept consequences for the outcome of care, treatment, or services if you do not follow the planned care, treatment or services.
- **YOU HAVE THE RESPONSIBILITY** to follow the program's policies and procedures.
- **YOU HAVE THE RESPONSIBILITY** to show respect and consideration of program's staff and property, as well as other individuals and their property.
- **YOU HAVE THE RESPONSIBILITY** to meet financial commitments.
- **YOU HAVE THE RESPONSIBILITY** to provide the program the signed written acknowledgement confirming that your responsibilities were explained.

I have read and understand the **CLIENT BILL OF RIGHTS** and **CLIENT RESPONSIBILITIES**.

Client Signature

Date

Staff Witness Signature

Date

(Original copy to client's chart, second copy for client records.)

NOTICE OF CONFIDENTIALITY LIMITS RELATED TO ALCOHOL AND DRUG ABUSE RECORDS

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

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

While these broad protections are applied to all Behavioral Health Department records, in some circumstances counseling records are afforded more stringent protections under Federal Law (42 CFR Part 2 for Federal Regulations). Notably medical services delivered in our Behavioral Health Department are not subject to this extended protection. No regulations protect any information about suspected child abuse or neglect from being reported.

I have read and understand these limits of CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE RECORDS

Client Signature

Date

Staff Witness Signature

Date

CPH BEHAVIORAL HEALTH

CLIENT RULES AND REGULATIONS

- No phone contact privileges unless it's a treatment task and under the direct supervision of a CT staff member. Telephone calls will be restricted to 10 minutes. We will only accept emergency incoming calls.
- There are no pass privileges off campus. Clients may also NOT visit each other's rooms.
- No smoking, vaping, or chewing tobacco allowed on facility property.
- Patients must be fully and appropriately dressed when in common area including footwear. Clothing must cover entire stomach, buttocks, and shoulders at all times. You will be asked to change if attire is deemed inappropriate by staff. No hats are to be worn in the treatment center.
- Meals and treatment activities are strongly encouraged. Meals will be eaten in common area, or in a location at the direction of the medical staff.
- When patient are physically able, they are required to maintain the cleanliness of their room including: making a bed, changing out linens and towels and wiping bedside table.
- No use of any mood-altering medications or chemicals will be permitted while at CT. A urinalysis test may be done randomly. **Compliance is mandatory.**
- Quiet time is 10:30 PM. Turning lights out and staying in your room is encouraged and using quiet voices is mandatory for the respect of others.
- Patients are not allowed to bring outside reading material including newspapers into CT. Faith based materials are allowed with prior approval. No CDs, tapes, headphones or unrelated treatment materials will be allowed on the premises. Television privileges are at the discretion of staff and will be limited.
- No cussing or intimidation of counselors or peers. Threatening behavior will result in dismissal from Care Transitions. Sexually harassing behavior will not be tolerated, this includes but is not limited to: touching, sexual innuendos, sexual humor, and stories of sexual content.

FAILURE TO COMPLY WITH RULES AND REGULATIONS MAY RESULT IN EARLY DISCHARGE

I have read and understand the CLIENT RULES AND REGULATIONS.

Client Signature

Date

Staff Witness Signature

Date

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

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 charges 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 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 of usual and customary rates. Please let us know if you have questions or concerns regarding our Financial Policy.

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

Client Name

Client Number

Client Signature

Date

OTHER: CARE TRANSITIONS-BEHAVIORAL HEALTH: WHAT TO BRING TO TREATMENT

We want your stay during detox treatment to be as comfortable as possible and we expect that you will bring some personal items that will help to enable your comfort. We would prefer, however, that all your personal belongings fit into one carry-on-size bag. We also provide plenty of food and healthy snacks, so there is no need to bring outside food items to detox.

Acceptable items to bring:

- Appropriate clothing for 3-4 days. We will provide flannel pants and T-shirts for sleeping. No spaghetti strap tank tops or low cut tops. You may bring flip-flops or slippers if preferred, but footwear is required. Also bring a coat, jacket, or sweatshirt, depending on the season. NO inappropriate logos or wording. Please do bring several pairs of underwear and socks for your stay.
- Any prescription medications you are taking **NEED** to be in original bottle with original label that includes doctor's name, name of medication, and dosage schedule.
- Stamps, envelopes, and writing paper if you wish to write letters (outgoing mail will be reviewed).
- Your own personal recovery associated books and materials. Faith-based materials if wanted.
- Picture identification. (ID or Driver's License, etc.)
- Personal hygiene products will be provided, but special hygiene products will be accepted on case-by-case basis (examples: ethnic specific shampoos and conditioners, etc.)
 - Unopened/new or a Providers order for approval
- A smile and positive attitude, to prepare for a better life that you deserve.

Unacceptable items to bring:

- **ANYTHING** containing alcohol or food items that contain sugar as a primary ingredient (first 5 ingredients in an item).
- No personal snacks.
- No colognes, perfumes, or body sprays. Most people become sensitive or nauseous to these products while in treatment.
- **NO TOBACCO PRODUCTS. THIS INCLUDES VAPING, CHEWING TOBACCO, CIGARETTES, ETC.** No zippo or butane lighter fuels or other flammable liquids.
- No cell phones or MP3/CD/radio players.

Any unlabeled medications without an active prescription or not in original container; contraband such as cigarettes, loose tobacco, vapes or vape juice, or other drug paraphernalia brought into the facility will be destroyed upon admission.

I have read and understand the WHAT TO BRING TO TREATMENT.

Client signature

Date _____

Staff Signature

(Original copy to client's chart, second copy for client records)

DRUG USE GUIDELINES

Please read the following expectations regarding recreational, over the counter, and prescription drug use while in CPH Behavioral Health Substance Use Treatment Programs.

Treatment plans for substance use disorders are individualized for each and every client in consultation with CPH Behavioral Health Department Counselors and Medical Providers. Our shared expectations are for our clients to be fully engaged in decision making regarding their treatment plan. This includes the decision to discontinue and avoid using legal or illicit drugs, prescription medications, or over the counter products that will likely interfere with recovery from substance abuse.

Some examples of medications/substances that must be avoided includes cannabis, alcohol, and herbal products with psychoactive effects such as kratom or valerian root. Examples of over the counter medications that should be avoided include Benadryl/diphenhydramine and Imodium/loperamide. Examples of prescription medications that are problematic for recovery include benzodiazepines (lorazepam/valium, Klonopin/clonazepam, alprazolam/Xanax), drugs used as sedatives (ambien/zolpidem, sonata/zaleplon, and lunesta/eszopiclone), and many muscle relaxants (flexeril/cyclobenzaprine, soma/carisoprodol, robaxin/methocarbamol, and baclofen). Also all drugs that fall into the opioid drug class (codeine, hydrocodone, oxycodone, tramadol, morphine, fentanyl, and hydromorphone), as well as all stimulants (Adderall/dextroamphetamine, Ritalin/methylphenidate, and vyvanse/lisdexamfetamine).

All clients that enter into our treatment programs with these drugs will be required to properly dispose of them in a designated charcoal disposal container before admission. We will not hold onto or store these types of drugs for our clients. Our goal is to eliminate your long term need to take addictive substances as part of your recovery plan. Expectations are made only in the event that the medications brought into the facility have been recently prescribed and are acceptable by the admitting medical provider to use as part of your tapering detox protocol.

While at Care Transitions detox facility, the medications prescribed and utilized are for use only while under the direct care of our team of providers. Individuals who leave against medical advice (AMA), will not be discharged with detox medications for ongoing use.

Please ask our staff nurse or medical provider during your admission process if you have any questions or concerns regarding this practice guideline.

I understand that above practice guideline and authorize the disposal of any unauthorized or prohibited substances or paraphernalia at the time of admission, as well as disposal of all detox medications at time of discharge.

I have read and understand the DRUG USE GUIDELINES.

Client Signature

Date