



Access to Recovery III Program Enrollment Application

Access Center: SCF PCC CITC VFRS New Hope Ascent Set Free Other: _____

Last Name:		First:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB: ____/____/____
Physical Address:				Apt. #	
City:	State:	Zip:	Email address:		
Mailing Address (if different):				Zip:	
Home Phone:		Cell Phone:		Work Phone:	
Emergency Contact Name:		Relationship:		Ph.:	
Next of Kin Name:		Relationship:		Ph.:	
Message Phone Name:		Relationship:		Ph.:	
Message Phone Name:		Relationship:		Ph.:	
Birthplace/city:		Where were you raised?		Number of years living in area: _____	
Native Heritage: <input type="checkbox"/> Athabaskan <input type="checkbox"/> Aleut <input type="checkbox"/> Haida <input type="checkbox"/> Inupiat <input type="checkbox"/> Tlinget <input type="checkbox"/> Tsimshian <input type="checkbox"/> Yupik <input type="checkbox"/> Other:					
Do you receive medical care at the Alaska Native Medical Center? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list where:					
Housing: <input type="checkbox"/> alone <input type="checkbox"/> with family <input type="checkbox"/> with non-related persons <input type="checkbox"/> in group home <input type="checkbox"/> detention center <input type="checkbox"/> shelter <input type="checkbox"/> other:					
Number of children in home: _____ Marital Status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> living as married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> widowed					
Employment Status: <input type="checkbox"/> employed <input type="checkbox"/> self-employed <input type="checkbox"/> unemployed <input type="checkbox"/> unemployed, seeking work <input type="checkbox"/> retired <input type="checkbox"/> disabled					
List your profession/work experience/skills/trade:					
Employer:		Title:		Address:	
Nutrition: Is there adequate food in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you receive public assistance and/or food stamps? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you receive WIC or other supplemental nutritional resources? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Education: <input type="checkbox"/> High School Diploma or equivalent <input type="checkbox"/> Vocational Training <input type="checkbox"/> College Degree Highest grade completed: _____					
Military Status: <input type="checkbox"/> Never in Military <input type="checkbox"/> Reserves or National Guard <input type="checkbox"/> Active Duty <input type="checkbox"/> Retired from Military <input type="checkbox"/> Veteran					
Legal Status: <input type="checkbox"/> None <input type="checkbox"/> OCS <input type="checkbox"/> ASAP <input type="checkbox"/> Court <input type="checkbox"/> VOA <input type="checkbox"/> ANJC <input type="checkbox"/> Probation/Parole <input type="checkbox"/> Pending Charges <input type="checkbox"/> Unknown					
Do you have a driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No-If no, reason: _____ Transportation: <input type="checkbox"/> my vehicle <input type="checkbox"/> bus <input type="checkbox"/> family/friends					
Who referred you to Access to Recovery? <input type="checkbox"/> Self <input type="checkbox"/> Other, list name:					
What do you want the most right now for your recovery? Please checkmark all that apply. <input type="checkbox"/> Stop using alcohol or other drugs <input type="checkbox"/> Reduce/manage alcohol or other drug use <input type="checkbox"/> Get support in recovery <input type="checkbox"/> Comply with legal requirements <input type="checkbox"/> Maintain/regain custody of my children <input type="checkbox"/> Maintain my employment <input type="checkbox"/> Maintain recovery/prevent relapse <input type="checkbox"/> Improve relationships <input type="checkbox"/> Gain employment <input type="checkbox"/> Connect with others in recovery <input type="checkbox"/> Obtain food, clothing, housing <input type="checkbox"/> Medical, dental, vision needs Please list any other reasons you would like to participate in the Access to Recovery program:					
Are you presently enrolled in an out-patient or in-patient treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name and address:					
Have you received substance abuse treatment in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list where and dates:					
What kinds of recovery support services are you interested in receiving? Please checkmark all that apply. <input type="checkbox"/> Cultural enrichment <input type="checkbox"/> Spiritual or faith-based mentoring <input type="checkbox"/> Conflict resolution/improve relationships <input type="checkbox"/> Educational goal setting <input type="checkbox"/> Pastoral/faith-based counseling <input type="checkbox"/> Marriage counseling <input type="checkbox"/> Employment search <input type="checkbox"/> Peer mentoring and coaching <input type="checkbox"/> Family wellness activities <input type="checkbox"/> Job or vocational training <input type="checkbox"/> Therapeutic recreation <input type="checkbox"/> Children and/or teen activities <input type="checkbox"/> Life skills classes <input type="checkbox"/> Clinical substance abuse treatment <input type="checkbox"/> Transportation assistance (bus pass) <input type="checkbox"/> Parenting classes <input type="checkbox"/> Domestic violence education <input type="checkbox"/> Learn about new hobbies/recreation					



Are there financial issues that make it difficult for you to reach your recovery goals? Yes No If yes, checkmark all that apply.
Money management No income Insufficient income Debt-owe too much money Legal fees Alimony/child support

Do you have any preference on type of individual, organization, or community providing your recovery support services?
No preference Substance abuse clinical provider Culturally-based provider Community-based service providers
Veterans services Vocational training provider Family-wellness provider Faith-based provider*

*If you would like faith-based services, list your religious/spiritual preference: _____

List any other recovery supportive services you are interested in receiving:

List your hobbies, leisure activities and talents:

What type of Life Skills would be helpful to you?

- Parenting classes Domestic skills: cooking Conflict resolution/anger management Money management
- Family wellness Learning about boundaries Respecting self and others Managing stress

Please list any other Life Skills you would like learn while participating in the Access to Recovery program:

List names of all children under age 18 living in household	M/F	Age	Relationship to you

List names of all adults age 18 and older living in household	M/F	Age	Relationship to you	Cell Phone Number

Customer-Owner Certification

I understand that I/we have the right to appeal any decision regarding the disposition of this application.
I declare under the penalty of perjury that the statements on this application are correct and true to the best of my knowledge.

Printed Name of the Customer-Owner

Signature of the Customer-Owner

Date

Signature of the Access Center Staff member

Date



Authorization for Use and Disclosure of Customer-Owner Information

I understand that I am not required to sign this form to receive services. My refusal will not affect my ability to obtain treatment or be eligible for benefits. However, I understand that Access To Recovery cannot pay for services delivered unless it has authorization from me to collect this required information. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I understand that health information released, if covered by federal law 42 C.F.R. Part 2 (Alcohol & drug abuse records); will continue to be protected by law from re-disclosure. I understand that information only covered by HIPAA (45 C.F.R. Parts 160 & 164) is subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Act. I may revoke the Releases of Information at any time, and will need to contact the Access Center. My revocation will take effect once contact is made.

 Signature, Customer-Owner Name Date

 Signature, Authorized representatives Name (state relationship to the customer-owner) Date

 Signature, Access Center Staff Date

Consent to Participate

I, _____, or my legal guardian, _____, consent to participation with the providers of Southcentral Foundation's Access To Recovery by signing below. I indicate with my signature that I understand my rights and responsibilities as a Customer of the Access To Recovery program. I have reviewed Access To Recovery's Consent to Participate document with a Assessment Center staff member, have asked any questions I might have, I understand the information in the document and have been given a copy of the document.

 Printed Customer-Owner Name Customer-Owner Signature Date

 Printed Witness Name Witness Signature Date

 Printed Parent/Legal Representative Legal Representative Signature Date
 Name & Relationship



Customer-Owner Rights and Responsibilities

Customer Rights – Treatment

- You and your family have the right to be informed of these rights in a language and method you understand.
- You have the right to designate a surrogate decision maker if you become incapable of understanding a proposed treatment/procedure, or are unable to communicate your wishes
- You have the right to ask about the educational and professional background of providers as well as licensing information.
- You have the right to reasonable access to care which respects your dignity, values and beliefs regardless of your race, religion, gender, sexual orientation, ethnicity, age or disability.
- You have the right to receive information about your treatment, alternative treatments and to seek a second opinion. Like other medical treatments, behavioral health treatment has benefits and risks and there are no guarantees with respect to outcome.
- Your participation is voluntary and you may end participation at any time. However, if the participation is court-ordered or required by another agency, ending treatment may result in consequences outside the control of your provider and the Access To Recovery Program.

Customer Rights – Confidentiality

Information you share with providers is generally confidential and your right to confidentiality and privacy is protected by law. Please understand that:

Your information is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit us from making any further disclosure of your 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 general 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. Once you sign an official release of information form and this information is released to another agency, Southcentral Foundation can no longer guarantee the confidentiality of this information. Providers may be required to disclose information without your authorization to protect your safety or the safety of others including:

- If you are in clear danger of hurting or killing yourself or unable to care for yourself.
- If you are in clear danger of hurting or killing someone else or have clearly threatened to hurt someone else.
- If you tell a provider about neglect or abuse of a child, an elder or an individual who is unable to care for him/ herself.
- If a child is witnessing domestic violence within the home.
- When records are subpoenaed or ordered to be released by a court of law.
- For purposes of program accreditation, certification or state agency reviews and audits.



Customer Responsibilities

- You have the responsibility to provide information about your present concerns, past illnesses and medication(s) to your provider(s).
- You have the responsibility to ask questions about anything you do not understand in the course of your assessment or treatment.
- You have the responsibility to actively participate in treatment including keeping scheduled appointments.
- You have the responsibility to follow the recommended treatment plan after adequate instructions have been provided. If you disagree with the recommended treatment plan, it is your responsibility to discuss these areas of disagreement with your provider.
- You have the responsibility to accept the consequences of not following the recommended treatment plan.
- You are responsible for seeking emergent mental health care when indicated. You can receive emergent care during regular business hours at the Behavioral Health Department. After 5:00 pm Monday through Friday, on weekends, and on major holidays, contact the ANMC Emergency Room at 729-1729 or Emergency Services at 563-3200.
- You have the responsibility to fulfill financial obligations, if applicable.

Resolution of Concerns

Customers and their families are encouraged to express any concerns or problems encountered during their course of treatment in a timely manner. Communication of concerns and problems are viewed as an opportunity to improve your participation and Access To Recovery as a whole.

Report concerns directly to your Centralized Access Center. If you think doing so is inappropriate, concerns can also be reported to a Southcentral Foundation’s Access To Recovery.

You may also report concerns to the Southcentral Foundation compliance hotline at 1-877-837-4251.

Anyone, including visitors or employees, who believe possible customer discrimination or abuse has occurred, should immediately contact any Southcentral Foundation staff member.

If you have serious concerns or complaints about a behavioral health practitioner, you can also contact the Division of Occupational Licensing, 3601 C Street, Suite #722, Anchorage, AK, 99503-5986, Telephone 907 269-8160.

Print, Name of the Customer-Owner

Signature, Name of the Customer-Owner

Date