

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)

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:

SUBSTANCE USE HISTORY

Client Name:	Date of Birth:	Assessment Date:
---------------------	-----------------------	-------------------------

Substance	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						

TOBACCO USE

Do you use tobacco? ☐ No ☐ Yes	If yes, what kind? _____	How much? _____
---	------------------------------------	---------------------------

Residential Treatment Intake Packet

Please read each section carefully. Ask staff to explain anything that is unclear. Your signature confirms that the information was reviewed with you; it does not waive any legal right.

PACKET CONTENTS

- Client Bill of Rights and Responsibilities
- Confidentiality of Substance Use Disorder Patient Records
- Financial Policy
- Group Confidentiality Acknowledgment
- Patient Rules and Regulations
- Proof of Income Checklist
- Medical Provider and Legal Obligations Policies

Client Bill of Rights

Serenity House supports and protects each client's fundamental human, civil, constitutional, and statutory rights.

The treatment program is designed to address your individual needs and support your recovery. You have a voice in your treatment services. Program evaluation forms and suggestion boxes are available, and completed forms may be given to any staff member.

1. Receive quality care and treatment with dignity and respect.
2. Receive complete and current information about your evaluation, treatment, and recovery in language you can understand.
3. Know the names and responsibilities of staff involved in your treatment.
4. Have your privacy and individuality considered, including your physical, social, religious, and psychological well-being, within the program setting.
5. Receive a reasonable response to requests within the program's therapeutic policies.
6. Receive information about relationships with other healthcare institutions and agencies when they relate to your care or referral.
7. Expect reasonable continuity of care, including information about staff availability and appointment times.
8. Have your treatment information and treatment record kept confidential as required by law.
9. Authorize disclosure of treatment information through a valid written Release of Information, except when disclosure is otherwise permitted or required by law.
10. Receive information about significant alternatives for care and treatment without violating your confidentiality.
11. Discuss non-disciplinary discharge planning.
12. Request in writing an appointment to inspect the program's Policy and Procedure Manual.
13. Refuse treatment to the extent permitted by law and be informed of the possible consequences.
14. Examine and receive an explanation of your bill, regardless of the source of payment.
15. Express a grievance or complaint about your treatment without retaliation.

Grievances and Client Responsibilities

HOW TO ADDRESS A GRIEVANCE

Every reasonable effort will be made to resolve concerns directly and respectfully.

16. Discuss the concern with your counselor.
17. If it is not resolved, submit the grievance in writing to the supervisor and request a meeting.
18. If it remains unresolved, contact Central Peninsula Hospital administration at (907) 714-4404.
19. If resolution is still outstanding, contact the State of Alaska Division of Behavioral Health at (907) 269-3600.

YOUR RESPONSIBILITIES

20. Provide accurate information about current concerns; past and current functioning; hospitalizations; medications; and other matters related to your behavioral and physical health.
21. Share your expectations of and satisfaction with the program.
22. Ask questions when you do not understand your care, treatment, services, or what is expected of you.
23. Follow your plan of care and promptly express concerns about your ability to follow it.
24. Accept responsibility for outcomes when you choose not to follow the agreed plan of care.
25. Follow program policies and procedures.
26. Treat staff, other clients, and property with respect and consideration.
27. Meet financial commitments or communicate promptly when assistance or arrangements are needed.
28. Sign the acknowledgment confirming that these responsibilities were explained to you.

ACKNOWLEDGMENT: I have reviewed and understand my rights, the grievance process, and my responsibilities.

Client Name: _____	Date: _____
Client Signature: _____	
Staff/Witness Signature: _____	Date: _____

Confidentiality of Substance Use Disorder Patient Records

The confidentiality of substance use disorder patient records maintained by this program is protected by federal law and regulations. Generally, the program may not tell a person outside the program that a patient attends the program or disclose information identifying a patient as having a substance use disorder unless one of the following applies:

- The patient gives written consent.
- The disclosure is authorized by a court order.
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation, as permitted by law.
- The disclosure concerns a crime committed, or a threat to commit a crime, on program premises or against program personnel, as permitted by law.

IMPORTANT LIMITS AND REPORTING

A program’s violation of applicable federal confidentiality law may be a crime. Suspected violations may be reported to the United States Attorney for the district in which the violation occurs.

Federal confidentiality law does not prevent reports of suspected child abuse or neglect when required under state law. Applicable authorities include 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2.

Questions about how your information may be used or disclosed should be directed to program staff before you sign.

ACKNOWLEDGMENT: I have read, or had read to me, and understand this confidentiality notice.	
Client Name: _____	Date: _____
Client Signature: _____	
Staff/Witness Signature: _____	Date: _____

Financial Policy

Thank you for choosing Serenity House as your treatment provider. We are committed to supporting your treatment. Please review this financial policy before treatment begins.

BILLING AND PAYMENT

- Services will be billed to insurance as appropriate.
- You are responsible for charges not paid by insurance, subject to applicable law and your coverage agreement.
- Extended payment arrangements may be available when financial need is documented. Contact staff promptly to discuss options.
- You must provide current insurance information, a copy of your insurance card, and any required claim forms.

INSURANCE

Your insurance policy is a contract between you and your insurance company. Serenity House is not a party to that contract. Our Utilization Review Team will complete clinical reviews required by your insurer. If your insurer has not paid an account within 45 days, you may be asked to address the balance, subject to applicable law, coverage rules, and any approved financial arrangements.

Serenity House charges rates established for its services. Insurance determinations about coverage, medical necessity, or usual and customary rates may not eliminate your financial responsibility. Please ask staff if you have questions about charges, coverage, or payment assistance.

ACKNOWLEDGMENT: I have read, understand, and agree to the Financial Policy.

Client Name: _____	Date: _____
Client Signature: _____	Client Number: _____

Group Confidentiality Acknowledgment

I understand that information disclosed about another client while I am receiving services at Serenity House Treatment Center is confidential.

A SAFE GROUP ENVIRONMENT

Groups are intended to provide a safe environment for sharing personal information, receiving support, and solving problems. Information shared by group members should remain within the group. Protecting that information is my responsibility and the responsibility of every group member.

MY AGREEMENT

- I will not repeat, post, record, photograph, or otherwise disclose information that identifies another client or describes what another client shared.
- I will respect the privacy of clients I see or meet through the program.
- I understand that program staff must follow applicable confidentiality laws and professional duties; client participants also have a responsibility to protect one another's privacy.
- I will ask staff if I am uncertain whether information may be shared.

Substance use disorder records are protected by federal law, including 42 C.F.R. Part 2. I understand that I may not disclose protected information without appropriate written authorization or another legal basis.

ACKNOWLEDGMENT: I have read, or had read to me, this agreement and agree to follow the group confidentiality expectations.

Client Name: _____	Date: _____
Client Signature: _____	
Staff/Witness Signature: _____	Date: _____

Patient Rules and Regulations

These expectations support safety, treatment participation, privacy, and a respectful recovery environment.

PHONE AND COMMUNICATION

- No phone privileges during the first week of treatment.
- Telephone hours are 5:30 p.m.–10:00 p.m. daily unless a call is a treatment task. Calls may not interfere with scheduled groups or activities and should be limited to 10 minutes.
- Only emergency incoming calls will be accepted.
- Cell phones, televisions, radios, CDs, tapes, headphones, and MP3 players are not permitted. Bring a phone card or charge card if needed for long-distance calls.

PASSES AND OFF-SITE ACTIVITIES

- No pass privileges during the first two weeks of treatment.
- After that period, a four-hour Saturday pass may be requested. Submit the request to the treatment team by the Tuesday before the proposed pass date.
- Urinalysis testing may be required after passes or outside meetings. Compliance is required; refusal may result in discharge.
- At the gym, remain on the premises, participate in the activity, and do not use the phone or tanning bed.

TOBACCO AND SUBSTANCES

- Smoking, vaping, chewing tobacco, and all tobacco products are prohibited on CPH property.
- Mood-altering substances are not permitted while in treatment.

Patient Rules and Regulations

Continued

ROOMS, DRESS, AND DAILY ROUTINE

- Clients may not enter the bedroom of a client of another gender.
- Be fully and appropriately dressed, including footwear, in common areas. Clothing must cover the stomach, buttocks, and shoulders. Staff may ask you to change attire.
- Hats are not permitted in the house.
- Attend meals and treatment activities on time. Even if you do not eat, remain at the table for at least 10 minutes with peers and participate respectfully in the meal routine.
- Clean your room and complete laundry during free time, not group time. Rooms are subject to inspection. Failure to meet room standards may affect group phone privileges.
- Lights out is 10:30 p.m. Return to your room and turn off lights.

FOOD, MATERIALS, AND COMMON AREAS

- Food and beverages must remain in the kitchen. Water is allowed outside the kitchen in a covered bottle.
- Candy, snack foods, and soda are not permitted in bedrooms.
- Outside reading materials, including newspapers, are not permitted unless approved as treatment-related material.

RESPECTFUL AND SAFE CONDUCT

- Cursing at, threatening, intimidating, or harassing staff or peers is prohibited.
- Sexual harassment is prohibited, including unwanted touching, sexual comments or innuendo, sexual humor, and sexual stories.

Failure to follow program rules may result in corrective action, loss of privileges, or early discharge, consistent with program policy and individual clinical and safety considerations.

ACKNOWLEDGMENT: I have read, understand, and agree to follow the Patient Rules and Regulations.

Client Name: _____	Date: _____
Client Signature: _____	
Staff/Witness Signature: _____	Date: _____

Proof of Income Checklist

Serenity House accepts major insurance plans, Medicaid, and self-pay clients. If you request financial arrangements, bring documentation of your household's gross income.

DOCUMENTS TO PROVIDE, AS APPLICABLE

✓	DOCUMENT
☐	Current pay stub for you and, if married, your spouse
☐	Most recent W-2
☐	Copy of last year's federal income tax return
☐	Unemployment benefit statement or current payment record
☐	Social Security income statement
☐	Retirement or pension statement
☐	Public assistance documentation
☐	Native corporation dividend documentation
☐	Permanent Fund Dividend filing confirmation or batch card
☐	Other documentation that verifies household income

If you have no income, tell your evaluator and ask what alternate documentation is required.

ACKNOWLEDGMENT: I have read and understand the Proof of Income requirements.

Client Name: _____	Date: _____
Client Signature: _____	

Medical Provider and Legal Obligations Policies

MEDICAL PROVIDER POLICY

While enrolled in Serenity House residential treatment, clients are expected to use the program's in-house medical provider for medical needs. Visits with outside medical providers—including dental and vision appointments—are not permitted unless the in-house provider determines that an outside visit is medically necessary. The treatment team will work to address medical needs and support continuity of care.

LEGAL OBLIGATIONS POLICY

- Before admission, notify attorneys, probation officers, Office of Children's Services (OCS) caseworkers, and other legal contacts that you will be in residential treatment and generally unavailable for in-person court hearings, meetings, or appointments.
- Serenity House may provide an admission-verification letter for legal contacts. You must sign an appropriate Release of Information before staff can communicate with those contacts.
- Ask your attorney whether a court date can be rescheduled. If it cannot be rescheduled, telephonic participation may be allowed when approved and arranged.
- Scheduled OCS visits with children may be permitted once per week and must be scheduled at least one week in advance.
- You are responsible for arranging safe transportation for an approved visit. OCS may be able to arrange or fund transportation.
- If a family member provides transportation, the family member must attend family group and receive approval from the primary clinician before the appointment.
- If transportation is provided by someone outside the family, that person must be a safe member of the recovery community with at least six months of sobriety and must be approved by the treatment team.

CURRENT OBLIGATIONS / PLANNING NOTES

Court or legal date(s): _____	Contact person: _____
OCS visit date(s): _____	Transportation plan: _____
Other appointment(s): _____	Release of Information completed: ☐ Yes ☐ No

ACKNOWLEDGMENT: I have read and understand the Medical Provider and Legal Obligations Policies.

Client Name: _____	Date: _____
Client Signature: _____	
Staff/Witness Signature: _____	Date: _____



CPH Behavioral Health

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

What to Bring

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

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

4–5 Pairs of Pants*

This includes jeans, slacks, skirts, yoga pants, and sweatpants.

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 is not allowed.

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

4–7 Pairs of Socks

4–7 Pairs of Underwear

(Women: include 3–5 bras)

1 Bathrobe (optional)

2 Pajama Sets/Gowns

1 Pair of Slippers/Indoor Shoes

The House has an "Indoor Shoes Only" policy. Bring something clean and comfortable to designate as your "House" shoes during your stay.

1–2 Pairs of Outdoor Shoes

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

Makeup*

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

1 Warm Coat, 1 Hat

There will be times when you will be outside. Bring a weather-appropriate coat or jacket and one weather-appropriate hat.

Personal-Hygiene Items, 1 of Each:

- Bath soap
- Comb/hairbrush
- Hand/body lotion (optional)
- Razor and shaving cream (optional)
- Toothpaste and toothbrush
- Non-alcohol mouthwash (optional)
- Shampoo and 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 bring perfume or cologne, it will not be allowed in bedrooms. It will be kept in a locked area due to its high alcohol content and available for use once per day.



CPH Behavioral Health

245 North Binkley St. Suite 202, Soldotna, AK 99669

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

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.

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).

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.

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.

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.

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.

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).

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.



CPH Behavioral Health

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

My To-Do List

Preparing for Residential Treatment at Serenity House

- ☐ **Fill out the Client Intake Packet Forms.** I can complete the forms myself or ask a close friend or family member to help me.
- ☐ **Ask for help if I need it.** If the forms feel overwhelming and I do not have someone available to help, I can call the Serenity Intake Office to schedule assistance: 907-714-4521, Monday-Friday, 9:00 a.m.-5:00 p.m.
- ☐ **Mail, fax, or drop off my completed Intake Packet.** If I mail or fax my packet, I will call 907-714-4521 to confirm it was received.
- ☐ **Serenity House Intake** 245 N. Binkley St., Suite 202, Soldotna, AK 99669 | Fax: 907-260-4063

MEDICAL

- ☐ **Talk with my doctor about withdrawal symptoms.** I will ask which symptoms to expect and which symptoms require medical attention.
- ☐ **Talk with my doctor about any health concerns.**
- ☐ **Review all medications with my doctor.** I will ask what to do if a medication is not approved for residential treatment, including narcotic medications.
- ☐ **Obtain a 30-day supply or refills of approved medications.** This helps prevent me from running out while I am in treatment.
- ☐ **Pack over-the-counter medications and vitamins correctly.** Any Tylenol, Centrum, fish oil, vitamins, or similar products must be in sealed, unopened containers.
- ☐ **Take care of my legal issues.** If I am involved with parole, probation, OCS, or an attorney, I will notify them, provide contact information, and obtain approval if required. I will record any pending court date and tell Serenity House as soon as possible so attendance can be arranged.
- ☐ **Get an official arrival date from the Intake Office.** I will confirm the date and time I am expected to arrive.
- ☐ **Pack my bags.** I will use the What to Bring sheet to prepare for my stay.
- ☐ **Say my goodbyes and prepare to arrive.** I will say goodbye to family, friends, and pets; grab my suitcase; take a deep breath; and go to the Intake Office on my scheduled arrival date.

My Arrival Date: _____ **Time:** _____



Authorization for Release of Protected Health Information

Patient name: _____ Maiden/Prior Names: _____
Patient Date of Birth: _____ Current Phone #: _____ Last Four of SSN: _____
Current Address: _____

Direction of Disclosure:

I authorize CPH Behavioral Health to (check one or both):

☐ **RELEASE** information to the person/organization below ☐ **REQUEST** information from the person/organization below

Agency/Organization: _____ **OR** ☐ Self - (address above)
Telephone number: _____ Fax Number: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Name/Attention To: _____

Method of Disclosure:

☐ Mail ☐ Fax ☐ Pick-Up ☐ Verbal exchange of information

Purpose of Disclosure:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use ☐ Academic ☐ Legal Investigation
☐ Billing/Insurance ☐ Other: _____

Dates of Service Requested: _____

☐ I authorize the release of the following information **including** all records that include any substance use disorder and/or substance use disorder treatment records, **or**

☐ I authorize the release of the following information **excluding** all records that include any substance disorder and/or substance use disorder treatment records, **or**

Only the information and records indicated below (check all that apply and/or specify if "Other" is checked):

☐ Continuity/Transition of Care ☐ Psychiatric Evaluation ☐ History and Physical ☐ Discharge Summary ☐ Progress Notes
☐ Physician Orders ☐ Lab/Diagnostic Reports ☐ Treatment Plan and Records ☐ Other: _____

This authorization will expire on ____/____/____. (If not indicated, authorization will expire one year from signature date).

This form must be completed in full before signing.

Patient Signature: _____ **Witness Signature/Credentials:** _____
Date: _____

This authorization is intended to allow Central Peninsula Hospital: Behavioral Health to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), and 45 CFR 160 and 164. ANY information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization from such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Signing this authorization is voluntary. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not a condition on signing this authorization. A photocopy or electronic copy of this signed authorization is valid as the original.

Revocation Signature: _____ Date/Time: _____