New Day, Inc.

Adult ASAM Level III.I

Braided Circle Recovery Home

**ADMISSION PACKET**

**New Day, Inc.**

**Adult ASAM Level III.I**

**Residential Recovery Home**

**Referral Information**

Resident’s Legal Name Date of Possible Admission \_\_\_\_\_\_\_\_\_\_\_

S.S.N. Gender: M\_\_\_\_\_ F\_\_\_\_\_ Date of Birth

Current Residence Address

City State Zip Phone

Previous Treatment Attended Address

City State Zip Phone

Previous Treatment Attended Address

City State Zip Phone

Current Medications (if any): \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribing Psychiatrist Phone

Name of Person Completing this Form Phone

Also, please include the following information for admission packet completion:

Participant’s court status (if applicable).

Copy of participant’s Medicaid card.

Cumulative health records and medical history including immunization records.

Most recent psychiatric evaluation, biopsychosocial assessment, chemical dependency assessment & other pertinent clinical reports.

**New Day, Inc.**

**Adult ASAM Level III.I**

**Residential Recovery Home**

**Demographic Profile**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth Age: \_\_\_\_\_\_\_\_ Birthplace

Gender Religious Preference

Racial/Ethnic/Tribe Composition Tribal Enrollment #

Language of Choice

Placement Agency/ Referral Source:

Address

Referral Source/Contract Person (Name)

Phone

Legal History (Including Current Legal Status, Facilities Detained In, Arrests/Charges Filed, Date of Incarceration and Date of Probation) If Applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant Other’s Name: \_\_\_ Address: \_ Phone:

Child(ren) Name(s): \_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Placement of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Completed by Date

**New Day, Inc.**

**Adult ASAM Level III.I**

**Residential Recovery Home**

**Authorization for Disclosure of Confidential Health Care Information**

The undersigned hereby authorizes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to disclose certain confidential health care information concerning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (participant) to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You are authorized to disclose all documents and files in your possession, including, but not limited to, admitting reports, discharge reports, summaries, progress reports, office records, hospital records, diagnostic test results, billing records, notes, correspondence, or any other documents relating to the treatment or evaluation of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (participant).

This Authorization shall be valid for thirty (30) months from the date recorded on this Authorization unless otherwise specified or revoked. The undersigned understands that this Authorization may be revoked at any time, upon written notification to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, except to the extent that action has been taken in reliance thereon.

The undersigned understands that this Authorization may include disclose of ALCOHOL AND DRUG ABUSE records which are protected by virtue of the provisions of Federal Regulations (42 C.F.R. Part 2)

The undersigned makes this Authorization upon the promise that all disclosures of any alcohol and drug abuse records made pursuant to this Authorization shall be accompanied by the following notice:

NOTE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulation (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of the information is NOT sufficient for this purpose.

The undersigned hereby acknowledges that he/she read, is familiar with, and fully understands the terms and conditions of this Authorization.

Photocopies of this signed Authorization shall be treated as executed originals.

Print Participant’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Signing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A copy of this document is to be delivered to the participant.

**New Day, Inc.**

**Adult ASAM Level III.I**

**Residential Recovery Home**

**Authorization to Use and Disclose Health Information**

Name: Date of Birth:

Maiden or Other Name:

To:

 Print Name Print Address

My health information may be disclosed under this authorization as marked:

* I authorize disclosure of the following types of individually identifiable health information maintained by you to New Day, Inc. Four Dances Residential Program.
* I authorize New Day, Inc. Four Dances Residential Program to disclose to you the following types of individually-identifiable health information.

Health information that may be used and disclosed through this authorization is as follows:

\_\_\_\_\_\_\_\_\_\_ Intake History/ Admission Information \_\_\_\_\_\_\_\_\_\_ Medication Records

\_\_\_\_\_\_\_\_\_\_ Psychological Testing \_\_\_\_\_\_\_\_\_\_ Psych/ Social Information

\_\_\_\_\_\_\_\_\_\_ Progress Notes/ Report \_\_\_\_\_\_\_\_\_\_ Treatment Plans

\_\_\_\_\_\_\_\_\_\_ Chemical Dependency Assessment Summary \_\_\_\_\_\_\_\_\_\_ Discharge Summary

\_\_\_\_\_\_\_\_\_\_ ACT Evaluation/ Recommendation Report

\_\_\_\_\_\_\_\_\_\_ Other (provide specific description of the information):

Specific purpose for the use or disclosure:

1. I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment.
2. I understand that information released by me may be subject to re-disclosure, and the information may no longer be protected by federal laws governing privacy of health information. However, if this disclosure consists of information about a client involved in chemical dependency services the following applies:

PROHIBITION OF REDISCLOSURE: this information has been disclosed to you from records 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 the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A federal authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

1. I understand that I may revoke this authorization in writing at any time. I understand that I must submit a written notice of revocation to the Administrator of New Day, Inc. I understand that the revocation will not apply to information that has been released in response to this authorization prior to my written notice.
2. I understand that my records may be transmitted by fax.
3. This consent will expire one hundred days (100) from the date this authorization is signed.
4. I have received a copy of this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date Witness Signature Date

New Day, Inc. Four Dances Residential Program Staff accepting authorization:

**New Day, Inc.**

**Adult ASAM Level III.I**

**Residential Recovery Home**

**Your Rights Regarding Your Health Information**

1. Communications: You can request that our facility communicate with you about health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of our health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our health information to only certain individuals involved in the care or the payment of the care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to New Day, Inc.
4. You may ask us to amend health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to New Day, Inc. You must provide us with a reason that supports your request for amendment.
5. Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, please contact New Day, Inc.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our facility or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice contact New Day, Inc. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our facility will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or out health information privacy policies, please contact New Day, Inc.

I hereby acknowledge that I have been presented with a copy of New Day, Inc. Notice of Privacy Practices.

Participant Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Day, Inc.**

**Adult ASAM Level III.I**

**Residential Recovery Home**

**Authorization for Treatment & Examinations**

The undersigned hereby authorize New Day, Inc., Billings, MT to provide an enrollment biopsychosocial assessment, mental health assessment, psychiatric assessment (if deemed necessary) and routine medical care and treatment to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (resident) as the New Day, Inc., staff consider to be necessary and as established pursuant to an existing treatment plan. I also give consent for continued testing as appropriate and pertinent for my treatment which may include psychological, academic, and/or physical testing.

The nature, purpose, and benefits of these routine treatments, the possible alternate methods to these treatments, any risks involved, and any possible side effects or complications arising from them will be explained to the undersigned and the patient prior to their use. Non-routine care and treatment or medications will not be administered to the patient without the patient’s informed consent.

The undersigned hereby consent to the rendering of such emergency medical treatment as may be necessary in the event of a medical emergency either while on an expedition, while completing a challenge activity or while at New Day’s facility.

Participant Name Date

Participant Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Staff Signature Date

**New Day, Inc.**

**Adult ASAM Level III.I**

**Residential Recovery Home**

**Notice of Privacy**

Name of Participant:

This notice describes how health information about the participant may be used and disclosed, and how the participant can get access to the participant’s health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Our commitment to the participant’s privacy:**

Our facility is dedicated to maintaining the privacy the participant’s health information. We are required by law to maintain the confidentiality of the participant’s health information:

**Use and disclosure of the participant’s health information in certain special circumstances:**

The following circumstances may require us to use or disclose the participant’s health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to the participants health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If the participant is a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if the participant is an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

Participant Signature

Date Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Day, Inc.**

**Adult ASAM Level III.I**

**Residential Recovery Home**

### Approved Items

In order to provide safety for all residents and staff in the Residential Recovery Home, please see the following list of items approved to be in the home and a list of items that are not approved to be in the home. New Day provides all kitchen items, furnishings, bedding, linen, etc.; however, residents are recommended to bring their own personal items. Items that are not allowed are considered contraband and will be sent home or put into storage until the time of discharge. Certain items *may* be accessible to residents but may remain in a locked closet and checked out to residents.

|  |  |
| --- | --- |
| **Recommended Items:*** 1 Heavy Coat
* 1 Light Jacket
* Shoes/Boots
* Jeans
* Socks
* Underwear
* T-Shirts
* Current Prescribed Medications
* Photo Identification Cards (Driver’s License, State ID, Tribal ID, etc.)
* Birth Certificate/Social Security Card
* EBT (SNAP) Card
* Insurance or Medicaid Card

**Additional Approved items:*** Books
* CDs
* Gloves
* Hat
* Movies (G or PG rating only)
* Pajamas
* Pillow, Blanket
* Hair Dryer/Curling Irons
* Stamps/Envelopes
* Feminine Hygiene Products

**Items to approved but must be kept in a locked room*** Antacids
* Cosmetics- anything without alcohol in first 4 ingredients
* Cell Phones
* Cigarettes (To be used off the property)
* Fingernail Polish and Polish Remover
* First Aid Kit/Rubbing Alcohol
* Hand Sanitizer
* Lighter, Matches (To be used off the property)
* MP3/IPods/Cell Phone/ Computers
* Over $50 in Cash
* Perfume, Body Spray, or Cologne w/Alcohol
* Portable DVD Players
* Prescribed Medication
* Razors
* Syringe Med Dispenser
* Tank Tops (shoulders must be covered w/no bra straps showing or worn under clothing)
* Vitamins
 | **Items Not Allowed (Contraband):*** Acrylic Nail Supplies
* Aerosol Cans (Of Any Kind)
* Alcohol
* Anything Expensive or Sentimental that Cannot be Replaced
* Bandanas or Colored Belts (red, blue, etc.)
* Bleach
* Candles
* Clothes w/Wording Referring to Sex, Alcohol, Profanity, Gangs, Tobacco, etc.
* Drug Paraphernalia/Illegal Drugs
* Face Cleaner with Alcohol
* Glass Items (picture frames, bottles, etc.)
* Glue
* Guns
* Hair Dyes
* Pornography
* Sharps, Knives, Pocketknives, Scissors
* Thong Underwear
* Tools
* White Out
 |