MY House
You're Welcome Here

Thank you for your interest in Residential Treatment with MY House!

A completed packet is to include all documents listed on the **Application Checklist**.

Application Checklist

- Application (Client Profile 5 pages)
- Agreement to Release Records or Information (2 pages)
- Emergency Contact Info (1 page)
- Health Screening Form/Clearance to Participate (3 pages)

**To be completed by a Health Care Provider within the past 45 days.

- Behavior Health Assessment (3.1 or 3.5 recommended level of care, completed within the past 6 months and inclusive of ASAM)
- Release of Information (ROI)—for any referring providers OCS, Medical Doctors, Probation,
- Case Management etc. (please use our form)
- Contact Preference Form

Applications should be scanned and sent via email to info@myhousematsu.org, or mailed or dropped off to:

MY House
300 N. Willow St.
Wasilla, AK 99654

Please contact (907) 373-4357 for questions regarding the application process.

No application will be processed without all required documents. This packet will include the needed ROI's, health screening form and your list of approved and not approved items. If you need assistance with completing the printable packet, please contact 907.373.4357 to schedule a meeting with one of our case managers.

Client Profile

To help guide your treatment in a manner that best meets your unique needs, please include the following information:

Identifying Data:

Full Legal Name: _____ DOB: _____ SSN: _____

What is your Maiden Name? _____ ☐ Not Applicable

Physical Address: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____

Miscellaneous:

List all medications/supplements/vitamins you are currently taking: _____

_____

What date are you available to enter treatment? _____

Billing Information/Authorization

Expected Payment Source (check all that apply):

☐ Insurance ☐ Medicaid (includes Denali Kid Care) ☐ Self-Pay ☐ Other

Medicaid ID number: _____

CLIENT INFORMATION

Are you female (defined as having female reproductive organs)? ☐ Yes ☐ No
Are you male (defined as having male reproductive organs)? ☐ Yes ☐ No

Marital Status: (please circle) Married - Living as married - Widowed/Widower – Separated - Single (never married)
Divorced: how long? _____

Race: (Please Circle) Aleut - American Indian – Asian – Athabascan - Black/African American – Caucasian – Hispanic – Inupiat – Tsimshian - Native Hawaiian – Tlingit - Pacific Islander – Yupik –
Other Alaska Native _____ Other _____

Legal Status:

☐ None/No involvement
☐ 30 Day Commitment
☐ 90 Day Commitment
☐ 180 Day Commitment
☐ Emergency Commitment
☐ Office of Children Services
☐ Probation/Parole
☐ Informal Probation
☐ Incarcerated
☐ Case Pending
☐ Deferred Prosecution
☐ Community Sentencing
☐ Court Ordered for alcohol treatment
☐ Court Ordered for mental health treatment
☐ Court Ordered for observation and evaluation
☐ Other _____

Military Status: (please circle) Never in Military- Active duty (combat)- Active duty (non-combat)- Reserves (combat)- Reserves (non-combat)- Retired (combat)-Retired (non-combat)- Military Dependent

Have you ever been charged with a crime against a vulnerable person (child, elderly, or disabled)? _____
If yes, please explain: _____
_____

Are you required by state or federal authorities to register as a sexual offender? _____
If yes, please explain: _____
_____

READINESS TO LEARN:

How do you like to learn? ☐ Watching ☐ Reading ☐ Listening ☐ Doing
What language is spoken primarily in your home? _____
Do you speak a second language? ☐ Yes ☐ No If YES, what language? _____
Do you need an interpreter? ☐ Yes ☐ No

Do you have special needs? (Check all that apply)

☐ Diagnosed memory and/or learning disabilities ☐ Severe Hearing Loss or Deaf

Do you need auditory aids? ☐ Hearing aids ☐ Other _____

☐ Visual Impairment or Blind

Do you need visual aids? ☐ Magnifying glasses ☐ Large print material ☐ Braille ☐ Other _____

☐ Major Difficulty in Ambulating; physical limitations ☐ Diagnosed chronic sleep problems

☐ Organic brain disorder ☐ Traumatic Brain Injury ☐ Other_____

What problem(s) brought you here today? (check all that apply)

☐ Alcohol problems ☐ Domestic violence ☐ Depression

☐ Drug problems ☐ Marital/Relationship Problems ☐ Psychological/emotional

☐ Alcohol/drug problems ☐ Family problems (non-marital) ☐ Suicide Attempt/Threat

☐ Legal problems ☐ Social/Interpersonal ☐ Victim of Child Abuse

☐ Victim of Sexual abuse ☐ Perpetrator of Sexual Abuse ☐ Perpetrator of Child Abuse

☐ Other: _____

What goals would you like to achieve to improve your quality of living? (check all that apply)

☐ Regaining custody of children/parenting issues ☐ Lack of stress management skills

☐ Social network problem (I.e. drug using friends/acquaintances) ☐ Education issues

☐ Lack of sober, social support ☐ Poor communication skills and/or poor

☐ Lack of self-esteem, self-confidence, or positive identity ☐ Conflict management skills

☐ Lack of structure and time management skills ☐ Housing

☐ Financial concerns or unpaid bills ☐ Other: Please explain Below:

_____

_____

_____

FAMILY/SOCIAL HISTORY:

Where do you live currently? _____ Monthly household Income: _____

Living Arrangements: ☐ Alone ☐ With Children ☐ With Spouse/Significant Other

☐ With Parents ☐ With Other Relatives ☐ With Non-Related Person

☐ Homeless ☐ Incarcerated ☐ Shelter

Where and with whom will you live after completing treatment? _____

Are you Pregnant? ☐ No ☐ Yes If YES, what is your due date? _____
Do you Have Children? ☐ No ☐ Yes
Are you the primary caretaker of your children? ☐ No ☐ Yes
If YES, have you arranged for childcare while you participate in treatment? ☐ No ☐ Yes

SPIRITUALITY:

During the past month, how would you rate your sense of connectedness, spirituality or relationship with a higher power?

☐ Excellent ☐ Good/Improving ☐ Fair/Not Changing ☐ Not Good ☐ Very Bad ☐ Other:

How important is spirituality in your life?

☐ Very important ☐ Somewhat Important ☐ Not Very Important ☐ Not At All Important

How often do you spend time on regular spiritual practices?

☐ Every day or almost every day ☐ Several times a month ☐ Occasionally ☐ Very rarely ☐ Not at all

What is your religious affiliation, if any? _____

Is there anything else that you would like us to know about your religious/cultural/spiritual practices?

_____

SUBSTANCE USE:

What is your drug of choice? _____
When is the last time you used alcohol and/or other drugs? _____
Are you currently injecting drugs? ☐ No ☐ Yes
Do you use Tobacco Products? ☐ No ☐ Cigarettes ☐ Smokeless tobacco (chew) ☐ Other

List your goal or goals for the future: _____

_____

Describe your personal challenges or things that make it difficult to reach your goals: _____

_____

What would you like to gain from treatment that would support your recovery goals?

_____

_____

MENTAL HEALTH SUMMARY:

Prior mental health history: (Check all that apply)

☐ No history ☐ Counseling ☐ Medication management ☐ Hospitalization

Are you currently involved in mental health services? ☐ No ☐ Yes If YES, with whom? _____

During the past 12 months, did you take any medication that was prescribed to treat a mental health or emotional condition? ☐ No ☐ Yes If YES, please list medication and dosage:

_____

_____

Dates of prior mental health hospitalizations: _____

PHYSICAL HEALTH SUMMARY:

Have you undergone, or are you currently undergoing hormonal therapy for transgender surgery? _____

If yes, is this process completed (physical surgery, hormonal treatment, and emotional counseling components)? _____ When was this process completed? _____

Do you intend to undergo hormonal therapy for transgender surgery while admitted to this program? _____

In general, how would you describe your current health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had any unplanned weight changes in the last 12 months? ☐ No ☐ Yes If YES, please explain:

_____

Do you have nutritional concerns? ☐ No ☐ Yes If YES, please explain:

_____

Do you have a primary medical provider? ☐ No ☐ Yes If YES, Who?

_____

If you do not have health benefits, what is your financial plan for prescribed medications? _____

Do you have allergies to foods or medications? ☐ No ☐ Yes If YES, please list:

_____

Do you have any chronic health or pain issues? ☐ No ☐ Yes If YES, please explain: _____

_____

SELF-ADMINISTATRATION OF MEDICATION ATTESTATION

I, _____, am able to self-administer the medication(s) prescribed to me, including if needed, the physician approved over-the-counter medications. It will be my responsibility to ask staff to retrieve my medication from the secure area when it is time for me to take my medication. I will assist in the documentation process by documenting each time I take medication on the "Self-Administration of Medication Form".

SIGNATURE: _____ DATE: _____

AUTHORIZATION TO RELEASE RECORDS OR INFORMATION

I AUTHORIZE: Release To: ☐ Obtain From: ☐ **Please Initial**

MY HOUSE
300 N WILLOW ST.
WASILLA, AK 99654
PH: (907)373-4357
FAX: (907)308-6825

_____
Name of Person or Agency

_____
Street Address

_____
City State Zip Code

PH:_____Fax:_____

Information to be released:
From (date) _____ To (date) _____

INITIAL all that apply:

____ Discharge
____ Intake Summary
____ SUD Assessment
____ Psychiatric Evaluation
____ Treatment Plan
____ Therapy Notes
____ Medications
____ Case Management
____ Community Support Services
____ Verbal

____ Other:

_____

_____

Receive by: Mail ____ Fax ____ Pick Up ____ Verbal ____ Electronic ____
Purpose of the Request: Treatment _____ Legal _____ Insurance _____ Personal_____ Other _____

**I understand that information in the Health Record may contain information relating to mental health or behavioral health, alcohol and drug abuse, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).*
**I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.*
**I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations*
**I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.*
**I understand I have the right to receive a copy of this authorization form. I also understand that upon my written request, MY House must provide me a record of any subsequent disclosures made for legal, administrative, or quality assurance purposes.*

Client Name (Please Print) _____
Date of Birth: _____ Phone Number: _____
Client Signature: _____ Date: _____
Parent/Guardian: _____ Date: _____
Witness: _____ Date: _____
This authorization will terminate one year from the date signed, or unless an earlier date or condition / event is specified here:

Recipient Information: if the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) Prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose.

This authorization is revoked: _____ Date: _____

<u>Instructions:</u> Please fill in the blanks/check the boxed for each question. <u>Do not leave anything</u> blank. CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION SUBSTANCE ABUSE PROGRAM, MEDICAID, PRIVATE INSURANCE, AND THE STATE OF ALASKA DHSS DIVISION OF BEHAVIORIAL HEALTH.

I, _____ authorize
MY House
300 N Willow St.
Wasilla, AK 99654
Phone (907)373-4357 Fax (907)
And
Medicaid
And
Primary or Secondary Insurance:_____
And
State of Alaska DHSS
Division of Behavioral Health
PO BOX 110607
Juneau, AK 99811-0607
To communicate with and disclose to one another via verbally, electronically, or in writing the following initialed information:
(Initial each category that applies)
____ my name and other personal identifying information;
____ my status as a patient in alcohol and/or drug treatment;
____ initial evaluation;
____ date of admission;
____ assessment results and history;
____ summary of treatment plan, progress, and compliance;
____ attendance
____ urinalysis results;
____ date of discharge and discharge status;
____ discharge plan;
____ other: _____

Signature: _____

MY House
Client Medical Release/Emergency Information Form

For your safety, the following information will be kept in a secure area, accessible only to staff members. All information must be current in case of emergency. Please complete the following:
I, _____, hereby give my consent to be given emergency medical treatment in the event of an accident, injury, or illness.
I hereby release MY House and its representatives from any liability rising from an emergency situation in which it is deemed necessary to pursue medical treatment.
In case of an emergency, MY House may contact:

1. _____ _____
Name & Relationship Phone #

_____
Address

2. _____ _____
Name & Relationship Phone #

_____
Address

Drug Allergies: _____
Medications: _____
Other Medical conditions:
_____
_____
Insurance Information or Medicaid number: _____
By signing below, I authorize the disclosure of the above information to appropriate emergency personnel

_____
Client Signature/Date

_____
Client Signature/Date

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Emergency Contact: _____

MY House
You're Welcome Here

Health Screening and Clearance to Participate

The following form must be completed in full, by your health care provider, to participate in True North Recovery Inc.'s, Residential Treatment Program.

Does this patient require detoxification prior to entering treatment? ☐ No ☐ Yes

Does this patient have any physical impairments/limitations? ☐ No ☐ Yes (If YES, please explain):

_____

_____

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

_____

Is the patient pregnant? ☐ No ☐ Yes (If YES, Due Date):_____

Diphtheria/Tetanus Booster: Current immunization required date given: ___/___/___

List known food or environmental allergies: _____

MEDICATION ALLERGIES:

_____

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

MEDICATION	DOSAGE	FREQUENCY AND ROUTE	INDICATION

If the patient is prescribed, addictive or narcotic medications are there non-narcotic alternatives? ☐ No ☐ Yes
If YES, please list:

_____

PHYSICAL EXAMINATION

SYSTEM	NORMAL	ABNORMAL	SYSTEM	NORMAL	ABNORMAL
VITAL SIGNS			ABDOMEN		
HEENT			EXTREM./MSK		
NECK/THYROID			NEUROLOGICAL		
CARDIOVASCULAR			SKIN		
PULMONARY			OTHER:		

True North Recovery Inc. is not rated as an assisted living facility. Therefore, potential clients must be able to perform the following activities without assistance: Daily living activities (such as cooking, cleaning, toileting, bathing/showering, dressing etc.), entering/exiting a building and general mobility (may use medical devices such as a wheelchair or walker.)

Is the patient able to perform these activities without assistance? ☐ No ☐ Yes

LABORATORY/RADIOGRAPHY

REQUIRED FOR ADMISSION	
	*TB date:
	Quantiferon Gold ☐ (-) ☐ (+) CXR if (+) Quantiferon (+) ☐ (wnl) ☐ (abnl)_____
ELECTIVE / NOT REQUIRED FOR ADMISSION	
hCG date: ☐ (-) ☐ (+)	CBC date: ☐ (wnl) ☐ (abnl)_____
UA date: ☐ (wnl) ☐ (abnl)_____	

Approved Over the Counter Medications

Provider: Mark Yes or No for the following medication to indicate your approval status

MEDICATION	APPROVED	NOT APPROVED	SAMPLE USES
Acetaminophen (Tylenol)	YES	NO	500 mg by mouth every 6 hours as needed for PAIN/HEADACHE/FEVER [Maximum 2000 mg/24hours]
Ibuprofen (Advil, Motrin) 400 mg	YES	NO	400 mg by mouth every 6 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS/FEVER [Maximum 1600 mg/24hours]
Naproxen(Aleve)	YES	NO	220 mg by mouth every 8 hours as needed for PAIN/HEADACHE/MENSTRUAL CRAMPS
Calcium Carbonate (Tums)	YES	NO	1000 mg by mouth every 4 hours as needed for HEARTBURN

Bismuth Subsalicylate (Pepto-Bismol)	YES	NO	30 ml. or two 262 mg tablets by mouth every 4 hours as needed for HEARTBURN/INDIGESTION/DIARRHEA
Lactaid	YES	NO	1 tablet by mouth when eating dairy products as needed for LACTOSE INTOLERANCE
Multi-vitamin	YES	NO	1 tablet by mouth daily as needed for NUTRITIONAL SUPPLEMENT
Loratadine (Claritin)	YES	NO	10 mg by mouth daily as needed for SEASONAL ALLERGIES
(Halls, cough drop) 1 lozenge	YES	NO	Cough Suppressant - 1 lozenge by mouth every 1 hour as needed for COUGH/SORE THROAT
Diphenhydramine hydrochloride (Benadryl)	YES	NO	25 mg by mouth every 4 hours as needed for SEVERE ITCHING/NASAL CONGESTION
Benzocaine local anesthetics (Orajel)	YES	NO	apply gel directly to sore tooth or gum every 6 hours as needed for TOOTH/GUM PAIN
OTHER: _____	YES	NO	
OTHER: _____	YES	NO	

This patient has been medically evaluated and cleared to participate in residential treatment, which may include, groups and other activities for 8 or more hours per day. ☐ No ☐ Yes

This patient has been medically evaluated and cleared to live in a group atmosphere. ☐ No ☐ Yes

This patient has been medically cleared to participate in moderate aerobic and strength training exercises. ☐ No ☐ Yes

☐ I have evaluated _____ and believe that this patient is capable and competent to self-administer his or her own medication, as prescribed.

_____ _____

PROVIDER SIGNATURE AND CREDENTIALS DATE

_____ _____

PROVIDER NAME PRINTED PHONE NUMBER

_____

NAME OF CLINIC OR OFFICE

APPROVED ITEMS TO BRING

Documents

- Photo I.D. (this is required)
- Calling card for long distance calls; local calls are free of charge.
- Stamps
- Social Security Card (if you have one)
- Medicaid Insurance Card (if you have one)
- Private Insurance Card
- Food Stamp Card (if you have one)
- Any important documentation you will need while in treatment (court documents etc.)
- Address book and phone numbers of sober support and loved ones

Clothing

Laundry facility and laundry detergent will be provided free of charge

- Warm Coat
- Light jacket
- Winter Gear
- 7 changes of clothing (No clothing with logos that depict alcohol, tobacco, violence, profanity, or sexual messages)
- 1 set of dress attire for church or special events
- 2 sets of exercise clothing
- 2 pajamas
- 7 pairs of socks
- 1 bathrobe
- 1 pair of indoor slippers
- 1 pair of everyday shoes
- 1 pair exercise shoes
- 1 pair of dress shoes
- 4 bras
- Underwear

Personal Toiletry Items

Alcohol MAY NOT be in the first 2 ingredients in these toiletries except for shampoo and conditioner and <u>all toiletries must be brand new.</u>

- Prescription glasses
- Contact lenses (if wearing contacts)
- 1 contact solution (if wearing contacts)
- 1 shampoo
- 1 conditioner
- 1 hair styling product (kept in locker)
- 1 body wash or soap bar
- 1 face wash
- 1 face moisturizer
- 1 pack Q-tips
- 1 deodorant
- 1 shave cream (optional)
- 4 razors (kept in the locker)
- 1 lotion
- 1 nail clipper for toes/ 1 for nails
- 1 nail file
- 1 set of dentures/cleaner/glue (if you have dentures)
- 1 toothbrush
- 1 toothpaste
- 1 water bottle
- 1 travel size hairspray (will be kept in the office)
- 1 body spray (aerosol free)
- 1 box of tampons or 1 bag of pads
- 1-quart size Ziploc bag of makeup

<u>Optional Items</u>

- 1 large priority box 12 ¼" x 12 ¼ x 6" of approved reading materials—recovery related literature, daily devotions, spiritual, self-help, educational etc.
- 1 large priority box 12 ¼" x 12 ¼ x 6" of coping materials—sewing knitting, beading, scrapbooking etc.
- Cell phone may be used only while out on pass

**If you do not have the financial ability to purchase these items, your case manager can assist you in obtaining the community resources necessary to provide for your needs.

PROHIBITED ITEMS

- Candles
- Air fresheners
- Febreeze
- Aerosol sprays of any kind
- Gum
- Unmarked hygiene items or powder
- Excessive amounts of money ($100) or expensive jewelry. The program is not responsible for lost or stolen items.
- Personal vehicle
- Electronic device such as laptops or tablets
- DVD movies
- Unapproved or previously opened over-the counter medications
- Pornography or sex toys
- Mood altering substances of any kind, legal or illegal, i.e., marijuana, spice k2, bath salts, herbal incense, kratom
- Firearms or Ammunition
- Weapons or any items that could be used as a weapon, i.e., knives, needles
- Loose razor blades
- Illegal drugs
- Drug paraphernalia
- Alcoholic beverages
- Synthetic drugs including but not limited to synthetic cannabinoid

**A personal belongings container with limited space is available to secure valuable personal belongings such as excessive money or expensive jewelry. However, if possible, it may be best to arrange with a friend or family member to secure those items for you. If you have any additional questions or concerns, please call.

REFFERAL FOR ADMISSION

To be completed by referring provider / agency

Applicant Name: _____ Date of Birth: _____ Age: _____

Physical Address (street/city/state/zip): _____

Mailing address (if different from residence): _____

Describe applicant's motivation to commit treatment:

☐ Motivated (understands she/he needs help and willing to do what it takes to get it)

☐ Ambivalent (acknowledges that others see she/he has a problem, but not fully prepared to deal with it. Accepting of treatment only with strong external motivators)

☐ Denial (unwilling to accept that she has problem despite evidence to the contrary)

☐ Resistant (denies problem, actively refusing or fighting efforts to provide help)

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

_____

_____

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

_____

_____

Has the applicant ever been referred/received substance abuse/dependence treatment? ☐ No ☐ Yes If YES, briefly describe (when, where, and the outcome). _____

_____

Has there been a substance uses assessment in the last 90 days? ☐ No ☐ Yes If YES, Where? _____ Is the assessment attached to this referral? ☐ No ☐ Yes

Has applicant ever been referred/received mental health treatment? ☐ No ☐ Yes If YES, briefly describe when, where, and the outcome:

_____

_____

Is applicant receiving mental health treatment now? ☐ No ☐ Yes If YES, please name provider

_____

Referral Information: (IF APPLICABLE)

Referring Individual Name: _____ Relationship to applicant: _____

Referring Agency Name (if applicable): _____

Address: _____

Phone: ( ) _____ FAX# _____ Email: _____

Will the client be returning to you after treatment? ☐ No ☐ Yes

If NO, who will provide follow-up care: _____

Referrer contact information (phone number/email address): _____

Referral Agent Signature: _____ Date: _____