

**SUPPORTING FAMILIES FACING SUBSTANCE ABUSE:
PRACTICAL TIPS AND IDEAS**

28 Day and 90 Day Treatment Facility Information

**Prepared By:
Kristen D. Antolini, Esq.**

Westbrook Health Service—Wood County

Amity Treatment Center - 12 Beds Male/Female
1011 Mission Drive
Parkersburg, WV 26101

Contact: Nikki Reed - 304-485-1781 Fax: 304-485-1782

NOTES: Will not tell if they have beds available. Must complete application-
Then you must call 3-4 times a week to keep active on the wait list. When a
space come available Nikki Reed will call you for a phone interview.



WESTBROOK

Health Services

Community Focused. People Driven.

1011 Mission Drive, Parkersburg, WV 26101 304-485-1781

Crisis Line 304-485-1725 or 1-800-579-5844

A letter requesting to be added onto the waiting list or a preadmission form has been received by Amity Treatment Center. The purpose of this letter is to provide you with necessary information regarding Amity, for example: what to expect, what funding we accept and other information that you may find helpful. Please continue to write Amity monthly to stay on the waiting list. Failure to write monthly will result in being taken off of the waiting list. The wait for incarcerated persons can be extensive; therefore it is suggested to get on other waiting lists at other facilities as well.

Amity Detox and Treatment center focuses approximately 5-6 hours of group therapy daily to a range of topics over the course of a 28 day treatment stay including the disease of addiction, the addiction cycle, root causes of cravings, stages of recovery, the warning signs of relapse, communication skills, anger management, coping skills, relapse prevention planning, the necessity of ongoing support, and building/utilizing a sober support network of people. Individual therapy sessions are offered throughout the treatment stay. While at Amity clients go to outside AA/NA meetings nightly. Amity takes these forms of payment:

- **WV Medicaid: Traditional, Basic, Special Authorization Letter.**
Amity can serve individuals who do not have the ability to pay for services if they meet income eligibility guidelines and after they have applied for financial assistance through WV Medicaid. We have a limited amount of Charity Care dollars and because of this there may be a significant wait time for a Charity Care bed. Admissions are priority-based on certain criteria and are not first-come first-served. Income Based Charity Care Fee Waiver for WV residents who reside in any of the following 8 counties: **Wood, Wirt, Tyler, Ritchie, Calhoun, Jackson, Roane, Pleasants.**
- **Self-payment.** The requirements at this time for establishing a self-pay contract are: the consumer will make a \$4000 down payment at the time of admission or before, the consumer agrees to pay the remainder of the cost of treatment averaging an additional \$4000, the consumer reviews the terms and conditions of the contract with Amity staff and signs his/her consent and agreement, the consumer will have a co-signer who will take responsibility for the unpaid balance in the event that the consumer has not followed through with the terms of the contract, the co-signer is present when the contract is established and he/she signs his/her consent and agreement.
- Amity does not accept private or military health insurance. Amity cannot accept clients with Medicare.

**Roane
County**
304-927-5200

**Jackson
County**
304-372-6833

**Pleasants
County**
304-684-2656

**Ritchie
County**
304-643-2996

**New Day Crisis
Unit**
304-485-1721

**Amity
Center**
304-485-1781



1011 Mission Drive, Parkersburg, WV 26101 304-485-1781
Crisis Line 304-485-1725 or 1-800-579-5844

I have enclosed releases of information for attorneys, family members, or anyone that will be calling to inquire about your status or helping you to get out of incarceration and into treatment. Please use the example to fill out the form, and send it back to our facility when you are finished.

Here are some things to take note of if you are admitted into Amity Treatment Center:

- Wake up is at 7:30 a.m. Monday through Sunday. Lights out is at 11 p.m. Sunday through Thursday and Midnight on Friday and Saturday. Your first group of the day starts at 9:00 a.m.
- There is no visitation your first weekend here, but your second weekend, you are able to have visitors. We do limit visitation to family and a significant other.
- There is no phone use for the first 5 days. On the 5th day, you are able to make 2 personal calls. There is only 2 personal calls allowed per client daily. We have a recovery phone in which you can use to call members of the same sex in your support network that you build in AA and NA. There is no limit on recovery calls.
- We are here to help, so do not hesitate to ask for help.

If you have any questions or concerns, please feel free to contact me at the numbers/address below.

Sincerely,

Kimberly McLeish, Admissions Coordinator
Amity Detox and Treatment Center
1011 Mission Drive
Parkersburg, WV 26101
Phone: 304-485-1721 ext. 624
Fax: 304-485-1782

Roane
County
304-927-5200

Jackson
County
304-372-6833

Pleasants
County
304-684-2656

Ritchie
County
304-643-2996

New Day Crisis
Unit
304-485-1721

Amity
Center
304-485-1781

AMITY TREATMENT CENTER PRE-ADMISSION ASSESSMENT FORM
1011 Mission Drive Parkersburg, WV 26101
Tel: 304.485.1781 Fax:304.485.1782

Date of referral: _____ Assessment taken by: _____ tel: _____

DEMOGRAPHIC INFORMATION

Name: First _____ Middle _____ Last _____

Address: _____ City/state _____ County _____ Zip _____

Marital Status: _____ Phone Number: H: _____ C: _____

Date of Birth: ____/____/____ SSN#: _____ - _____ - _____ Currently Incarcerated? Yes ___ No ___

Race: _____ Hispanic? Yes ___ No ___ Give Westbrook permission to check insurance? Yes ___ No ___

Any chance client could be pregnant? _____ If yes, how many months? _____ OB/GYN: _____

If not pregnant: Date of last menstrual cycle: _____ Using any birth control? _____ What? _____

Any children? Names/ages: _____

Where are they? _____

Any current involvement with CPS? Explain: _____

CPS Worker's Name and Contact Information: _____

**THIS PART MUST BE COMPLETED BEFORE WE WILL REVIEW
PAYOR SOURCE**

Does client have West Virginia Medicaid? _____

WV Medicaid # (11digits) _____ BA/TR/EN

Does client have other insurance OR Medicare? _____ If yes, we do not accept private insurance or Medicare at Amity, please give them lists of other facilities and encourage them to call their insurance for suggested treatment options.

Will the client be self pay? _____ Self pay requires \$4000 down with a co-signer before admittance into Amity and approximately \$4000 more within 30 days after leaving treatment.

Will client be applying for a fee waiver? _____ We accept fee waivers from these counties: Wood, Wirt, Tyler, Roane, Jackson, Pleasants, Calhoun and Ritchie. We cannot give fee waivers to anyone that has insurance of any kind. **If yes, please fill out the following questions.**

What is the client's family annual income? _____ This includes client and anyone else working in the household.

Is client currently employed? _____ If so, where? _____

Will the client be able to be off of work for 28 days for treatment? _____

Will a special billing letter be given by a CPS worker for treatment at Amity? _____

If client will be special billing from a CPS worker, please let them know that we will need a release of information in order to discuss funding with their worker and to ensure that treatment will be paid for.

CHEMICAL HISTORY INFORMATION

Why do you want treatment now? What is going on? What event prompted this call for help?

Last time you drank/used/got high? _____ What? _____ How much? _____

What? _____ How much? _____ How often? _____

How many years have you been using alcohol/drugs(s): _____ Longest time quit? _____

Have you ever used any substances IV? _____ When was the last IV use? _____

What substances were used IV? _____

Have you ever had treatment in the past for alcohol/drug(s)? Examples: Hospital detox, Inpatient, Outpatient, VA Hospital? _____

Have you ever had serious withdrawal symptoms (DT's, Seizures, Hallucinations) When? _____

Describe symptoms? _____

Legal Information

Any current legal charges pending? _____ If yes, what _____

Have you ever been charged/convicted of Domestic Violence, Assault, or other violent behaviors? If yes, explain what, when, and what happened. _____

Currently on probation or parole? If yes, list convictions: _____

Psychiatric History

Have you ever seen a psychiatrist or are you currently under the care of one now? Yes _____ No _____

If yes, please identify the name/date/reason for psychiatric treatment. _____

Have you ever attempted suicide in the past? _____ If yes, when and how? _____

Are you currently suicidal or homicidal? _____ [If yes, need to make a referral]where: _____
Do you have a plan for harming yourself or someone else? If yes, what is the plan? _____

Have you ever been treated in the hospital for a psychiatric reason? When, where, why? _____

Medical/Physical History

Do you have any physical disabilities or limitations or special needs? _____ If yes; explain them: _____

Do you have any ongoing medical conditions for which you have received treatment or hospitalization?

(Diabetes, heart problems, ulcers, kidney, Hep C or liver problems?): _____

Do you have any allergies? _____ Name of primary care physician? _____

Are you currently taking any medications? If yes, list them, the dosage, and the reason for the medication:

THE CLIENT IS REQUIRED TO BRING ALL CURRENT MEDICATIONS IN CORRECT RX BOTTLE AT THE TIME OF ADMISSION

Are you currently taking METHADONE? _____ What dose? _____ (Client must be at 30mg or less daily with proof of dosage from Methadone treatment center to be detoxed at our CSU.)

Are you currently taking SUBOXONE? _____ What dose? _____ (Client must be at 6mg or less)

Please call once a week while on the waiting list and check in with a staff member. If there are any changes to your information, please have staff note this on call in sheet. Also, please begin attending AA/NA meetings in your area.

**Consent to the Use and Disclose Health Information for
Treatment, Payment, or Healthcare Operations (Release of Information) v4**

I, _____, Date of Birth: _____, Social Security Number: _____

Hereby give my consent to: _____ Westbrook Health Services _____ Other _____

To release my health information, as specified below, to: _____

I authorize the following information to be released (initial all that apply):

Narrative Summary Psychiatric Evaluation Psychological Evaluation Assessment (s)
 History Waiver Packet Info. Consultation Treatment Time Periods
 Urine Screens Other (be specific): _____

I understand that the information to be released that I have initialed or check-marked above may include: (Initial below as appropriate)

<input type="checkbox"/>	Diagnoses and/or treatment for mental / behavioral health, alcohol and/or drug abuse	<input type="checkbox"/>	Diagnoses and/or treatment relating to other communicable diseases
<input type="checkbox"/>	AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment;	<input type="checkbox"/>	HIV test results;

Except as limited (be specific): _____

This Consent for Use/Disclosure is for the following purpose: _____

This Consent will remain effective for 90 days 180 days other date/condition/event: _____

_____ I understand that I have the right to revoke this Consent, in writing, at any time, and that the revocation will be effective except to the extent Westbrook Health Services or its staff has already taken action in reliance on my consent. My written statement that I want to revoke my consent is delivered to Medical Records at Westbrook Health Services, 2121 Seventh Street, Parkersburg, WV 26101.

_____ I understand that as part of my healthcare, Westbrook Health Services, Inc. originates and maintains health records including my Protected Information (PHI) describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and medical information to my bill, a means by which a third-party can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the performance of healthcare professionals.

_____ I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information use and disclosures. I understand that I have the right to review the notice prior to signing this Consent. I understand that Westbrook Health Service reserves the right to change the notice and practices and prior to implementation will arrange for me to receive a copy of any revised notice. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Westbrook Health Services, Inc. is required to agree to the restrictions requested. I understand that my refusal to sign this Consent will **not** affect my ability to obtain treatment, payment or enrollment in a health plan.

Signed: _____ Printed Name _____ Date _____

Witness: _____ Printed Name _____ Date: _____

If the signer is not the Individual, what Relationship and Authority does he/she have to act on behalf of this person: _____

Means used to identify the signer (Driver's License, Guardianship papers, etc): _____

For Office Use Only

Staff person releasing information: Signature _____ Print Name _____

Date information released: _____

MH/MR: "This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. Regulation of this information is your right to make any further disclosure of this information without prior written consent of the person to whom it pertains."

SA: "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 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 do not restrict any use of the information to criminally investigate or prosecute an alcohol or drug patient."

Westbrook Health Services, Inc.
Consent to the Use and Disclose Health Information for
Treatment, Payment, or Healthcare Operations (Release of Information) v4

I, _____, Date of Birth: _____, Social Security Number: _____
 Hereby give my consent to: _____ Westbrook Health Services _____ Other _____
 To release my health information, as specified below, to: _____
 I authorize the following information to be released (initial all that apply):

- Narrative Summary Psychiatric Evaluation Psychological Evaluation Assessment (s)
 History Waiver Packet Info. Consultation Treatment Time Periods
 Urine Screens Other (be specific): _____

I understand that the information to be released that I have initialed or check-marked above may include: (Initial below as appropriate)

<input type="checkbox"/>	Diagnoses and/or treatment for mental / behavioral health, alcohol and/or drug abuse	<input type="checkbox"/>	Diagnoses and/or treatment relating to other communicable diseases
<input type="checkbox"/>	AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment;	<input type="checkbox"/>	HIV test results;

Except as limited (be specific): _____

This Consent for Use/Disclosure is for the following purpose: _____

This Consent will remain effective for 90 days 180 days other date/condition/event: _____

_____ I understand that I have the right to revoke this Consent, in writing, at any time, and that the revocation will be effective except to the extent Westbrook Health Services or its staff has already taken action in reliance on my consent. My written statement that I want to revoke my consent sh be delivered to Medical Records at Westbrook Health Services, 2121 Seventh Street, Parkersburg, WV 26101.

_____ I understand that as part of my healthcare, Westbrook Health Services, Inc. originates and maintains health records including my Protected H Information (PHI) describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treat. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professi who contribute to my care, a source of information for applying my diagnosis and medical information to my bill, a means by which a third-party p can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the compet of healthcare professionals

_____ I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses disclosures. I understand that I have the right to review the notice prior to signing this Consent. I understand that Westbrook Health Services, reserves the right to change the notice and practices and prior to implementation will arrange for me to receive a copy of any revised notice. I under: that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Westbrook Health Services, Inc. i required to agree to the restrictions requested. I understand that my refusal to sign this Consent will **not** affect my ability to obtain treatment, paymen enrollment in a health plan.

Signed: _____ Printed Name _____ Date _____

Witness: _____ Printed Name _____ Date: _____

If the signer is not the Individual, what Relationship and Authority does he/she have to act on behalf of this person: _____

Means used to identify the signer (Driver's License, Guardianship papers, etc): _____

For Office Use Only

Staff person releasing information: Signature _____ Print Name _____

Date information released: _____

ME/MR: "This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. Regulation your right to make any further disclosure of this information without prior written consent of the person to whom it pertains."

SA: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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 Feder restrict any use of the information to criminally investigate or prosecute an alcohol or drug patient"

WESTBROOK HEALTH SERVICES, INC.
Consent to the Use and Disclose Health Information for
Treatment, Payment, or Healthcare Operations (Release of Information) v4

I, your name, Date of Birth: DOB, Social Security Number: SSN

Hereby give my consent to: Westbrook Health Services Other _____
 To release my health information, as specified below, to: name of whom needs information
 I authorize the following information to be released (initial all that apply):

I = initials

Narrative Summary _____ Psychiatric Evaluation _____ Psychological Evaluation Assessment (s)
 History _____ Waiver Packet Info. _____ Consultation Treatment Time Periods
 Urine Screens Other (be specific): Program compliance, progress toward treatment goals and objectives.

I understand that the information to be released that I have initialed or check-marked above may include: (Initial below as appropriate)

<input checked="" type="checkbox"/>	Diagnoses and/or treatment for mental / behavioral health, alcohol and/or drug abuse	<input checked="" type="checkbox"/>	Diagnoses and/or treatment relating to other communicable diseases
	AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment;		HIV test results;

Except as limited (be specific): _____

This Consent for Use/Disclosure is for the following purpose: Continuity of care.

This Consent will remain effective for 90 days 180 days other date/condition/event: _____

I understand that I have the right to revoke this Consent, in writing, at any time, and that the revocation will be effective except to the extent Westbrook Health Services or its staff has already taken action in reliance on my consent. My written statement that I want to revoke my consent s be delivered to Medical Records at Westbrook Health Services, 2121 Seventh Street, Parkersburg, WV 26101.

I understand that as part of my healthcare, Westbrook Health Services, Inc. originates and maintains health records including my Protected Health Information (PHI) describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and medical information to my bill, a means by which a third-party can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information use disclosures. I understand that I have the right to review the notice prior to signing this Consent. I understand that Westbrook Health Services reserves the right to change the notice and practices and prior to implementation will arrange for me to receive a copy of any revised notice. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Westbrook Health Services, Inc. required to agree to the restrictions requested. I understand that my refusal to sign this Consent will not affect my ability to obtain treatment, payment, enrollment in a health plan.

Signed: Sign Printed Name Print Date date

Witness: witness sign Printed Name print Date: date

If the signer is not the Individual, what Relationship and Authority does he/she have to act on behalf of this person: _____

Means used to identify the signer (Driver's License, Guardianship papers, etc): _____

For Office Use Only

Staff person releasing information: Signature _____ Print Name _____

Date information released: _____

MB/MR: "This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. Regulation your right to make any further disclosure of this information without prior written consent of the person to whom it pertains."

SA: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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 restrict any use of the information to criminally investigate or prosecute an alcohol or drug patient"

Marion County (will take pregnant women)

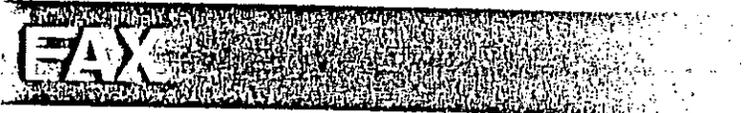
Act Unit - 10 Beds Male/Female
100 Crosswind Drive
Fairmont, WV 26554

Contact: Courtney Gear - 304-363-2228 Ext. 4330 Fax: 304-363-2282

NOTES: Must fill out application. Follow up with a call.



<p>Valley HealthCare System</p> <p>ACT UNIT</p>	<p>100 CROSSWIND DRIVE FAIRMONT, WV 26564 PHONE: 304-363-2228 FAX: 304-363-2282</p>
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CONFIDENTIALITY NOTICE

This fax transmission, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and / or privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, please contact the sender by phone and destroy / delete all copies of the original message.



RESIDENTIAL SUBSTANCE ABUSE REFERRAL TO:

Name of facility where referral is being made

This referral form is designed to facilitate the immediate and appropriate treatment of individuals referred to SA residential programs. Please complete this form in its entirety. Return fax to 304-363-2282. Thank you for your assistance.

1. Date & Time of Referral _____

2. Type: Voluntary _____
Commitment _____
Other _____

3. Less restrictive options attempted: I.O.P _____ Outpatient _____ None _____

4. Name of Person Making Referral _____

5. Telephone _____

6. Local CBHC _____

7. Telephone _____

8. Client Status: Unknown _____ Active _____ Inactive _____

9. Client Name _____

10. DOB: _____

11. SS # _____ 12. Gender: M F 13. Race _____ 14. Phone: _____

15. Address: _____

16. Employment _____

17. Education _____

18. Pregnant: Yes ___ No ___ N/A ___ If yes, How far along are you? _____

19. Number of minor children living with client _____

20. Emergency Contact: _____ 21. Relationship: _____

22. Phone: _____

23. Payor Source: Self Pay _____ Medicaid _____ Insurance _____ OBHS _____

24. Substance Use History: Last Six Months (Check drug used, circle frequency, list amount/date of last use)

<u>Drug</u>	* by drug of choice	<u>Frequency</u>	<u>Amount/Date of Last Use</u>
_____	marijuana	Daily	(3-5x per week)(1-8x/mo.) (Less than once/mo.) _____/____
_____	cocaine	Daily	(3-5x per week)(1-8x/mo.) (Less than once/mo.) _____/____
_____	heroin	Daily	(3-5x per week)(1-8x/mo.) (Less than once/mo.) _____/____
_____	PCP	Daily	(3-5x per week)(1-8x/mo.) (Less than once/mo.) _____/____
_____	LSD	Daily	(3-5x per week)(1-8x/mo.) (Less than once/mo.) _____/____
_____	amphetamines	Daily	(3-5x per week)(1-8x/mo.) (Less than once/mo.) _____/____
_____	barbiturates	Daily	(3-5x per week)(1-8x/mo.) (Less than once/mo.) _____/____
_____	inhalants	Daily	(3-5x per week)(1-8x/mo.) (Less than once/mo.) _____/____
_____	opiates	Daily	(3-5x per week)(1-8x/mo.) (Less than once/mo.) _____/____
_____	other (specify)	Daily	(3-5x per week)(1-8x/mo.) (Less than once/mo.) _____/____
_____	alcohol	Daily	(3-5x per week)(1-8x/mo.) (Less than once/mo.) _____/____

B.A.C. If known: _____ Date Obtained: _____ Time: _____

25. In the last six months, what is the longest period of abstinence? _____

26. IV drug use (Last 6 Months) Yes _____ No _____

27. Any History of IV Drug Use Yes _____ No _____

28. Previous Treatments: Please describe type such as I.O.P., residential, or outpatient.

When	Type	Program Name	Length of Stay
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

29. Diagnostic Impression (s): Axis I: _____
(Must Have) Axis II: _____

Medical History

30. Does the client require medical clearance? Yes _____ No _____

31. Name and phone # of physician authorizing medical clearance: _____

32. Reason medical clearance is not required: _____

Page 3 of 4

33. Is the client currently experiencing any of the following: (Circle any that are appropriate)

- | | | | | | |
|------------------|-----------------------|-----------------|--------------|-----------------|----------------------------|
| Tremors | hallucinations | seizures | agitation | nausea/vomiting | vomiting blood |
| Insomnia | delusions | sweating | irritability | mood swings | shortness of breath |
| cirrhosis | heart problems | stroke | diabetes | dental problems | high blood pressure |
| hepatitis | pancreatitis | asthma | headaches | vision problems | breathing problems |
| headaches | tuberculosis | chest pain | | | |
- other (specify) _____

If there are one or more of the bolded conditions then medical clearance must be obtained.

34. Is the client self-ambulatory? Yes _____ No _____

35. Medications currently prescribed:

Name	Amount	Time Taken	Prescribed by	currently taking - If not why not
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

36. List any scheduled medical appointments within the next four weeks. Give date/time/with whom

37. Does the client have a history of suicide attempts or violence toward self?: Yes _____ No _____

If yes: Date

Method

_____	_____
_____	_____

38. Does the client have a history of violence toward others? Yes _____ No _____ If yes, explain

NOTE: Questions 37 and 38 are to be used to schedule additional staff, if needed.

39. Are there family members willing to be involved in the treatment process if the client agrees?

Yes _____ No _____ If yes, give name, relationship, and phone number: _____

Page 4 of 4

Legal History

40. Is the client facing any legal charges? Yes ___ No ___ If yes, explain what they are and give any Court dates. State source of information.

41. Is there a detainer on this client? Yes ___ No ___ if yes, give name and telephone number of Persons to contact prior to discharge

42. Is the client currently on probation or parole? Yes ___ No ___ If yes, list where, reason, and name of P.O.

43. List other placements/facilities attempted, reasons denied, if applicable; or any other important information.

Valley HealthCare System CONSENT FOR RELEASE OF INFORMATION

Consumer Name: _____ Case Number, _____

Address: _____ DOB: ___/___/___ SSN: ___-___-___

_____ Phone: _____ (H) _____ (W)

I authorize _____ to release protected
(state agency, facility, program or institution AND name of individual)
health information to _____ for the stated
(state agency, facility, program or institution AND name of individual)
purpose of: _____

Information to be released that is minimally necessary to meet the stated purpose:

- Admission/Discharge Date
- History/Physical
- Lab Tests
- Psycho-Social History
- Intake/Assessment
- Progress Notes
- Discharge Summary
- Neuro-psych Testing
- Progress Report
- Psychological Testing
- Medical Information
- Medication Record
- Other(s): _____

I understand that the information to be released includes: (Initial appropriate boxes)

Diagnoses and/or treatment related to communicable diseases

AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment

Except as limited as follows: _____

I understand that my records are protected under Federal and State regulations governing the confidentiality of patient records and cannot be disclosed without my written consent unless provided for in regulation. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that action has already been taken.

This consent will expire on _____ or 180 days, whichever comes first.

Signature of Consumer Date

Signature of Legal Representative Date

See Back for Redisclosure Statement

Prohibition on Redisclosure of patient information regarding psychiatric, alcohol and other drugs, HIV/AIDS, and other categories specifically protected by State and Federal confidentiality laws. This notice accompanies a disclosure of patient information specifically protected by State and Federal law which prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person for whom it pertains, or as otherwise permitted by Federal or State law. A general authorization for 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 patient.

INSTRUCTIONS

The following is a direct quotation from the Federal Register, 42 CFR, Part 2, Chapter 1, Subpart C, §2.32:

"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 general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient."

The following is a direct quotation from the Behavioral Health Licensure Rules, 64CSR11, 6.9.c.1-3, 7/1/2000:

6.9.c. Consumer records shall be released without written consent as follows:

6.9.c.1. In a proceeding under W.Va. Code §27-5-4 to disclose the results of an involuntary civil commitment;

6.9.c.2. In a proceeding under W.Va. Code §27-6A-1 et seq. to disclose the results of an involuntary examination;

6.9.c.3. Pursuant to a court order based upon a finding that said information is sufficiently relevant to a proceeding before the court to outweigh the importance of maintaining the confidentiality established by this rule.

6.9.c.4. To protect against a clear and substantial danger of imminent injury by a consumer to self or to another; and

6.9.c.5. To staff of the Center for treatment or internal review purposes.



Please acknowledge that you are aware of the following conditions for treatment by initialing in the blank to the left of each statement and by signing at the bottom of the form. The rare exceptions to any of these conditions must be expressly coordinated and approved in advance by the treatment team.

____ I understand that the Valley HealthCare System A.C. T. Unit is a 28 day substance abuse treatment facility, and that I will be expected to remain at the A.C.T. Unit for the full 28 days.

____ I understand that my treatment at the Unit may be extended beyond the 28 days if I, and the treatment team, agree that an extension is in my best interest. I understand that the A.C.T. Unit may assist in facilitating placement in additional and/or longer term treatment in another facility if necessary. I agree to accept the aftercare recommendations made by the treatment team and to follow through with such recommendations.

____ I understand that the treatment experience at the A.C. T. Unit has various components and I will be expected to participate in all activities including group and individual therapy, recreation activities, and designated meetings.

____ I understand that I need to arrange transportation to treatment by a means other than driving myself, and that I will not be permitted to have a vehicle on the grounds during my treatment stay. I understand that VHCS A.C.T. Unit may be able to assist with transportation needs, but that transportation assistance is not guaranteed.

____ I understand that I will not be permitted to bring any contraband (including any controlled substance including prescribed opiates, benzodiazepines, or alcohol) into the treatment facility. I further understand and consent that, should I bring these items to treatment, they will be confiscated as contraband and destroyed.

____ I understand that I will not be permitted to have weapons, including firearms and knives, while at the A.C. T. Unit. Common possessions that may be considered potential weapons must be surrendered and stored during treatment.

____ I understand that the use of electronic devices such as pagers and cell phones are not permitted while in treatment. If any of these items are brought to the treatment facility, I understand the staff will secure them until discharge.

____ I understand the use of tobacco products (including smokeless tobacco) is not permitted in the building. Use of such is restricted to the outside of the building and, at no time, am I permitted to leave programming to use such products.

____ I understand that VHCS and the A.C.T. Unit will not divulge that I am a client at the treatment facility without my written consent, and that if I chose to have others know where I am, I will need to inform them myself as to my whereabouts. I further understand that, if there is a court order requiring treatment, the ACT Unit will inform the proper authorities of my discharge, whether the completion of the program or if I leave against professional advice before the completion of the program.

Prestera – Kanawha County

Next Step - Male Only

2305 Dunbar Avenue

Dunbar, WV 25064

304-766-7336 Ext 1500 Fax: 304-768-7826

NOTES: Co-Occurring Program- Must already be a Prestera client and have a diagnosis from Prestera.



PRESTERA CENTER FOR MENTAL HEALTH SERVICES
SUBSTANCE ABUSE RESIDENTIAL PROGRAM REFERRAL FORM

All Prestera substance abuse residential programs are listed below with a brief descriptor, fax number and email contact for referral information. Please send referrals to the fax numbers or emails indicated below. All emails are the name indicated below followed by @prestera.org.

Riverside Short Term Men 304-722-1795 Ronald.Jackson Fax: 304-727-5887	Pinecrest Short Term Men & Women 304-525-7851x1124 Leslie.Varble Fax:304-525-2040	Mattie V Lee Long Term Women & Children 304-344-1827 Samantha.Nooney Fax:304-344-1828	Renaissance Long Term Women & Children 304-525-7851x2552 Theresa.Jackson Fax:304-697-1280	Laurelwood Charleston Long Term Men 304-768-6119 Amanda Cruz Fax:304-768-7286	Laurelwood Huntington Long Term Men 304-399-1029 Scott.Harrison Fax:304-525-5250
--	---	---	---	---	--

Name of person making referral: _____ Telephone#: _____
 E-Mail Address _____ Date: _____

CLIENT NAME: _____ **Date of Birth:** _____

SS# _____ Gender: Male ___ Female: ___ Telephone#: _____

Address: _____

County: _____ Race: _____

Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___

Number of minor children living with the client: _____

Education: Highest Grade Completed (GED, HS Graduate, College, Trade School): _____

Employed ___; Employer _____ Unemployed ___ Disabled ___ Retired ___

Monthly Family Income: _____ Primary Income Source (SSI, SSDI, ADC, Other): _____

Payment Source: Self Pay ___ Insurance ___ Medicaid ___ Special Medical Card _____

Medicaid # and State it is through: _____

Name of Insurance Company: _____

Insured's Name: _____ Insured's Employer: _____

Member ID: _____ Group #: _____

Claims Address: _____

Telephone # off the back of Insurance Card (for provider to obtain benefits): _____

IF POSSIBLE PLEASE ATTACH A COPY OF ANY INSURANCE CARD OR MEDICAID CARD

Please check one of the following:

- I **DO** give verbal permission for Prestera Center to call my insurance company to verify that I have benefits that will pay for part of my service while in treatment.
- I **DO NOT** give Prestera Center permission to call my insurance company to verify that I have benefits that will pay for part of my service while in treatment.

If you are self pay, you must bring verification of income (Pay Stub, Tax Return, Ect...something that shows income) at the time of admission. If you do not have a source of income, you must bring an affidavit stating that you do not have income at the time of admission. You may qualify for a fee reduction based on the information provided. If you do not bring this information with you, you may not be admitted.

IF YOU HAVE INSURANCE OR A MEDICAL CARD YOU MUST BRING YOUR CARDS WITH YOU AND PRESENT THEM UPON ADMISSION.

Do you have any pending legal charges? Yes _____ No _____ If yes, please explain what they are and give any court dates. State source of information: _____

Are you currently on Probation/Parole? Yes _____ No _____ If yes, list where, reason, and the name and Number of Parole/Probation officer: _____

In the last six months, what is the longest period of time you have gone without using alcohol or other drugs: _____

Have you used a needle for drug use in the last six months? Yes _____ No _____
 Are you currently using or do you have a history of IV drug use? Yes _____ No _____

Are you currently receiving treatment for addiction or psychiatric conditions? Yes _____ No _____
 If Yes, where and for what _____

List any current psychiatric problems such as anxiety, depression, mood swings, hallucinations, etc _____

Previous Treatment for **Addiction**: (Please describe type such as Outpatient, In-Patient, Residential, and Intensive Outpatient):

When	Type	Program Name	Length of Stay

Previous Treatment for **Psychiatric Conditions**: (Outpatient, In-Patient, Residential):

When	Type	Program Name	Length of Stay

Are you able to walk and take care of your personal hygiene without assistance? Yes _____ No _____

Do you smoke cigarettes? Yes _____ No _____ Use smokeless tobacco? Yes _____ No _____

Are you currently experiencing any of the following? (Some may need stabilized prior to admission)

- | | | | | |
|--|---------------------------------------|--|---|--|
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Insulin/Diabetes |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Liver Failure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Internal Bleeding | <input type="checkbox"/> Stroke | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Vomiting Blood | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure |

Other Health Problems: _____

If you noted any health issues you are currently experiencing above, please explain: _____

Name, address, and phone number of your physician (if you have one): _____

List any medical appointments you have within the next four (4) weeks. Give date, time, and with whom the appointment is with: _____

Medication currently used: Include those prescribed regularly (including those you do not take but should), and any taken within the last 24 hours, include those recently given in the ER, and/or over the counter illegal drugs:

Name of Medication	Amount & Time Taken	Prescribed By	Currently Taking? If no, why?

Substance Use History for the Last TWO (2) Months: (Check drug used, circle frequency, list amount/date of last use)

DRUG (Put a * beside drug(s) of choice)	Frequency (Please circle one (1) option)	Date Last Used	Amount Last Used
Benzodiazepines (Valium, Xanax, Ativan, Ect.)	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Marijuana	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Cocaine/Crack	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Heroin	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
PCP	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
LSD	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Amphetamines (Speed)	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Barbiturates (Downers)	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Inhalants	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Opiates (Pain Killers)	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Methadone/Suboxone	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Alcohol	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Other (Please write in):	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		

Have you ever attempted suicide or tried to hurt yourself? Yes _____ No _____

If Yes, List dates and methods: _____

Have you ever been violent towards others? Yes _____ No _____ If yes, explain: _____

Do you currently have an open CPS case? Yes _____ No _____ If yes, in what county: _____

Who is your worker? _____ Phone Number: _____

Additional Comments: _____

Mattie V Lee/Renaissance Applicant's Only

Number of Dependent Children: _____

Child's Name	Age	Gender	Admitted with You? (circle)	
		M F	YES	NO
		M F	YES	NO
		M F	YES	NO
		M F	YES	NO

Where do your children live now? _____

Is this a safe environment? Yes _____ No _____ If no, explain. _____

Thank you for your interest in our program,
we will review your referral and get back with you within the next 1-3 business days.

Presteria-- Cabell County

Pinecrest - 24 Beds Male/ Female
1420 Washington Avenue
Huntington, WV 25704

Contact: Leslie Varble - 304-525-7851 Ext 5321 Fax: 304-525-1743 (ext.
5310 (front desk) 2543 (@ night)

NOTES: This program wants you to call every day to check on bed availability. If you don't after a week you will not be on the active list.



PRESTERA CENTER FOR MENTAL HEALTH SERVICES
SUBSTANCE ABUSE RESIDENTIAL PROGRAM REFERRAL FORM

All Prestera substance abuse residential programs are listed below with a brief descriptor, fax number and email contact for referral information. Please send referrals to the fax numbers or emails indicated below. All emails are the name indicated below followed by @prestera.org.

Riverside Short Term Men 304-722-1795 Ronald.Jackson Fax: 304-727-5887	Pinecrest Short Term Men & Women 304-525-7851x1124 Leslie.Varble Fax:304-525-2040	Mattie V Lee Long Term Women & Children 304-344-1827 Samantha.Nooney Fax:304-344-1828	Renaissance Long Term Women & Children 304-525-7851x2552 Theresa.Jackson Fax:304-697-1280	Laurelwood Charleston Long Term Men 304-768-6119 Amanda Cruz Fax:304-768-7286	Laurelwood Huntington Long Term Men 304-399-1029 Scott.Harrison Fax:304-525-5250
---	--	--	--	--	---

Name of person making referral: _____ Telephone#: _____
 E-Mail Address _____ Date: _____

CLIENT NAME: _____ **Date of Birth:** _____

SS# _____ Gender: Male ___ Female: ___ Telephone#: _____

Address: _____

County: _____ Race: _____

Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___

Number of minor children living with the client: _____

Education: Highest Grade Completed (GED, HS Graduate, College, Trade School): _____

Employed ___; Employer _____ Unemployed ___ Disabled ___ Retired ___

Monthly Family Income: _____ Primary Income Source (SSI, SSDI, ADC, Other): _____

Payment Source: Self Pay ___ Insurance ___ Medicaid ___ Special Medical Card ___

Medicaid # and State it is through: _____

Name of Insurance Company: _____

Insured's Name: _____ Insured's Employer: _____

Member ID: _____ Group #: _____

Claims Address: _____

Telephone # off the back of Insurance Card (for provider to obtain benefits): _____

IF POSSIBLE PLEASE ATTACH A COPY OF ANY INSURANCE CARD OR MEDICAID CARD

Please check one of the following:

- I **DO** give verbal permission for Prestera Center to call my insurance company to verify that I have benefits that will pay for part of my service while in treatment.
- I **DO NOT** give Prestera Center permission to call my insurance company to verify that I have benefits that will pay for part of my service while in treatment.

If you are self pay, you must bring verification of income (Pay Stub, Tax Return, Ect...something that shows income) at the time of admission. If you do not have a source of income, you must bring an affidavit stating that you do not have income at the time of admission. You may qualify for a fee reduction based on the information provided. If you do not bring this information with you, you may not be admitted.

IF YOU HAVE INSURANCE OR A MEDICAL CARD YOU MUST BRING YOUR CARDS WITH YOU AND PRESENT THEM UPON ADMISSION.

Do you have any pending legal charges? Yes _____ No _____ If yes, please explain what they are and give any court dates. State source of information: _____

Are you currently on Probation/Parole? Yes _____ No _____ If yes, list where, reason, and the name and Number of Parole/Probation officer: _____

In the last six months, what is the longest period of time you have gone without using alcohol or other drugs: _____

Have you used a needle for drug use in the last six months? Yes _____ No _____
 Are you currently using or do you have a history of IV drug use? Yes _____ No _____

Are you currently receiving treatment for addiction or psychiatric conditions? Yes _____ No _____
 If Yes, where and for what _____

List any current psychiatric problems such as anxiety, depression, mood swings, hallucinations, etc _____

Previous Treatment for **Addiction**: (Please describe type such as Outpatient, In-Patient, Residential, and Intensive Outpatient):

When	Type	Program Name	Length of Stay

Previous Treatment for **Psychiatric Conditions**: (Outpatient, In-Patient, Residential):

When	Type	Program Name	Length of Stay

Are you able to walk and take care of your personal hygiene without assistance? Yes _____ No _____

Do you smoke cigarettes? Yes _____ No _____ Use smokeless tobacco? Yes _____ No _____

Are you currently experiencing any of the following? (Some may need stabilized prior to admission)

- | | | | | |
|--|---------------------------------------|--|---|--|
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Insulin/Diabetes |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Liver Failure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Internal Bleeding | <input type="checkbox"/> Stroke | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Vomiting Blood | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure |

Other Health Problems: _____

If you noted any health issues you are currently experiencing above, please explain: _____

Name, address, and phone number of your physician (if you have one): _____

List any medical appointments you have within the next four (4) weeks. Give date, time, and with whom the appointment is with: _____

Medication currently used: Include those prescribed regularly (including those you do not take but should), and any taken within the last 24 hours, include those recently given in the ER, and/or over the counter illegal drugs:

Name of Medication	Amount & Time Taken	Prescribed By	Currently Taking? If no, why?

Substance Use History for the Last TWO (2) Months: (Check drug used, circle frequency, list amount/date of last use)

DRUG (Put a * beside drug(s) of choice)	Frequency (Please circle one (1) option)	Date Last Used	Amount Last Used
Benzodiazepines (Valium, Xanax, Ativan, Ect.)	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Marijuana	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Cocaine/Crack	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Heroin	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
PCP	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
LSD	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Amphetamines (Speed)	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Barbiturates (Downers)	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Inhalants	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Opiates (Pain Killers)	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Methadone/Suboxone	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Alcohol	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		
Other (Please write in):	<u>Daily</u> <u>3-5x/week</u> <u>1-8x/month</u> <u>Less than 1x/month</u>		

Have you ever attempted suicide or tried to hurt yourself? Yes _____ No _____

If Yes, List dates and methods: _____

Have you ever been violent towards others? Yes _____ No _____ If yes, explain: _____

Do you currently have an open CPS case? Yes _____ No _____ If yes, in what county: _____

Who is your worker? _____ Phone Number: _____

Additional Comments: _____

Mattie V Lee/Renaissance Applicant's Only

Number of Dependent Children: _____

Child's Name	Age	Gender	Admitted with You? (circle)	
		M F	YES	NO
		M F	YES	NO
		M F	YES	NO
		M F	YES	NO

Where do your children live now? _____

Is this a safe environment? Yes _____ No _____ If no, explain. _____

Thank you for your interest in our program,
we will review your referral and get back with you within the next 1-3 business days.

Southern Highlands—Princeton in Mercer County

Legends - 10 Beds Male Only
12th Street Extension
Princeton, WV 24640

Contact: Matt Huffman - 304-425-9489 Fax: 304-487-3984

NOTES: Must fill out application. Meet every Wednesday to decide if the applicate is appropriate for their program or not. Will call to advice if accepted on Wednesday and will send letter.

L. E. G. E. N. D. S
All Male 28 Day Program

"Learning, Enjoying, Growing, Evolving,
Nurturing, Doing, and Succeeding".



W.A.V.E.S

All Female 28 Day Program

"Women Achieving Values, Esteem, and
Sobriety"

Substance Abuse Residential Consumer Referral Form

Date Referral is being made: _____

Name of person making referral: _____ Agency: _____

Address of person making referral: _____

Relationship to applicant: _____ Phone: _____ Fax: _____

Applicant's name: _____ Age: ____ Date of Birth: _____ Gender: M / F

Applicants Home Address: _____

Current address if differs from home address: _____

Applicants phone number: _____ Marital Status: M S W D Sep.

Social Security Number: _____ - _____ - _____

Type of admission: Voluntary Court Ordered * Please be aware this is not a locked facility, consumer may leave at any time*

Applicants Emergency Contact: _____ Relation: _____

Emergency Contact Phone Number: _____

Does the applicant have health coverage: Yes No

If yes, what type of health coverage? Private Insurance Medicare Traditional Medicaid

MCO Aetna MCO Beacon MCO The Health Plan MCO Unicare

IT IS PREFERRED THE APPLICANT COMPLETE THE FOLLOWING PAGES. IF FOR ANY REASON THE APPLICANT CANNOT COMPLETE THIS APPLICATION, A REPRESENTATIVE MAY COMPLETE THE APPLICATION PREFERABLY WITH THE APPLICANT PRESENT IN ORDER TO PROVIDE ACCURATE INFORMATION.

Why are you seeking treatment? _____

What type of treatment are you seeking?

Abstinence treatment, Suboxone Treatment, Vivitrol Treatment

Please note at this time LEGENDS does not provide Suboxone treatment

Please describe you substance use background for the past six months. Check drugs used indicating drugs of choice with an additional star, circle how often you used, list the amount and date of last use.

SUBSTANCE USE	FREQUENCY				AMOUNT	DATE OF LAST USE
	<i>Please circle correct frequency.</i>					
Alcohol	Daily	3-5 times week	1-8 times month	Less than once per month		
Marijuana	Daily	3-5 times week	1-8 times month	Less than once per month		
Cocaine	Daily	3-5 times week	1-8 times month	Less than once per month		
Heroin	Daily	3-5 times week	1-8 times month	Less than once per month		
Opioids	Daily	3-5 times week	1-8 times month	Less than once per month		
PCP	Daily	3-5 times week	1-8 times month	Less than once per month		
LSD	Daily	3-5 times week	1-8 times month	Less than once per month		
Amphetamines	Daily	3-5 times week	1-8 times month	Less than once per month		
Benzodiazepines	Daily	3-5 times week	1-8 times month	Less than once per month		
Barbiturates	Daily	3-5 times week	1-8 times month	Less than once per month		
Inhalants	Daily	3-5 times week	1-8 times month	Less than once per month		
Other (specify)	Daily	3-5 times week	1-8 times month	Less than once per month		

What has been your longest period of abstinence in the past six months? _____

Have you used IV in the past six months? ___Yes ___ No

Have you ever been treated at LEGENDS or WAVES before? If yes when _____

Do you have family members currently being treated at LEGENDS and/or WAVES? ___ Yes ___ No

Residents of LEGENDS/WAVES are required to complete daily written and reading assignments in group and homework individually; therefore, our residents are required to be able to read and write on at least an 8th grade level.

Are you capable of performing these tasks? ___Yes ___ No

What was the last grade of school completed? _____

Pregnancy

(Females only)

Are you on any forms of contraceptives ___Yes ___ No

If yes, specify what kind and how long: _____

Are you pregnant? ___Yes ___No First day of last menstrual cycle _____

If yes what is your expected due date? _____ Who is your treating physician? _____

Treating Physician Phone Number: _____ Address: _____

****Please note that any female that is pregnant requires a letter or statement from their physician stating they are medically cleared to attend treatment. All females will be given a pregnancy test upon admission****

Medical

Have you ever been diagnosed with any of the following conditions?

Please check all that apply. Please ensure to specify the physician treating the condition as well as any limitations.

✓	Condition	Physician	Comments
	High Blood Pressure		
	Difficulty Walking		
	Cirrhosis		
	GI Bleeding		
	Hepatitis		
	Coronary Artery Disease		
	Renal Failure		
	Liver Disease		
	Seizure Disorder		
	Blood Clots		
	Pancreatitis		
	Diabetes		
	Heart Problems		
	Inability to take oral medications		
	Tuberculosis		
	Breathing Problems		
	Headaches		
	Any other medical concerns		
	Teeth issues		

Please list any other medical provider(s) not listed:

Have you ever been hospitalized for any of the above medical conditions? ___ Yes ___ No

If yes, which conditions and when? _____

What medications are you currently taking? Please list all below.

If admitted to LEGENDS or WAVES you must bring a 28-day supply of medications or refills for medications. You will not be transported to a doctor for any medication that you require on a daily basis. Controlled substances are not permitted. A physician must prescribe all medications. No OTC drugs are allowed unless a prescription is provided.

LEGAL

Are you facing legal charges? YES NO if yes, Note charges and give any upcoming court dates.

****Please note that LEGENDS and WAVES will not transport consumers to court dates while enrolled in the program****

Will you have to return to custody of the legal system? YES NO if yes, give name and telephone numbers of all persons who must be contacted prior to discharge. Please list weekend and holiday contact information as well.

Are you currently on probation or parole? YES NO If yes, list where, reason, and contact information for PO.

Mental Health

Have you ever been treated for any mental health conditions (depression, anxiety, bipolar, etc.) other than addiction? YES NO if Yes what type of mental health condition.

Have you ever been hospitalized for any mental health condition other than addiction? YES NO If yes, where, when, and was it a mental hygiene?

Do you have a history of suicide attempts or self-harm? YES NO If yes, list date and method.

Do you have a history of violence towards others? YES NO if yes, explain

Have you experienced auditory or visual hallucinations? YES NO If yes, how frequent and are they related to your mental health problem.

Substance Use Related

When you have stopped using or drinking the past, have you experienced any of the following withdrawal symptoms?

- Tremors Delirium Tremors Hallucinations Insomnia Seizures Sweats
 Agitation Irritability Nausea/Vomiting Mood Swings Black Outs Muscle Aches

Have you ever been in treatment for detox? YES NO If yes, where and when?

Have you ever received outpatient substance abuse treatment, this includes Methadone, Vivitrol, and Suboxone treatment.

YES NO. If yes, where, when, and how long were you clean after completing treatment?

Have you ever been in an inpatient rehabilitation facility? YES NO If yes, where, when, and how long were you clean after completing treatment?

Have you ever attended AA/NA or other recovery support groups? YES NO If yes, where and when?

- LEGENDS and WAVES are not medical facilities
- Please note that all applications must pass a drug screen and breathalyzer at the time of INTAKE; therefore, detox must occur prior to being admitted.
- During your stay at LEGENDS and WAVES, no passes or visitation (other than legal representatives) will be granted.

You have now completed the application portion of our referral process. Please verify that all areas have been answered to the best of your Knowledge. If areas have been left blank, this could delay approval and placement on our waiting list.

All applicants will receive a letter or phone call in regards to their application status.

Please maintain weekly contact (if applicable) to inquire about your application/waitlist status. Note legal representatives can maintain your waitlist status. If accepted into another treatment facility please let LEGENDS and/or WAVES know to remove you from the waitlist.

Applicants Signature: _____ Date: _____

If you aided applicant in completing this application please sign below

_____ Date: _____

Relation: _____

Items allowed

Valley Healthcare systems ACT Unit

5 pairs of Jeans or Pants

5 shirts (no spaghetti straps, tanks or wife beaters)

7 undergarments, socks and Bras

3 Pajama Outfits

1 Coat

1 Hoodie

2 Pairs of shoes (may also bring shower shoes) *Please keep note that the ACT Unit may take walks during recreation activity*

1 Pocket Book

Prescribed medication and OTC medication must have a Doctors order and must arrive to the unit with a 30 day supply plus refill. *A Doctors order consists of the medication dosage and directions for use*.

Smoking is permitted during free time and during breaks from group during the day. Smoke breaks of an evening are scheduled on the hour with staff present after 5pm. *a 30 day supply of tobacco products is required upon admission*

Insurance card/ID and paystubs if working.

Stamps and envelopes

Breakfast, lunch and dinner are provided. You may bring unopened snacks and beverages. This must be kept at a minimum.

Makeup and cosmetics must be limited to one cosmetic bag.

No suitcases, totes, Duffel bags bring all belongings in trash bags.

\$10.00 for Soda machine

Waves through Southern Highland for Women- Beckley

8 Beds

611 Shannon Drive
Bluefield WV 24701

304-800-4847

NOTES: Will take pregnant women but it depends on how far along they are.

L. E. G. E. N. D. S
All Male 28 Day Program

"Learning, Enjoying, Growing, Evolving,
Nurturing, Doing, and Succeeding".



W.A.V.E.S

All Female 28 Day Program

"Women Achieving Values, Esteem, and
Sobriety"

Substance Abuse Residential Consumer Referral Form

Date Referral is being made: _____

Name of person making referral: _____ Agency: _____

Address of person making referral: _____

Relationship to applicant: _____ Phone: _____ Fax: _____

Applicant's name: _____ Age: ____ Date of Birth: _____ Gender: M / F

Applicants Home Address: _____

Current address if differs from home address: _____

Applicants phone number: _____ Marital Status: M S W D Sep.

Social Security Number: _____ - _____ - _____

Type of admission: Voluntary Court Ordered * Please be aware this is not a locked facility, consumer may leave at any time*

Applicants Emergency Contact: _____ Relation: _____

Emergency Contact Phone Number: _____

Does the applicant have health coverage: Yes No

If yes, what type of health coverage? Private Insurance Medicare Traditional Medicaid

MCO Aetna MCO Beacon MCO The Health Plan MCO Unicare

IT IS PREFERRED THE APPLICANT COMPLETE THE FOLLOWING PAGES. IF FOR ANY REASON THE APPLICANT CANNOT COMPLETE THIS APPLICATION, A REPRESENTATIVE MAY COMPLETE THE APPLICATION PREFERABLY WITH THE APPLICANT PRESENT IN ORDER TO PROVIDE ACCURATE INFORMATION.

Why are you seeking treatment? _____

What type of treatment are you seeking?

Abstinence treatment, Suboxone Treatment, Vivitrol Treatment

Please note at this time LEGENDS does not provide Suboxone treatment

Please describe you substance use background for the past six months. Check drugs used indicating drugs of choice with an additional star, circle how often you used, list the amount and date of last use.

SUBSTANCE USE	FREQUENCY				AMOUNT	DATE OF LAST USE
	<i>Please circle correct frequency.</i>					
Alcohol	Daily	3-5 times week	1-8 times month	Less than once per month		
Marijuana	Daily	3-5 times week	1-8 times month	Less than once per month		
Cocaine	Daily	3-5 times week	1-8 times month	Less than once per month		
Heroin	Daily	3-5 times week	1-8 times month	Less than once per month		
Opioids	Daily	3-5 times week	1-8 times month	Less than once per month		
PCP	Daily	3-5 times week	1-8 times month	Less than once per month		
LSD	Daily	3-5 times week	1-8 times month	Less than once per month		
Amphetamines	Daily	3-5 times week	1-8 times month	Less than once per month		
Benzodiazepines	Daily	3-5 times week	1-8 times month	Less than once per month		
Barbiturates	Daily	3-5 times week	1-8 times month	Less than once per month		
Inhalants	Daily	3-5 times week	1-8 times month	Less than once per month		
Other (specify)	Daily	3-5 times week	1-8 times month	Less than once per month		

What has been your longest period of abstinence in the past six months? _____

Have you used IV in the past six months? ___Yes ___ No

Have you ever been treated at LEGENDS or WAVES before? If yes when _____

Do you have family members currently being treated at LEGENDS and/or WAVES? ___ Yes ___ No

Residents of LEGENDS/WAVES are required to complete daily written and reading assignments in group and homework individually; therefore, our residents are required to be able to read and write on at least an 8th grade level.

Are you capable of performing these tasks? ___Yes ___ No

What was the last grade of school completed? _____

Pregnancy

(Females only)

Are you on any forms of contraceptives ___Yes ___ No

If yes, specify what kind and how long: _____

Are you pregnant? ___Yes ___No First day of last menstrual cycle _____

If yes what is your expected due date? _____ Who is your treating physician? _____

Treating Physician Phone Number: _____ Address: _____

****Please note that any female that is pregnant requires a letter or statement from their physician stating they are medically cleared to attend treatment. All females will be given a pregnancy test upon admission****

Medical

Have you ever been diagnosed with any of the following conditions?

Please check all that apply. Please ensure to specify the physician treating the condition as well as any limitations.

✓	Condition	Physician	Comments
	High Blood Pressure		
	Difficulty Walking		
	Cirrhosis		
	GI Bleeding		
	Hepatitis		
	Coronary Artery Disease		
	Renal Failure		
	Liver Disease		
	Seizure Disorder		
	Blood Clots		
	Pancreatitis		
	Diabetes		
	Heart Problems		
	Inability to take oral medications		
	Tuberculosis		
	Breathing Problems		
	Headaches		
	Any other medical concerns		
	Teeth issues		

Please list any other medical provider(s) not listed:

Have you ever been hospitalized for any of the above medical conditions? ___Yes ___ No

If yes, which conditions and when? _____

What medications are you currently taking? Please list all below.

If admitted to LEGENDS or WAVES you must bring a 28-day supply of medications or refills for medications. You will not be transported to a doctor for any medication that you require on a daily basis. Controlled substances are not permitted. A physician must prescribe all medications. No OTC drugs are allowed unless a prescription is provided.

LEGAL

Are you facing legal charges? YES NO if yes, Note charges and give any upcoming court dates.

****Please note that LEGENDS and WAVES will not transport consumers to court dates while enrolled in the program****

Will you have to return to custody of the legal system? YES NO if yes, give name and telephone numbers of all persons who must be contacted prior to discharge. Please list weekend and holiday contact information as well.

Are you currently on probation or parole? YES NO If yes, list where, reason, and contact information for PO.

Mental Health

Have you ever been treated for any mental health conditions (depression, anxiety, bipolar, etc.) other than addiction? YES NO if Yes what type of mental health condition.

Have you ever been hospitalized for any mental health condition other than addiction? YES NO
If yes, where, when, and was it a mental hygiene?

Do you have a history of suicide attempts or self-harm? YES NO If yes, list date and method.

Do you have a history of violence towards others? YES NO if yes, explain

Have you experienced auditory or visual hallucinations? YES NO If yes, how frequent and are they related to your mental health problem.

Substance Use Related

When you have stopped using or drinking the past, have you experienced any of the following withdrawal symptoms?

- Tremors Delirium Tremors Hallucinations Insomnia Seizures Sweats
 Agitation Irritability Nausea/Vomiting Mood Swings Black Outs Muscle Aches

Have you ever been in treatment for detox? YES NO If yes, where and when?

Have you ever received outpatient substance abuse treatment, this includes Methadone, Vivitrol, and Suboxone treatment.

YES NO. If yes, where, when, and how long were you clean after completing treatment?

Have you ever been in an inpatient rehabilitation facility? YES NO If yes, where, when, and how long were you clean after completing treatment?

Have you ever attended AA/NA or other recovery support groups? YES NO If yes, where and when?

- LEGENDS and WAVES are not medical facilities
- Please note that all applications must pass a drug screen and breathalyzer at the time of INTAKE; therefore, detox must occur prior to being admitted.
- During your stay at LEGENDS and WAVES, no passes or visitation (other than legal representatives) will be granted.

You have now completed the application portion of our referral process. Please verify that all areas have been answered to the best of your Knowledge. If areas have been left blank, this could delay approval and placement on our waiting list.

All applicants will receive a letter or phone call in regards to their application status.

Please maintain weekly contact (if applicable) to inquire about your application/waitlist status. Note legal representatives can maintain your waitlist status. If accepted into another treatment facility please let LEGENDS and/or WAVES know to remove you from the waitlist.

Applicants Signature: _____ Date: _____

If you aided applicant in completing this application please sign below

_____ Date: _____

Relation: _____

Items allowed

Valley Healthcare systems ACT Unit

5 pairs of Jeans or Pants

5 shirts (no spaghetti straps, tanks or wife beaters)

7 undergarments, socks and Bras

3 Pajama Outfits

1 Coat

1 Hoodie

2 Pairs of shoes (may also bring shower shoes) *Please keep note that the ACT Unit may take walks during recreation activity*

1 Pocket Book

Prescribed medication and OTC medication must have a Doctors order and must arrive to the unit with a 30 day supply plus refill. *A Doctors order consists of the medication dosage and directions for use*.

Smoking is permitted during free time and during breaks from group during the day. Smoke breaks of an evening are scheduled on the hour with staff present after 5pm. *a 30 day supply of tobacco products is required upon admission*

Insurance card/ID and paystubs if working.

Stamps and envelopes

Breakfast, lunch and dinner are provided. You may bring unopened snacks and beverages. This must be kept at a minimum.

Makeup and cosmetics must be limited to one cosmetic bag.

No suitcases, totes, Duffel bags bring all belongings in trash bags.

\$10.00 for Soda machine

Logan/ Mingo Mental Health—Logan County

Anchor Point - 12 Beds Male/Female
On Lando Campus (Does not have a Physical address)
Just outside of Delbarton

Amanda or Josh - 304-475-3366 Fax: 304-475-3368

NOTES: The treatment program will not accept any Coventry Insurance by Medicaid.

**LOGAN-MINGO AREA MENTAL HEALTH
RESIDENTIAL SUBSTANCE ABUSE REFERRAL TO:**

**ANCHOR POINT RESIDENTIAL TREATMENT CENTER
P.O. BOX 176
LOGAN WV 25670**

PHONE: 304-475-3366

FAX: 304-475-3368

Name of person making referral: _____ Telephone# _____

E-Mail address: _____ Date: _____

Consumer Name: _____ Date of Birth: _____

Soc. Sec.# _____ Race: _____ Telephone# _____

Address: _____

County: _____ Marital Status: Single ___ Married ___ Divorced ___ Widower ___

Number of minor children living with the consumer: _____ Veteran: Yes ___ No ___

Education: Highest Grade Completed (HS Graduate, GED, Collogo, etc.): _____

Employed: ___; Employer _____ Unemployed: ___ Disabled ___ Retired ___

Monthly Family Income: _____ Pimary Income Source (SSI, SSDI, Other): _____

Payment Source: Medicaid ___ Insurance ___ Self Pay ___ Other _____

Medicaid # _____

Name of Insurance Company: _____

Insured's Name: _____ Insured's Employer: _____

Member ID: _____ Group #: _____

Claims Address: _____

Telephone Number on back of Insurance Card (for provider to obtain benefits): _____

IF POSSIBLE PLEASE ATTACH A COPY OF MEDICAID OR INSURANCE CARD

Do you have any pending legal charges? Yes _____ No _____ If yes, please explain what they are and give any court dates. State source of information:

Are you currently on Probation/Parole? Yes _____ No _____ If yes, please list where, reason, and the name and number of Probation/Parole officer:

In the last six months, what is the longest period of time you have gone without using alcohol or other drugs: _____

Any history of IV drug use? Yes _____ No _____

Are you currently receiving treatment for addiction or psychiatric conditions? Yes _____ No _____

List any current psychiatric problems such as anxiety, depression, mood swings, hallucinations, etc: _____

Previous Treatment for Addiction:

When	Type	Program Name	Length of Stay

Previous Treatment for Psychiatric Conditions

When	Type	Program Name	Length of Stay

Are you able to walk and take care of your personal hygiene without assistance? Yes _____
 No _____

Do you use tobacco products? Yes _____ No _____

Are you currently experiencing any of the following? (Some need stabilized prior to admission)

Cirrhosis	Tuberculosis	Asthma	Chest Pain	Diabetes
Meningitis	Seizures	Pregnancy	Broken Bones	Kidney Failure
Liver Failure	Ulcers	Internal Bleeding	Stroke	Breathing Problems
Hepatitis	Pancreatitis	Vomiting Blood	Heart Problems	High Blood Pressure

Other Health Problems: _____

If you noted any health issues you are currently experiencing, please explain:

Name, address, and phone number of your physician (If you have one):

List any medical appointments you have within the next four (4) weeks. Give date, time, and with whom the appointment is with: _____

Medication currently used: Include those prescribed regularly (including those you do not take but should) and any taken within the last 24 hours, include those recently given in ER, and/or over the counter, and illegal drugs.

Name of Medication	Amount & Time taken	Prescribed by	Currently taking? If no, why?

Substance Use History for the last two (2) months: (Check drug used, circle frequency, list amount and date of last use.)

DRUG (Put a * beside drug(s) of Choice)	Frequency	Date Last Used	Amount Used
Benzodiazepines (Vallum, Xanax, etc.)	Daily 3-5x/week 1-8x/month Less than 1x/month		
Marijuana	Daily 3-5x/week 1-8x/month Less than 1x/month		
Cocaine/Crack	Daily 3-5x/week 1-8x/month Less than 1x/month		
Heroin	Daily 3-5x/week 1-8x/month Less than 1x/month		
PCP	Daily 3-5x/week 1-8x/month Less than 1x/month		
LSD	Daily 3-5x/week 1-8x/month Less than 1x/month		
Amphetamines (Speed)	Daily 3-5x/week 1-8x/month Less than 1x/month		
Barbiturates (Downers)	Daily 3-5x/week 1-8x/month Less than 1x/month		
Inhalants	Daily 3-5x/week 1-8x/month Less than 1x/month		
Opiates	Daily 3-5x/week 1-8x/month Less than 1x/month		
Methadone/Suboxone	Daily 3-5x/week 1-8x/month Less than 1x/month		
Alcohol	Daily 3-5x/week 1-8x/month Less than 1x/month		
Other (Write in)	Daily 3-5x/week 1-8x/month Less than 1x/month		

Have you ever attempted suicide or tried to hurt yourself? Yes _____ No _____

If Yes, list dates and methods: _____

Have you ever been violent towards others? Yes _____ No _____

If yes, explain: _____

Do you currently have an open CPS case? Yes _____ No _____

If yes, what county: _____ Who is your worker? _____

Phone number: _____

Are there any family members willing to be involved in treatment if client agrees?

Yes _____ No _____

If yes, give name, relationship, and phone number below.

Name	Relationship	Phone Number

Additional Comments:

St. Joseph's- Wood County

64 Beds Male/Female
1824 Murdoch Avenue
Parkersburg, WV 26101

304-916-1881, Monday - Friday 8:30am-6pm

NOTES: Application and medical clearance required. Will prescribe MAT, will do counseling and prescribe meds if needed. Accepts Medicaid and self-pay

Smoking: Yes Cell Phones: No
Visitation: Yes, after 7 days every Thursday and Saturday

SCREENING FORM

DATE: _____

Do you have difficulty with reading/writing? YES NO

PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB _____

SSN _____ Gender _____

Address _____

Phone Number _____ Ok to leave voice messages at this number? () Y () N

Best days/times to be reach the patient: _____

Insurance Provider(s) Names _____ Relationship: Self Spouse Dependent

Policy Holder Name: _____ Policy Holder DOB _____

Policy Holder SSN _____ Policy # _____ Group # _____

Is substance abuse treatment covered? ____ Yes ____ No/Unknown

Opiate and other substance use history (include current and past addiction/abuse of alcohol, prescriptions drugs and illegal drugs) and treatment history _____

Current & Past Medical History Current & Past Medical History (i.e., psychiatric diagnoses/admissions, DM, HTN, Schizophrenia, Autism, Unable to Perform Activities of Daily Living Without Assistance, etc.):

Current Medications: _____

Previous or Current (circle one) Employment _____

If no longer employed: Why? _____

Any Current or Past Legal Issues: (Current and Past Jail Time) _____

Probation Officer Name: _____ Phone # _____

County and State of Probation Officer: _____
County State

Person Completing Form _____ Patient Signature (If unable to sign write reason in place of signature)

(Circle one) ACCEPTED DENIED (Circle one) LEVEL 3.1 3.5 3.7



INTAKE INTERVIEW

NAME (LAST) _____ (FIRST) _____ (MI) _____

AGE _____ DATE OF BIRTH _____ GENDER (CIRCLE ONE) M F

Past Medical History _____

Family Medical History _____

Check any of the following diseases/ symptoms that you are experiencing or have experienced in the past:

- | | |
|--|--|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Bleeding Tendencies |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Tachycardia (pulse over 100) |
| <input type="checkbox"/> History of Blackout | <input type="checkbox"/> Weakness or numbness of limbs |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> DT's | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Cancer |

What prescription medications are you currently taking? _____

Allergies to Medications? _____

Any other allergies? _____

Past Surgeries and Hospitalizations _____

Suicide Attempts? (if yes, list mo. and yr.) _____ Overdose?(if yes, list mo. and yr.) _____

Family History

Marital Status: (circle one) Single Married Divorced Widowed Separated

Children? Yes or No Number of Children _____ Ages _____

Family History of Substance Abuse? _____

Family History of Alcohol Abuse? _____

History of Sexual Abuse? _____

History of Physical Abuse? _____

Education (circle one)

____ Grade Did not graduate High School High School Graduate
GED Some College College Graduate

Employment

Are you currently employed? (circle one) Yes No Place of Employment _____

Length of Employment _____ years Occupation _____

Military History

Are you a veteran or active military member? (circle one) Yes No If yes, list Branch of service _____

Substance Abuse History

Drug(s) of Choice: _____

How often do you use? _____ Method of Use?(smoke, snort, IV) _____

What age did abuse start? _____

Alcohol Use

Do you currently drink alcohol?(circle one) Yes No How often do you drink? _____ Amount? _____



Please mark the following as it relates to your drug and/or alcohol use

- Using 1 or more times weekly to intoxication
- Driving while impaired by drugs or alcohol
- Loss of family relationships
- Mood Swings
- Inability to set or follow limits of use
- Hangovers
- Using drugs or alcohol in a social setting
- Loss of friends
- Tolerance (needing more to get the same effect)
- Fights or conflicts
- Frequently using more than you planned
- Secretive Use
- Treatment Failure
- Giving up other activities to use
- Failure to meet family/work obligations
- Drug/alcohol related legal problems

Abstinence from Drugs and/or Alcohol

Have you ever tried to quit?(circle one) Yes No Longest period of Abstinence? _____

Have you ever been in treatment (NA, 12 Step, outpatient, residential, etc) _____

If yes, when and where? _____

Smoking

Do you smoke? (circle one) Yes No Have you ever tried to quit? (circle one) Yes No Packs per day _____

Legal History

Have you ever been arrested? Yes No Have you ever been convicted of a crime? Yes No

If yes, list convictions and time served _____

Probation officer name and address _____

By signing below, I attest that the information provided below is truthful and accurate, to the best of my knowledge.

Patient Name (print) _____ Date _____

Patient Signature _____

Form completed by: _____

What's My ACE Score?

Prior to your 18th birthday:

1. Did a parent or other adult in the household **often or very often** ...
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **often or very often** ...
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever** ...
Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes No If yes enter 1 _____
4. Did you **often or very often** feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____
5. Did you **often or very often** feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____
6. Was a biological parent **ever** lost to you through divorce, abandonment, or other reason?
Yes No If yes enter 1 _____
7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No If yes enter 1 _____
10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Patient Registration

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Birth Date: _____ Phone: _____ Work: _____ Fax: _____

Contact By: Phone Paper Fax Email Email: _____ Sex: M F

Marital Status: Single Married Divorced Widowed Separated Other SSN: _____

Race: Black Hispanic Native American Oriental/Asian White Other Language: _____

Chinese Filipino Native Hawaiian Multiracial Pacific Islander Japanese

Employment Status: Full-time Part-time Self-employed Retired Student Child Unemployed Other

Responsible Party (Party responsible for payment) : Self Spouse Parent Other

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Phone: _____ Work: _____ Fax: _____ Email: _____

Primary Insurance: _____

Insured Party: Self Spouse Parent Other Group #: _____ ID #: _____

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Phone: _____ Work: _____ Fax: _____

Secondary Insurance: _____

Insured Party: Self Spouse Parent Other Group #: _____ ID #: _____

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Phone: _____ Work: _____ Fax: _____

**St. Francis Addiction Healing Center Male and Female DETOX AND
REHAB**

Over the Phone Intake

4605 MacCorkle Avenue SW
Charleston, WV 25309

304-766-4526

Hope for Tomorrow- Mason County Male and Female

3471 Ohio River Road
Point Pleasant, WV

304-857-6494

Smoking: Yes

NOTES: MUST BE REFERRED TO BY A DOCTOR

Harmony Ridge- Male and Female DETOX AND REHAB

47 Chambers Circle
Walker, WV 26810

304-867-4098

NOTES: Does not provide mat/over the phone referral. Will take those on meth- case by case decision. Will take those pregnant up to the 2nd trimester.

Healthways-Ohio County

Miracles Happen Center - 10 beds Male

201 Edington Lane
Wheeling, WV 26003

304-242-0217

Healthways- Brook County

Miracles Blossom Center - 10 beds Female

2 Church Street
Beach Bottom, WV 26030

304-394-5507

WVU Medicine: Center for Hope and Healing- Morgantown

12 Bed Detox/ 30 Bed Rehab Male/Female

751 Benefactor Drive
Morgantown, WV 26501

304-974-3100

NOTES: This is a specialized program for recent overdose survivors and pregnant women. DETOX AND REHAB

WVU Medicine Center for Hope and Healing
general information and referral process

Thank you for your interest in WVU Medicine Center for Hope and Healing. This facility provides medically-monitored withdrawal management services and clinically-managed high intensity residential services, both of which are designed to treat moderate to severe substance use disorders. The length of stay for medically-monitored withdrawal management typically lasts between 3-7 days but is contingent on each individual's unique needs. The clinically-managed high intensity residential program is designed to last 28 days.

There are several criteria that each individual must meet in order to be eligible for both levels of care. These criteria are outlined below, and are adapted from the American Society of Addiction Medicine (ASAM) admission criteria for the level of care 3.7 (medically-monitored withdrawal management) and level of care 3.5 (clinically-managed medium/high intensity residential services).

Residential Adult Services with Withdrawal Management (level of care 3.7):

The goal of is to treat and resolve withdrawal symptoms that occur from discontinuation of substance use so client can improve chances of recovery in lower levels of care.

- Severe withdrawal that has been uncomplicated by significant medical occurrences, including delirium tremens, seizure activity, etc.
 - Demonstrated biomedical stability that does not require intensive medical monitoring or interventions
 - Client is unable to manage symptoms independently or without intensive treatment or support
-
-

- Moderate emotional/behavioral disruption that requires 24 hour support but does not require emergency intervention

Clinically-managed medium/high intensity residential services (level of care 3.5):

The goal of this level of care is to address the psychosocial component of substance use disorders in an effort to improve chances of recovery in lower levels of care.

- Minimal risk for withdrawal (withdrawal resolved in the medically-managed withdrawal management portion of WVU Medicine Center for Hope and Healing)
- Biomedical stability (with or without medication) without the need for intensive medical monitoring or intervention
- Impulse-control or personality issues that require intensive and highly-structured programming to influence and shape pro-recovery behavior
- Demonstrated difficulty in developing recovery skills in a lower level of care, as evidenced by ongoing unsafe or dangerous behavior associated with substance use
- Demonstrated lack of insight, motivation, or skills that prevent continued use or dangerous consequences of use in a lower level of care
- Demonstrated need for highly-structured environment in which to develop recovery skills

The referral process will begin by sending the attached referral form to WVU Medicine Center for Hope and Healing. You may also call WVU Medicine Center for Hope and Healing at 304-974-3100 with the referral information or fax the completed form to 304-974-3099. Once that information is collected, the treatment team will reach out for further information or to coordinate a bed date. If you have questions regarding the referral/admission process, please contact WVU Medicine Center for Hope and Healing and staff will assist you.

Thank you for considering WVU Medicine Center for Hope and Healing as a treatment provider. We look forward to working with you as we join together for a healthier community.

WVU Medicine Center for Hope and Healing

PRE-SCREENING AND REFERRAL FORM

Date: _____ Source of referral: _____

Name: _____ Age: _____ Date of Birth: _____

Complete Home address: _____ Phone: _____

Insurance Provider: _____ Insurance ID: _____

Emergency Contact Name: _____ Phone: _____

Reason for referral: _____

Substances Used:	Date of Last Use:	Route of Administration:	Frequency:
Street opioids (heroin, opium, etc.)			
Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], Methadone, buprenorphine, etc.)			
Methamphetamine (speed, crystal meth, ice, etc.)			
Amphetamine			
Benzodiazepines (Valium, Xanax, Klonopin, Ativan, etc.)			
Alcohol			
Tobacco (cigarettes, chewing tobacco, cigars, e-cigarettes, etc.)			
Cocaine			
Cannabis			
Prescription Stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)			
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)			
Other (gabapentin) – specify:			

Previous treatment for substance use (most recent date and setting): _____

Guest Items to bring List

5 weather appropriate outfits (no offensive logos, alcohol or drug related advertisements or related images)

No revealing clothing, low cut, holes higher than the thighs

5 pair of under garments

5 pair of socks

1 pair gym shoes

1 pair shower shoes

Hygiene products without alcohol (shampoo, conditioner, body wash, mouth wash, toothpaste)

Tooth brush

Hairbrush/comb

Home medications (Residential guests)

Glasses, dentures, hearing aids as applicable

Make up and hair styling items permitted

Home medications (residential)

Contraband List

The following items are not permitted in the hospital or on the unit. If found, they will be confiscated and secured, sent home, and/or destroyed. Items with an (*) may be used under staff supervision with the context of the program.

- ***Sprays:** Includes items such as hair spray, air fresheners, computer duster, etc.
- ***Metal containers:** such as Altoids cans, aluminum, steel
- **Drugs, alcohol, controlled substances, tobacco, tobacco products, vapes, etc.**
- **Drug paraphernalia**
- **Drug, gang, death/torture themed and/or offensive material:** This includes videos, magazine, pictures, clothing, jewelry, books, or CDs, etc.
- ***Glass:** includes but is not limited to cups, bottles and containers.
- ***Glue**
- ***Inhalants:** paint, correction fluid, shoe polish, etc.
- **Stuffed animals**
- **Hair dye**
- **Lighters or matches**
- ***Pins:** includes safety pins, straight pins, pushpins, or sewing/crocheting needles
- **Laundry Detergent**
- **Pornographic or sexually explicit materials:** this includes videos, magazines, pictures, clothing, jewelry, books, or CDs, etc.
- ***Scissors or sharp objects**
- **Weapons:** includes tools, knives, guns, and all "homemade" weapons, etc.
- ***Appliances, electrical devices:** headphones, computer/laptops without internet access
- ***Any hygiene items containing alcohol**
- ***Credit/ phone cards**
- **Wire hangers**
- **Over the counter medication:** includes Tylenol and Motrin, etc.
- **Bedding or towels**
- **Hair clippers**
- **Cameras**
- **Musical instruments**
- **Food**
- **Others items may be added at the discretion of the Treatment Team when clinically indicated.**

This list is not exhaustive of items that will be considered.

Contraband list for WVU Medicine Center for Hope and Healing

This list is not comprehensive, but serves as a guide for items you should not bring to treatment at WVU Medicine Center for Hope and Healing.

- Aerosol sprays of any kind
- Any toiletry that includes alcohol in its ingredient list
- Perfume/cologne
- Illicit drugs or paraphernalia
- Over the counter drugs
- Tobacco or nicotine products or paraphernalia
- Electronics of any kind
- Drug, gang, death/torture-themed or offensive material
- Glass or metal items/objects
- Glue or other inhalants
- Stuffed animals
- Bedding/towels
- Hair dye
- Laundry detergent/dryer sheets
- Pornography
- Weapons
- Credit cards
- Cameras or recording devices
- Musical instruments
- Food items, including drinks, candy, snacks, etc.
- Weapons
- Other items based on treatment staff discretion

WVU Medicine
Center for Hope and Healing
Guest Handbook

Withdrawal management unit

3/22/2019

WVU Medicine Center for Hope and Healing

WVU Hospitals and WVU Department of Behavioral Medicine and Psychiatry have created WVU Medicine Center for Hope and Healing to provide care to people who suffer from substance use disorders. The following descriptions provide information about the two levels of care offered in WVU Medicine Center for Hope and Healing.

Withdrawal management: WVU Medicine Center for Hope and Healing has an on-site medically monitored withdrawal management unit that will provide services to guests who are experiencing withdrawal from substances. The length of stay is individualized and is based on the unique needs and presentation of each guest. The guest will meet with a physician/physician extender, attend groups, peer recovery services, and psychoeducation throughout his or her stay in this level of care. The daily schedule can be found at the end of this document.

28-day residential treatment: Following successful completion of the medically-monitored withdrawal management unit, the guest will transition into the clinically-monitored high intensity residential unit. The residential unit will offer a variety of therapeutic, educational, and educational services that support developing and maintaining recovery by using a combination of psychosocial, addiction medicine, and peer recovery supports. Each guest will work with a treatment team to develop an individual treatment plan. Each guest will see a variety of professional staff that will address his or her unique needs. The daily schedule can be found at the end of this document.

Please use this handbook as a guide during your stay with WVU Medicine Center for Hope and Healing. If you have questions, please reach out to a member of your treatment team or any of the staff of WVU Medicine Center for Hope and Healing.

WVU Medicine Center for Hope and Healing looks forward to partnering with you as you develop your path to recovery.

Guest Rights in Treatment

1. The right to treatment and services that support a guest's liberty and result in positive outcomes to the maximum extent possible.
 2. The right to an individualized, written treatment plan to be developed promptly after admission, treatment based on the plan, periodic review and reassessment of needs, and appropriate revisions of the plan including a description of the services that may be needed for follow up.
 3. The right to treatment and services in the least restrictive, most appropriate, and potentially the most effective setting
 4. The right to an individualized treatment plan as defined under this rule
 5. The right to ongoing informed participation in the treatment plan process
 6. The right to refuse treatment at any time
 7. The right to legal representative when unable to act on his or her behalf
 8. The right to be free from involuntary experimentation
 9. The right to freedom from restraint and seclusion. Restraint and seclusion shall only be used in situations where there is imminent danger to the guest or others and all less restrictive methods of control have been used
 10. The right to a humane treatment environment in which personal dignity and self-esteem are promoted
 11. The right to confidentiality of records, as provided in this rule
 12. The right to access to his or her own guest records in accordance with state law
 13. The right to assert grievances, orally or in writing, with respect to the infringement of all rights, including the right to have all grievances considered in a fair, timely, and impartial procedure
 14. The right of access to an available advocate in order to understand, exercise, and protect his or her rights
 15. The right to be informed in advance of any charges for services
 16. The right to all available services without discrimination because of race, religion, color, sex, sexual orientation, disability age, national origin, or marital status
 17. The right to exercise his or her civil rights
 18. The right to referral, as appropriate, to other providers of behavioral health services
 19. The right to be free from physical, verbal, sexual, or psychological abuse or punishment
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20. The right to be free from unnecessary or excessive medication
 21. The right to medication that is not used as punishment, for the convenience of staff, or as a substitute for programming, or in quantities that interfere with the treatment program
 22. The right to be free from uncompensated labor, except for guests in residential facilities who perform housekeeping tasks
 23. The right to be informed orally, in writing and in appropriate language and terms of the rights described in this section. The right to be housed with guests of the same approximate ages, developmental levels, and social needs
 24. The right to unimpeded access to his or her attorney or religious advisor
 25. The right to constant access to his or personal possessions unless contraindicated by treatment needs
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Treatment guidelines and expectations

Daily living guidelines:

- I agree to refrain from using illicit substances, including alcohol, while in treatment.
- I agree not to have drug paraphernalia or drug ingredients in my possession while in treatment.
- I agree to refrain from participating in criminal activity or committing crimes while in treatment.
- I agree to behave respectfully toward other guests and staff. Verbal abuse, including profanity, negative, demeaning, disrespectful language directed toward others or intimidation of others is unacceptable and considered abuse of others. Verbal abuse of staff, others in the program, or other people can result in discharge.
- I agree to remain in my assigned bed between the hours of 11:00 pm and 5:00 am.
- I agree to be out of bed at the designated times (by 6:45 am on weekdays, 7:00 am on weekends and holidays), unless I have an approved bed-pass. I understand that I may wake up earlier to shower/prepare for the day if I wish.
- I agree not to return to bed until after dinner at 6:00 pm, unless I have an approved bed-pass.
- I agree to sign in and sign out of WVU Medicine Center for Hope and Healing every time I leave for any outing, including group, activities, passes, medical appointments, etc.
- I agree not to steal from other guests, staff, kitchen, closet, etc.
- I agree not to sell, buy, or trade anything from other guests or staff.
- I agree not to have any weapons, including (but not limited to) firearms, knives (pocket knives), pepper spray, etc.
- I understand that food or items ordered/delivered to CHH by myself or others will not be accepted and will be sent back.

Living space guidelines:

- I agree to keep my room neat at all times. This includes my bed, floors, window sills, closets, furniture, and the bathroom.
- I agree to only use my assigned space, I will not go into other bedrooms.
- I agree not to have food or drink in my living space at any time.
- I agree not to have pornographic material while in treatment.
- I agree not to use offensive, abusive, or obscene language or gestures.

- I agree to not use fire doors unless in the case of an emergency.
- Bedbug infestation is a potential issue at any residential provider. I agree to follow the guidelines listed below in an effort to minimize the risk of an infestation.
 - I agree not to have more than 7 changes of clothes.
 - I agree to have no more than 5 books brought from home.
 - I agree not to have food or drink in my room.
 - I agree to wash and dry my bed linens often.
 - I agree not to share or borrow items or products from other guests.
 - I agree not to bring additional clothing after I am admitted into treatment, and I will not exceed 7 changes of clothing while in treatment.

Daily Chores

I understand that a part of treatment involves taking care of myself and my living space. Below are chores that I will complete while in treatment.

- Do laundry as needed
- Change sheets every 3 days
- Make bed every morning
- Clean up room area daily
- Practice ADLs daily (shower, brush teeth, brush hair, put on clean clothes)
- Clean up personal trash (wrappers, empty cups, etc.)

Personal hygiene guidelines:

- I agree to have adequate personal hygiene, including brushing my teeth and showering daily, and be dressed and prepared for my scheduled breakfast.
 - I will keep my clothing neat and clean at all times. I agree to wear seasonally appropriate and tasteful clothing.
 - I agree to dress neatly and appropriately.
 - I agree to wear casual and comfortable clothing that fits and covers my body appropriately.
 - I agree not wear clothing that has pro-drug, alcohol, or tobacco messages, vulgar, or offensive language.
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- I agree to wear shoes at all times.
- I agree to not wear pajamas during the day. I will only wear pajamas at night.

Clinical/treatment guidelines:

- I understand that if I am deemed a danger to self or others, I will be referred to an alternate level of care.
- I understand that my treatment is determined by my progress or lack of progress made, and that I may be discharged to an alternative level of care.
- I understand that I am expected to participate in all treatment functions, and failure to do so may indicate that I am in the wrong level of care.
- I understand that the treatment team cannot disclose my status or protected health information to anyone without a release. If I want people to know where I am, I will communicate that independently.
- I agree to be prepared for all scheduled groups and appointments.
- I agree to maintain confidentiality – what is said in group stays in group and should not be discussed outside of group.
- I agree not to engage in cross-talk. I will allow one person to speak at a time.
- I agree to remain engaged during group by not coloring, writing letters, etc.
- I agree to come to group and scheduled activities on time.
- I agree to complete all assignments within the time frame assigned by my treatment staff.
- I understand that assignments that are due are my ticket into the group. I understand that if I did not complete my homework, I will not be permitted into group.
- I agree to clean up after myself.
- I agree to remain seated during group, unless I have to use the restroom and it is an emergency. Only one person is permitted to leave the group room at a time.
- I agree to use the restroom before group begins and will make an effort to limit leaving group to use the restroom.
- I am responsible to schedule and maintain individual sessions. Failure to do so may indicate that I require an alternative level of care.
- I am responsible to inform the treatment staff ahead of time and reschedule if I am unable to attend my individual sessions.

General policies and procedures

Search policy:

WVU Medicine Center for Hope and Healing strives to create a treatment environment that is safe for each guest, staff, and visitor. WVU Medicine Center for Hope and Healing will take every reasonable effort to prevent the presence of substances or other items that jeopardize safety and/or recovery efforts.

- I agree to allow staff members (RN/LPN) to thoroughly search my person in a respectful and safe manner.
- I agree to allow staff members to check my belongings, including my pockets, handbags, food containers, and all other items at the time I check into the facility.
- I also agree to regular, random searches of any or all of the above items/areas, whether I am present or not.
- I consent to random and frequent room inspections.
- I understand that if I do not cooperate with WVU Medicine Center for Hope and Healing and refuse to surrender contraband, the authorities will be contacted, and I may face legal consequences.

Contraband:

It is WVU Medicine Center for Hope and Healing's mission to create a safe and drug-free treatment environment. I agree to comply with the following guidelines regarding contraband (illicit drugs or paraphernalia). I understand that in order to ensure the safety of all guests in WVU Medicine Center for Hope and Healing, staff members need to ensure that every reasonable effort is being made to prevent the presence of substances or other items that jeopardize safety and/or recovery efforts.

- I will not knowingly bring contraband, including but not limited to illegal drugs, tobacco, lighters, over the counter drugs, weapons, cell phones, etc., onto WVU Medicine Center for Hope and Healing property. A more comprehensive list of unapproved items, or contraband, is attached to this Client Handbook.
 - If I do not cooperate with WVU Medicine Center for Hope and Healing staff and refuse to surrender illegal contraband, the authorities may be contacted and I may face legal consequences.
 - I agree to allow staff members and/or police officers to search my person, all my belongings, including my pockets, handbags, food containers, and all other items at the time I check into the facility. I also agree to regular, random searches of any or all of the above items/areas, whether I am present or not.
 - I consent to frequent room inspections.
 - I agree to turn in all medications, including over the counter medications, to nurse staff upon arrival at WVU Medicine Center for Hope and Healing. I understand that my medications will be kept in a locked box by nurse staff and will be dispensed at designated medication times.
 - I understand that any medications, including over the counter (OTC), must be kept with nurse staff in the medication room and cannot be kept in my room or on my person.
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Smoking on program property, in the program van, on program outings of any kind, or inside the facility—including, but not limited to, guest rooms, bathrooms, and all common areas—is prohibited at all times and can result in my discharge.

Property guidelines

I am permitted to have certain personal items (in limited quantities) while I am in treatment. These items are listed below. I understand that if I arrive to treatment with more items than permitted, the WVU Medicine Center for Hope and Healing will not be able to store these items. Regarding property, I understand the following:

Regarding property, I understand the following:

- Personal property that exceeds what is allowed on the approved items list will not be accepted. The personal property that is permitted includes:
 - 7 weather appropriate outfits (no offensive logos, alcohol or drug-related advertisements or related images)
 - No revealing clothing, low cut, holes higher than the thighs
 - 7 pair of under garments
 - 7 pair of socks
 - 1 pair gym shoes
 - 1 pair shower shoes
 - Hygiene products without alcohol (shampoo, conditioner, body wash, mouth wash, toothpaste, all non-aerosol)
 - Tooth brush
 - Hairbrush/comb
 - Glasses, dentures, hearing aids as applicable
 - Limited makeup and hair styling items (all alcohol free and non-aerosol)
 - Home medications or prescriptions (to be dispensed by nursing staff)
 - No more than \$50 cash (to be used in vending machines)
- Cell phones and wallets are not permitted on the treatment units and will be stored in a safe during my stay in treatment. I will not have access to these items until the end of my treatment stay.
- Illegal or drug-related items are not permitted on property and will not be stored on property.
- If I have an approved visit and I want my visitor to bring me items, I will complete the Property Drop-off Request Form (attached to the Client Handbook). If I do not have an approved Property Drop-off Request Form, the items brought will not be accepted.

Property Drop-off Procedure:

A property drop-off is permitted if a person in the community wishes to bring you items of personal property while you are in treatment. The items should not exceed the property guidelines described above. Below are the guidelines for property drop-off submission, approval, and implementation. Regarding Property Drop-off Procedure, I understand the following:

- In order to receive a property drop-off, I must first complete and submit a property drop-off by following the instructions on the Property Drop-off Request Form (attached to the Client Handbook). I understand that if I do

not follow procedure for a drop-off, my drop-off may be delayed.

- Property drop-offs must occur at the scheduled time, and only items approved by the treatment team will be permitted.
- Property drop-off must occur in the presence of a treatment team member and must occur as scheduled between 12p and 3:30p.
- Unapproved drop-offs will not be accepted.
- Food deliveries will not be accepted.

Violent/aggressive behavior, threats of violence, or creating an unsafe environment:

It is WVU Medicine Center for Hope and Healing's mission to create a safe environment in which guests can focus on recovery. Violent, aggressive, or abuse behavior compromise the safety of the unit, and the treatment environment for everyone.

- I understand that violence or threats of violence will not be tolerated while in treatment. This includes aggressive or threatening language, posturing, or other intimidating behavior.
- Acts of violence will result in immediate discharge of the program.
- Threats of violence or intimidating behavior can result in discharge of the program.

Drug Screen Policy:

While a guest at WVU Medicine Center for Hope and Healing, I agree to the following drug screen policy:

- I agree to submit to an initial and random urine drug screens throughout my stay at WVU Medicine Center for Hope and Healing.
 - It is the policy of WVU Medicine Center for Hope and Healing Program to discharge guests for dishonesty about drug use. We encourage you to be honest about drug use so that we can adapt treatment strategies to better support your healing and recovery. If a lab tested or on-site tested drug screen result detects the presence of an illicit substance, your treatment team will review options, which can result in treatment adjustment or possible referral to an alternative level of care.
 - In order to participate in treatment at WVU Medicine Center for Hope and Healing Program, staff must be able to conduct random **urine** drug testing of all participants. If a guest is unable or unwilling to provide a **valid** urine specimen for drug testing within a reasonable time, he or she may be referred to an alternative level of care.
 - Unless otherwise directed by staff, urine specimens are expected to be provided by the time posted on the days you are asked to screen. If you cannot/do not provide a non-diluted urine sample by deadline posted, the test will be considered illicit. A second failure to provide a suitable, non-diluted sample can result in a referral to an alternative level of care.
-

Regarding Protective Oversight:

I understand that in order to ensure the safety and security of the unit, the treatment staff will be providing protective oversight 24 hours a day, 7 days a week. Protective oversight is defined as consistent and thorough staff awareness at all times of client location and welfare, as well as the ability to intervene on behalf of the client in the event of an emergency or other unsafe situation.

Protective oversight can include frequent observations from staff, safety checks at least every thirty minutes, and general awareness of client location, function, and behavior.

- I understand that staff will be monitoring my behavior as a part of my treatment, and if I am engaging in unsafe inappropriate behavior, staff will redirect me
- I understand that if my behavior persists, the treatment team will address these issues with me in an attempt to assist me in adjusting my behavior
- I understand that if my behavior continues to be problematic, non-responsive to intervention, or unsafe, it may result in my discharge from WVU Medicine Center for Hope and Healing

Phone call procedures:

Connecting with safe and healthy family, friends, and community support is an integral part of my recovery. Below are the guidelines for phone use while in treatment.

- I understand that I will not be permitted to use the phone for the 72 hours of my stay at WVU Medicine Center for Hope and Healing. This allows me to focus on settling into treatment.
- I agree to not have a cell phone on my person or in my possession during my stay in treatment.
- I understand that each treatment unit will have time for phone use as listed on the daily schedule, and that this time is to be shared among all guests.
- I understand that I am permitted to have 10 minutes of phone time each day. I am responsible to manage myself in a way that is respectful and cooperative with other clients, and I agree to not use the phone beyond my allotted 10 minutes.
- I understand that other calls can be made with my therapist outside of these scheduled times if I feel it is important. This can be discussed with my therapist.
- I understand that if I demonstrate limited treatment progress, an inability to self-manage phone use, or create issues with others during phone times, my phone privileges may be interrupted.

Please refer back to policy regarding "Violent/aggressive behavior, threats of violence, or creating an unsafe environment"

Visit Policy and Procedure

Visits are a treatment tool that can be earned effective treatment participation in the residential component of the Center for Hope and Healing. Visits will not be permitted while you are engaged in withdrawal management component of your treatment at WVU Medicine Center for Hope and Healing.

Appointment Policy and Procedures

The following are guidelines regarding how to handle non-treatment appointments, such as meetings with parole/probation, court, medical appointments, etc. We understand that appointments will sometimes conflict with group and treatment activities. I agree to comply with the following guidelines so these appointments do not interfere with my treatment.

- I understand that all appointments should be scheduled before or after group time Monday through Friday. If I am unable to schedule the appointment outside of group time, I understand that it will lengthen my stay in treatment.
- I understand that I am responsible for making staff aware of my impending absence, if I have a scheduled appointment.
- I understand that I will need to make up any missed group or treatment functions if I am unable to attend due to a scheduled appointment.
- I understand that if I fail to notify staff of my absence, it will be considered a "no show." Failure to comply will result in a treatment team meeting to determine appropriateness for this level of care.

Exercise room

- I understand that I may use the exercise room during as indicated on the daily schedule
- I understand that protective oversight will be provided throughout the unit, including the exercise room
- I agree to use the equipment as intended
- I agree to notify staff if I begin to feel sick or over-extended due to exercise

WVU Medicine Center for Hope and Healing

Property Drop-off Request Form

I am requesting to have safe family or friend deliver items that I need during my stay in treatment.

- I have reviewed the property guidelines in my Client Handbook, and the items I am requesting comply with property guidelines.
- I understand that in order for my property request to be reviewed by staff, I must turn it into my primary counselor no later than 8:15 am. Property request forms turned in after this time will be reviewed on the following day.
- If my property drop-off request is approved, my property drop-off must occur between 12pm and 3:30pm. Property deliveries that occur outside of this time will not be accepted by staff.
- I understand that I am not to modify or deviate from the property drop-off listed on this form after the treatment team has approved it. I will follow up with staff to review the status of this request.

Name: _____

Date: _____

Name of person bringing property: _____

Relationship to person bringing property: _____

Date and time of delivery: _____

Incoming property (list each items in detail):

Treatment team approval date (include one staff signature): _____

3.5 Men's Weekly Schedule

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6:45AM	Lights On/ADLs/VS	Lights On/ADLs/VS	Lights On/ADLs/VS	Lights On/ADLs/VS	Lights On/ADLs/VS	Lights On/ADLs/VS	Lights On/ADLs/VS
7:30AM	Med Pass	Med Pass	Med Pass	Med Pass	Med Pass	Med Pass	Med Pass
8:00AM	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast
8:30AM	Free Time/Phone	Free Time/Phone	Free Time/Phone	Free Time/Phone	Free Time/Phone	Free Time/Phone	Free Time/Phone
8:50AM	Supportive Group(DA) (Ends at 9:50AM)	Supportive Group(DA) (Ends at 9:50AM)	Supportive Group(DA) (Ends at 9:50AM)	Supportive Group(DA) (Ends at 9:50AM)	Supportive Group(DA) (Ends at 9:50AM)	Supportive Group(DA) (Ends at 9:50AM)	Supportive Group(DA) (Ends at 9:50AM)
10:00AM	Group Psychotherapy (Therapist)	Group Psychotherapy (Therapist)	Group Psychotherapy (Therapist)	Group Psychotherapy (Therapist)	Group Psychotherapy (Therapist)	Group Psychotherapy (Therapist)	Group Psychotherapy (Therapist)
11:30AM	Individuals/Phone	Individuals/Phone	Individuals/Phone	Individuals/Phone	Individuals/Phone	Individuals/Phone	Individuals/Phone
12:30PM	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
1:15PM	Group Psychotherapy (Therapist)	Group Psychotherapy (Therapist)	Group Psychotherapy (Therapist)	Group Psychotherapy (Therapist)	Group Psychotherapy (Therapist)	Group Psychotherapy (Therapist)	Group Psychotherapy (Therapist)
2:45PM	Free Time/Phone	Free Time/Phone	Free Time/Phone	Free Time/Phone	Free Time/Phone	Free Time/Phone	Free Time/Phone
3:00PM	Family Visits/Coaching	Treatment Assignments/Chores/Phone					
3:30PM	Supportive Group Family visit if scheduled	Supportive Group(DA)					
4:30PM	Med Pass/Phone	Free Time/Phone					
5:00PM	Med Pass/Phone	Med Pass/Phone	Med Pass/Phone	Med Pass/Phone	Med Pass/Phone	Med Pass/Phone	Med Pass/Phone
5:30PM	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner
6:00PM	Phone Time	Phone Time	Phone Time	Phone Time	Phone Time	Phone Time	Phone Time
6:30PM	Therapeutic Activity	Therapeutic Activity	Therapeutic Activity	Therapeutic Activity	Therapeutic Activity	Therapeutic Activity	H&I/NA
7:00PM	Free Time	Free Time	Free Time	Free Time	Free Time	Free Time	Free Time/Phone
8:30PM	Wrap Up Group	Wrap Up Group	Wrap Up Group	Wrap Up Group	Wrap Up Group	Wrap Up Group	Wrap Up Group
8:45PM	Med Pass/Phone	Med Pass/Phone	Med Pass/Phone	Med Pass/Phone	Med Pass/Phone	Med Pass/Phone	Med Pass/Phone
9:15PM	Self-Care/Free Time	Self-Care/Free Time	Self-Care/Free Time	Self-Care/Free Time	Self-Care/Free Time	Self-Care/Free Time	Self-Care/Free Time
9:30PM	Lights Out	Lights Out	Lights Out	Lights Out	Lights Out	Lights Out	Lights Out
10:00PM							

WVU Medicine
Center for Hope and Healing
Guest Handbook

Residential Unit

3/22/2019

WVU Medicine Center for Hope and Healing

WVU Hospitals and WVU Department of Behavioral Medicine and Psychiatry have created WVU Medicine Center for Hope and Healing to provide care to people who suffer from substance use disorders. The following descriptions provide information about the two levels of care offered in WVU Medicine Center for Hope and Healing.

Withdrawal management: WVU Medicine Center for Hope and Healing has an on-site medically monitored withdrawal management unit that will provide services to guests who are experiencing withdrawal from substances. The length of stay is individualized and is based on the unique needs and presentation of each guest. The guest will meet with a physician/physician extender, attend groups, peer recovery services, and psychoeducation throughout his or her stay in this level of care. The daily schedule can be found at the end of this document.

28-day residential treatment: Following successful completion of the medically-monitored withdrawal management unit, the guest will transition into the clinically-monitored high intensity residential unit. The residential unit will offer a variety of therapeutic, educational, and educational services that support developing and maintaining recovery by using a combination of psychosocial, addiction medicine, and peer recovery supports. Each guest will work with a treatment team to develop an individual treatment plan. Each guest will see a variety of professional staff that will address his or her unique needs. The daily schedule can be found at the end of this document.

Please use this handbook as a guide during your stay with WVU Medicine Center for Hope and Healing. If you have questions, please reach out to a member of your treatment team or any of the staff of WVU Medicine Center for Hope and Healing.

WVU Medicine Center for Hope and Healing looks forward to partnering with you as you develop your path to recovery.

Guest Rights in Treatment

1. The right to treatment and services that support a guest's liberty and result in positive outcomes to the maximum extent possible.
 2. The right to an individualized, written treatment plan to be developed promptly after admission, treatment based on the plan, periodic review and reassessment of needs, and appropriate revisions of the plan including a description of the services that may be needed for follow up.
 3. The right to treatment and services in the least restrictive, most appropriate, and potentially the most effective setting
 4. The right to an individualized treatment plan as defined under this rule
 5. The right to ongoing informed participation in the treatment plan process
 6. The right to refuse treatment at any time
 7. The right to legal representative when unable to act on his or her behalf
 8. The right to be free from involuntary experimentation
 9. The right to freedom from restraint and seclusion. Restraint and seclusion shall only be used in situations where there is imminent danger to the guest or others and all less restrictive methods of control have been used
 10. The right to a humane treatment environment in which personal dignity and self-esteem are promoted
 11. The right to confidentiality of records, as provided in this rule
 12. The right to access to his or her own guest records in accordance with state law
 13. The right to assert grievances, orally or in writing, with respect to the infringement of all rights, including the right to have all grievances considered in a fair, timely, and impartial procedure
 14. The right of access to an available advocate in order to understand, exercise, and protect his or her rights
 15. The right to be informed in advance of any charges for services
 16. The right to all available services without discrimination because of race, religion, color, sex, sexual orientation, disability age, national origin, or marital status
 17. The right to exercise his or her civil rights
 18. The right to referral, as appropriate, to other providers of behavioral health services
 19. The right to be free from physical, verbal, sexual, or psychological abuse or punishment
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20. The right to be free from unnecessary or excessive medication
 21. The right to medication that is not used as punishment, for the convenience of staff, or as a substitute for programming, or in quantities that interfere with the treatment program
 22. The right to be free from uncompensated labor, except for guests in residential facilities who perform housekeeping tasks
 23. The right to be informed orally, in writing and in appropriate language and terms of the rights described in this section. The right to be housed with guests of the same approximate ages, developmental levels, and social needs
 24. The right to unimpeded access to his or her attorney or religious advisor
 25. The right to constant access to his or personal possessions unless contraindicated by treatment needs
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Treatment guidelines and expectations

Daily living guidelines:

- I agree to refrain from using illicit substances, including alcohol, while in treatment.
- I agree not to have drug paraphernalia or drug ingredients in my possession while in treatment.
- I agree to refrain from participating in criminal activity or committing crimes while in treatment.
- I agree to behave respectfully toward other guests and staff. Verbal abuse, including profanity, negative, demeaning, disrespectful language directed toward others or intimidation of others is unacceptable and considered abuse of others. Verbal abuse of staff, others in the program, or other people can result in discharge.
- I agree to remain in my assigned bed between the hours of 11:00 pm and 5:00 am.
- I agree to be out of bed at the designated times (by 6:45 am on weekdays, 7:00 am on weekends and holidays), unless I have an approved bed-pass. I understand that I may wake up earlier to shower/prepare for the day if I wish.
- I agree not to return to bed until after dinner at 6:00 pm, unless I have an approved bed-pass.
- I agree to sign in and sign out of WVU Medicine Center for Hope and Healing every time I leave for any outing, including group, activities, passes, medical appointments, etc.
- I agree not to steal from other guests, staff, kitchen, closet, etc.
- I agree not to sell, buy, or trade anything from other guests or staff.
- I agree not to have any weapons, including (but not limited to) firearms, knives (pocket knives), pepper spray, etc.
- I understand that food or items ordered/delivered to CHH by myself or others will not be accepted and will be sent back.

Living space guidelines:

- I agree to keep my room neat at all times. This includes my bed, floors, window sills, closets, furniture, and the bathroom.
 - I agree to only use my assigned space, I will not go into other bedrooms.
 - I agree not to have food or drink in my living space at any time.
 - I agree not to have pornographic material while in treatment.
 - I agree not to use offensive, abusive, or obscene language or gestures.
-
-

- I agree to not use fire doors unless in the case of an emergency.
- Bedbug infestation is a potential issue at any residential provider. I agree to follow the guidelines listed below in an effort to minimize the risk of an infestation.
 - I agree not to have more than 7 changes of clothes
 - I agree to have no more than 5 books brought from home
 - I agree not to have food or drink in my room.
 - I agree to wash and dry my bed linens often.
 - I agree not to share or borrow items or products from other guests.
 - I agree not to bring additional clothing after I am admitted into treatment, and I will not exceed 7 changes of clothing while in treatment.

Personal hygiene guidelines:

- I agree to have adequate personal hygiene, including brushing my teeth and showering daily, and be dressed and prepared for my scheduled breakfast.
- I will keep my clothing neat and clean at all times. I agree to wear seasonally appropriate and tasteful clothing.
- I agree to dress neatly and appropriately.
- I agree to wear casual and comfortable clothing that fits and covers my body appropriately.
- I agree not wear clothing that has pro-drug, alcohol, or tobacco messages, vulgar, or offensive language.
- I agree to wear shoes at all times.
- I agree to not wear pajamas during the day. I will only wear pajamas at night.

Clinical/treatment guidelines:

- I understand that if I am deemed a danger to self or others, I will be referred to an alternate level of care.
- I understand that my treatment is determined by my progress or lack of progress made, and that I may be discharged to an alternative level of care.
- I understand that I am expected to participate in all treatment functions, and failure to do so may indicate that I am in the wrong level of care.
- I understand that the treatment team cannot disclose my status or protected health information to anyone without a release. If I want people to know where I am, I will communicate that independently.

- I agree to be prepared for all scheduled groups and appointments.
- I agree to maintain confidentiality – what is said in group stays in group and should not be discussed outside of group.
- I agree not to engage in cross-talk. I will allow one person to speak at a time.
- I agree to remain engaged during group by not coloring, writing letters, etc.
- I agree to come to group and scheduled activities on time.
- I agree to complete all assignments within the time frame assigned by my treatment staff.
- I understand that assignments that are due are my ticket into the group. I understand that if I did not complete my homework, I will not be permitted into group.
- I agree to clean up after myself.
- I agree to remain seated during group, unless I have to use the restroom and it is an emergency. Only one person is permitted to leave the group room at a time.
- I agree to use the restroom before group begins and will make an effort to limit leaving group to use the restroom.
- I am responsible to schedule and maintain individual sessions. Failure to do so may indicate that I require an alternative level of care.
- I am responsible to inform the treatment staff ahead of time and reschedule if I am unable to attend my individual sessions.

Daily Chores

I understand that a part of treatment involves taking care of myself and my living space. Below are chores that I will complete while in treatment.

- Do laundry as needed
- Change sheets every 3 days
- Make bed every morning
- Clean up room area daily
- Practice ADLs daily (shower, brush teeth, brush hair, put on clean clothes)
- Clean up personal trash (wrappers, empty cups, etc.)

General policies and procedures

Meal and snack times

Kitchen/dining room availability:

- Mealtime is 7:30a-8:30a, 12p-1p, 5p-6p
- The kitchen/dining room will be locked outside of these times, except for scheduled events with staff
- I agree to not take food/drink from kitchen. I understand that I will have access to snacks and drinks on unit
- I agree to clean up after myself and I will use a cup with a lid (provided by kitchen for your drinks)
- I agree to get coffee/drinks from cafeteria only during my scheduled meal times

Coffee/water stocking on residential unit:

- Coffee, creamer, sweetener, etc., and water will be available to me on the unit throughout the day
- I will be welcome to drink the coffee and water that is provided on the unit. Coffee will be taken from units at 6 pm each night.
- If I want soda outside of meal time, I can purchase soda from the vending machines
- I will clean up after myself, and I will use a cup with a lid (provided by kitchen for your drinks)

Snack times:

- The kitchen staff will provide a snack basket at 2:30pm and 6 pm to the residential units
- The items in the snack basket will be ample snacks (each client will have more than one serving of snack) to eat at their leisure
- If I want additional snacks or drink items, I can purchase it from the vending machines.
- I will clean up after myself, and I will use a cup with a lid (provided by kitchen for your drinks)

Search policy:

WVU Medicine Center for Hope and Healing strives to create a treatment environment that is safe for each guest, staff, and visitor. WVU Medicine Center for Hope and Healing will take every reasonable effort to prevent the presence of substances or other items that jeopardize safety and/or recovery efforts.

- I agree to allow staff members (RN/LPN) to thoroughly search my person in a respectful and safe manner.
- I agree to allow staff members to check my belongings, including my pockets, handbags, food containers, and all other items at the time I check into the facility.

- I also agree to regular, random searches of any or all of the above items/areas, whether I am present or not.
- I consent to random and frequent room inspections.
- I understand that if I do not cooperate with WVU Medicine Center for Hope and Healing and refuse to surrender contraband, the authorities will be contacted, and I may face legal consequences.

Exercise room

- I understand that I may use the exercise room at my leisure during scheduled free-time only
- I agree to notify unit staff if I choose to utilize the exercise room and understand that protective oversight will be provided throughout the unit, including the exercise room
- I agree to use the equipment as intended
- I agree to notify staff if I begin to feel sick or over-extended due to exercise
- I agree to not use the exercise room during the scheduled time allotted for detox clients

Contraband:

It is WVU Medicine Center for Hope and Healing's mission to create a safe and drug-free treatment environment. I agree to comply with the following guidelines regarding contraband (illicit drugs or paraphernalia). I understand that in order to ensure the safety of all guests in WVU Medicine Center for Hope and Healing, staff members need to ensure that every reasonable effort is being made to prevent the presence of substances or other items that jeopardize safety and/or recovery efforts.

- I will not knowingly bring contraband, including but not limited to illegal drugs, tobacco, lighters, over the counter drugs, weapons, cell phones, etc., onto WVU Medicine Center for Hope and Healing property. A more comprehensive list of unapproved items, or contraband, is attached to this Client Handbook.
- If I unknowingly have contraband in my possession, I will cooperate fully with WVU Medicine Center for Hope and Healing staff to ensure that the contraband is secured at initial search of my person and property at intake.
- If I do not cooperate with WVU Medicine Center for Hope and Healing staff and refuse to surrender illegal contraband, the authorities may be contacted and I may face legal consequences.
- I agree to allow staff members and/or police officers to search my person, all my belongings, including my pockets, handbags, food containers, and all other items at the time I check into the facility. I also agree to regular, random searches of any or all of the

above items/areas, whether I am present or not.

- I consent to frequent room inspections.
- I agree to turn in all medications, including over the counter medications, to nurse staff upon arrival at WVU Medicine Center for Hope and Healing. I understand that my medications will be kept in a locked box by nurse staff and will be dispensed at designated medication times.
- I understand that any medications, including over the counter (OTC), must be kept with nurse staff in the medication room and cannot be kept in my room or on my person.
- Smoking on program property, in the program van, on program outings of any kind, or inside the facility—including, but not limited to, guest rooms, bathrooms, and all common areas—is prohibited at all times and can result in my discharge.

Property guidelines

I am permitted to have certain personal items (in limited quantities) while I am in treatment. These items are listed below. I understand that if I arrive to treatment with more items than permitted, the WVU Medicine Center for Hope and Healing will not be able to store these items. Regarding property, I understand the following:

- The items that I bring into treatment should be limited to necessary clothing and toiletries. Non-essential items should be left at home.
- WVU Medicine Center for Hope and Healing is not responsible for lost or stolen property.
- Personal property that exceeds what is allowed on the approved items list will not be accepted. The personal property that is permitted includes:
 - 7 weather appropriate outfits (no offensive logos, alcohol or drug-related advertisements or related images)
 - No revealing clothing, low cut, holes higher than the thighs
 - 7 pair of under garments
 - 7 pair of socks
 - 1 pair gym shoes
 - 1 pair shower shoes
 - Hygiene products without alcohol (shampoo, conditioner, body wash, mouth wash, toothpaste, all non-aerosol)
 - Tooth brush
 - Hairbrush/comb
 - Glasses, dentures, hearing aids as applicable
 - Limited makeup and hair styling items (all alcohol free and non-aerosol)
 - Home medications or prescriptions (to be dispensed by nursing staff)

- No more than \$50 cash (to be used in vending machines)
- Cell phones and wallets are not permitted on the treatment units and will be stored in a safe during my stay in treatment. I will not have access to these items until the end of my treatment stay.
- Illegal or drug-related items are not permitted on property and will not be stored on property.
- If I have an approved visit and I want my visitor to bring me additional items, I will complete the Property Drop-off Request Form (attached to the Client Handbook). If I do not have an approved Property Drop-off Request Form, the items brought will not be accepted.

Property Drop-off Procedure:

A property drop-off is permitted if a person in the community wishes to bring you items of personal property while you are in treatment. The items should not exceed the property guidelines described above. Below are the guidelines for property drop-off submission, approval, and implementation. Regarding Property Drop-off Procedure, I understand the following:

- In order to receive a property drop-off, I must first complete and submit a property drop-off by following the instructions on the Property Drop-off Request Form (attached to the Client Handbook). I understand that if I do not follow procedure for a drop-off, my drop-off may be delayed.
- Property drop-offs must occur at the scheduled time, and only items approved by the treatment team will be permitted.
- Property drop-off must occur in the presence of a treatment team member and must occur as scheduled between 12p and 3:30p.
- Unapproved drop-offs will not be accepted.
- Food deliveries will not be accepted.

Violent/aggressive behavior, threats of violence, or creating an unsafe environment:

It is WVU Medicine Center for Hope and Healing's mission to create a safe environment in which guests can focus on recovery. Violent, aggressive, or abuse behavior compromise the safety of the unit, and the treatment environment for everyone.

- I understand that violence or threats of violence will not be tolerated while in treatment. This includes aggressive or threatening language, posturing, or other intimidating behavior.

- Acts of violence will result in immediate discharge of the program.
- Threats of violence or intimidating behavior can result in discharge of the program.

Drug Screen Policy:

While a guest at WVU Medicine Center for Hope and Healing, I agree to the following drug screen policy:

- I agree to submit to an initial and random urine drug screens throughout my stay at WVU Medicine Center for Hope and Healing.
- It is the policy of WVU Medicine Center for Hope and Healing Program to discharge guests for dishonesty about drug use. We encourage you to be honest about drug use so that we can adapt treatment strategies to better support your healing and recovery. If a lab tested or on-site tested drug screen result detects the presence of an illicit substance, your treatment team will review options, which can result in treatment adjustment or possible referral to an alternative level of care.
- In order to participate in treatment at WVU Medicine Center for Hope and Healing Program, staff must be able to conduct random urine drug testing of all participants. If a guest is unable or unwilling to provide a valid urine specimen for drug testing within a reasonable time, he or she may be referred to an alternative level of care.
- Unless otherwise directed by staff, urine specimens are expected to be provided by the time posted on the days you are asked to screen. If you cannot/do not provide a non-diluted urine sample by deadline posted, the test will be considered illicit. A second failure to provide a suitable, non-diluted sample can result in a referral to an alternative level of care.

Regarding Protective Oversight:

I understand that in order to ensure the safety and security of the unit, the treatment staff will be providing protective oversight 24 hours a day, 7 days a week. Protective oversight is defined as consistent and thorough staff awareness at all times of client location and welfare, as well as the ability to intervene on behalf of the client in the event of an emergency or other unsafe situation.

Protective oversight can include frequent observations from staff, safety checks at least every thirty minutes, and general awareness of client location, function, and behavior.

- I understand that staff will be monitoring my behavior as a part of my treatment, and if I am engaging in unsafe inappropriate behavior, staff will redirect me
- I understand that if my behavior persists, the treatment team will address these issues with me in an attempt to assist me in adjusting my behavior

- I understand that if my behavior continues to be problematic, non-responsive to intervention, or unsafe, it may result in my discharge from WVU Medicine Center for Hope and Healing

Phone call procedures:

Connecting with safe and healthy family, friends, and community support is an integral part of my recovery. Below are the guidelines for phone use while in treatment.

- I understand that I will not be permitted to use the phone for the 72 hours of my stay at WVU Medicine Center for Hope and Healing. This allows me to focus on settling into treatment.
- I agree to not have a cell phone on my person or in my possession during my stay in treatment.
- I understand that each treatment unit will have time for phone use as listed on the daily schedule, and that this time is to be shared among all guests.
- I understand that I am permitted to have 10 minutes of phone time each day. I am responsible to manage myself in a way that is respectful and cooperative with other clients, and I agree to not use the phone beyond my allotted 10 minutes.
- I understand that other calls can be made with my therapist outside of these scheduled times if I feel it is important. This can be discussed with my therapist.
- I understand that if I demonstrate limited treatment progress, an inability to self-manage phone use, or create issues with others during phone times, my phone privileges may be interrupted.

Please refer back to policy regarding "Violent/aggressive behavior, threats of violence, or creating an unsafe environment"

Visit Policy and Procedure

Visits are a treatment tool that can be earned effective treatment participation. Below are the guidelines for visit submission, approval, and implementation.

- Personal visits will be permitted once my treatment team deems it clinically appropriate.
- I understand that visits are a treatment tool that is earned through effective treatment participation and program compliance. The treatment team must approve the visit, and approval will be based on my progress in treatment. I will not earn a visit if I do not comply with the rules of both the residential and treatment components of this program. I understand that I will not earn a visit if I do not comply with the program rules of WVU Medicine Center for Hope and Healing.

- I understand that to request a visit, I must complete the attached "visit request form." I understand that my visit request form must be turned into my therapist no later than Wednesday at noon of the week I wish for my visit to occur.
- I understand that I must identify who will be visiting. I also understand that this list is subject to treatment staff approval.
- I understand that my visitors will be required to complete a confidentiality and security agreement.
- I agree to not use or have in my possession any drug, including alcohol, while on the property. I understand that this applies to my approved visitors as well.
- I understand that I must comply with court-orders and CPS guidelines regarding contact.
- WVU Medicine Center for Hope and Healing Staff has the right to check IDs of ALL on-site visitors.
- I understand that visits can be revoked by clinical staff if doing so is determined to be in my best interest.
- I understand that my failure to comply with these guidelines may result in not earning a visit.
- I agree to not have unauthorized visits or drop-offs while in treatment.

Appointment Policy and Procedures

The following are guidelines regarding how to handle non-treatment appointments, such as meetings with parole/probation, court, medical appointments, etc. We understand that appointments will sometimes conflict with group and treatment activities. I agree to comply with the following guidelines so these appointments do not interfere with my treatment.

- I understand that all appointments should be scheduled before or after group time Monday through Friday. If I am unable to schedule the appointment outside of group time, I understand that it will lengthen my stay in treatment.
- I understand that I am responsible for making staff aware of my impending absence, if I have a scheduled appointment.
- I understand that I will need to make up any missed group or treatment functions if I am unable to attend due to a scheduled appointment.
- I understand that if I fail to notify staff of my absence, it will be considered a "no show." Failure to comply will result in a treatment team meeting to determine appropriateness for this level of care.

Family Visiting/Family Therapy

WVU Medicine Center for Hope and Healing understands that addiction is a disease that effects the entire family. WVU Medicine Center for Hope and Healing offers weekly family group and intensive family program to assist families in managing the impact a substance use disorder can have on the individual and family.

The goals of these programs are:

- Encourage and maintain safe family support.
- Provide psychoeducation to guest and family.
- Patrice safe relationship building through therapeutic activities and engagement.
- Prepare for a safe and supportive return to community environment.

WVU Medicine Center for Hope and Healing Family Program

- **Weekly family group-** Family members will be invited to help each other in a group setting where they will share experiences and insight while getting professional and group feedback. Both family members and guests will be invited to participate in this group regularly, and it will be offered free of charge for family members of WVU Medicine Center for Hope and Healing guests/alumni.
- **Intensive Family Program-** This program will be offered once a month and will provide psychoeducation, support, and counseling (individual and group) to the guest and family member as they develop skills in boundary setting and aftercare planning. Participants will become familiar with family support groups, such as Al-Anon, Nar-Anon, and others. This program will be offered to families free of charge.
- **Weekly phone coaching:** Weekly phone coaching will be offered to families who are unable to attend family group or the intensive family program. The goal of this services is to assist the guest in building a recovery team that can support him/her when he/she returns to the community, to educate the family about addiction and recovery, and to identify relapse warning signs, and to develop a crisis plan should the guest relapse upon discharge.

Contraband list for WVU Medicine Center for Hope and Healing

This list is not comprehensive, but serves as a guide for items you should not bring to treatment at WVU Medicine Center for Hope and Healing.

- Aerosol sprays of any kind
- Any toiletry that includes alcohol in its ingredient list
- Perfume/cologne
- Illicit drugs or paraphernalia
- Over the counter drugs
- Tobacco or nicotine products or paraphernalia
- Electronics of any kind
- Drug, gang, death/torture-themed or offensive material
- Glass or metal items/objects
- Glue or other inhalants
- Stuffed animals
- Bedding/towels
- Hair dye
- Laundry detergent/dryer sheets
- Pornography
- Weapons
- Credit cards
- Cameras or recording devices
- Musical instruments
- Food items, including drinks, candy, snacks, etc.
- Weapons
- Other items based on treatment staff discretion

WVU Medicine Center for Hope and Healing

On-Site Visit Request Form

I am requesting a 2 hour visit. I am requesting this visit by the Wednesday at noon prior to the date of my anticipated visit. Visit approval is granted by my treatment team, and is approved based on my participation in treatment and my compliance with treatment rules. I understand that I am not permitted to have my visitors bring me additional property or belongings without a property drop-off form. I understand that I am not to modify or deviate from the plans listed on this form after staff have approved it. I will follow up with staff to review the status of this request.

Name: _____ Date: _____

Visitor(s) names and relationship to you: _____

Visitor(s) phone number: _____

Start and end time of visit (2 hours): _____

Any additional information or special instructions:

Staff approval: _____

Date: _____

WVU Medicine Center for Hope and Healing

Property Drop-off Request Form

I am requesting to have safe family or friend deliver items that I need during my stay in treatment.

- I have reviewed the property guidelines in my Client Handbook, and the items I am requesting comply with property guidelines.
- I understand that in order for my property request to be reviewed by staff, I must turn it into my primary counselor no later than 8:15 am. Property request forms turned in after this time will be reviewed on the following day.
- If my property drop-off request is approved, my property drop-off must occur between 12pm and 3:30pm. Property deliveries that occur outside of this time will not be accepted by staff.
- I understand that I am not to modify or deviate from the property drop-off listed on this form after the treatment team has approved it. I will follow up with staff to review the status of this request.

Name: _____ Date: _____

Name of person bringing property: _____

Relationship to person bringing property: _____

Date and time of delivery: _____

Incoming property (list each items in detail):

Treatment team approval date (include one staff signature): _____

Mountaineer Recovery Center

49 Beds Male/Female
3094 Charles Town Road
Kearneysville, WV 25430

Contact: Mandy Linton - 304-901-2070 ext. 125

United Summit Center—Harrison County

Bob Mays Recovery Center - 18 Beds Male/Female 18-24 years old

5 Hospital Drive
Clarksburg, WV 26301

Contact: Whitney - 304-342-3361 Fax: 304-969-9053

NOTES: Must fill out application. It must be filled out by doctor/Lawyer/PO/Social Worker. Then you can call the Director Kathy Love to get into program.

RESIDENTIAL SUBSTANCE ABUSE REFERRAL TO:
BOB MAYS RECOVERY CENTER: FAX: 304 969-9053
(Name Of Facility To Where Referral Is Being Made)

This referral form is designed to facilitate the immediate and appropriate treatment of individuals referred to SA residential programs. Please complete this form in its entirety.

1. Date & Time of Referral: _____
2. Type: Voluntary _____
Commitment _____
Other _____
3. Less restrictive options attempted: I.O.P. _____ Outpatient: _____ None: _____
4. Name of Person Making Referral: _____
5. Telephone: _____
6. Local CBHC: _____
7. Telephone: _____
8. Client Status: Unknown: _____ Active: _____ Inactive: _____
9. Client Name: _____
10. DOB: _____
11. SS#: _____
12. Gender: M ___ F ___
13. Race: _____
14. Phone: _____
15. Address: _____
16. Employment: _____
17. Education: _____
18. Pregnant: Yes ___ No ___ N/A ___
19. Number of minor children living with client: _____
20. Emergency Contact: _____
21. Relationship: _____
22. Phone: _____
23. Payer Source/#: Self-Pay: _____
Medicaid: _____
Insurance: _____
OBHS: _____

24. Substance Use History: Last Six Months (Check drug used, circle frequency, list amount/date of last use)

Drug [put * by drug(s) of choice]	Frequency	Amount/Date of Last Use
___ marijuana	(daily) (3-5x/week) (1-8x/mo.) (less than once/mo.)	_____/_____/_____
___ cocaine	(daily) (3-5x/week) (1-8x/mo.) (less than once/mo.)	_____/_____/_____
___ heroin	(daily) (3-5x/week) (1-8x/mo.) (less than once/mo.)	_____/_____/_____
___ benzo's	(daily) (3-5x/week) (1-8x/mo.) (less than once/mo.)	_____/_____/_____
___ amphetamines	(daily) (3-5x/week) (1-8x/mo.) (less than once/mo.)	_____/_____/_____
___ barbiturates	(daily) (3-5x/week) (1-8x/mo.) (less than once/mo.)	_____/_____/_____
___ inhalants	(daily) (3-5x/week) (1-8x/mo.) (less than once/mo.)	_____/_____/_____
___ opiates	(daily) (3-5x/week) (1-8x/mo.) (less than once/mo.)	_____/_____/_____
___ other(specify)	(daily) (3-5x/week) (1-8x/mo.) (less than once/mo.)	_____/_____/_____
___ alcohol	(daily) (3-5x/week) (1-8x/mo.) (less than once/mo.)	_____/_____/_____

B.A.C. if known: _____ Date Obtained: _____ Time: _____

25. The last six months, what is the longest period of abstinence?: _____

26. IV drug use in the last 6 months?: Yes ___ No ___ 27. History of IV drug use?: Yes ___ No ___

28. Previous Treatments: Please describe type such as outpt., I.O.P., residential, or inpatient.

When	Type	Program Name	Length of Stay
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

29. Diagnostic Impression(s): Axis I: _____
Axis II: _____

Medical History

30. Does the client require medical clearance? Yes _____ No _____

31. Name and phone # of physician authorizing medical clearance: _____

32. Reason medical clearance is not required: _____

33. Is the client currently experiencing, or diagnosed with, any of the following (circle any that are appropriate)

- | | | | | | |
|--------------|-----------------|---------------------|-----------------------|----------------|--------------------|
| tremors | hallucinations | headaches | cirrhosis | tuberculosis | dental problems |
| insomnia | delusions | shortness of breath | diabetes | heart problems | vision problems |
| agitation | nausea/vomiting | chest pain | pancreatitis | stroke | difficulty walking |
| irritability | vomiting blood | breathing problems | hepatitis | seizures | sweating |
| mood swings | asthma | high blood pressure | other(specify): _____ | | |

If the client is experiencing one or more of the above conditions, medical clearance must be obtained.

34. Is the client self-ambulatory?: Yes _____ No _____

35. Medications currently used: include those prescribed regularly, and any taken in the last 24 hours, include those given recently in an ER, and/or over the counter and illegal drugs.

Name	Amount/Time Taken	Prescribed By	Currently taking-if not, why not?
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36. List any scheduled medical appointments within the next four weeks. Give date/time/with whom. _____

37. Does the client have a history of suicide attempts or violence toward self?: Yes _____ No _____

If yes: Date

Method

38. Does the client have a history of violence toward others?: Yes _____ No _____ If yes, explain: _____

NOTE: Questions 37 and 38 are to be used to schedule additional staff, if needed:

39. Are there any family members willing to be involved in the treatment process if the client agrees?: Yes _____ No _____ If yes, give name, relationship, and phone number: _____

Legal History

40. Is the client facing any legal charges?: Yes _____ No _____ If yes explain what they are and give any court dates. State source of information.

41. Is there a detainer on this client? Yes _____ No _____ If yes, give name and telephone number of person(s) who must be contacted prior to discharge.

42. Is the client currently on probation or parole? Yes _____ No _____ If yes, list where, reason, & name of P.O.

Other

43. List other placements/facilities attempted, reasons denied, if applicable, or any other important information:

**Bob Mays Recovery Center (Voluntary Treatment Unit)
Acknowledgment of Admission and Treatment Conditions**

Please acknowledge that you are aware of the following conditions for admission by initialing in the blank to the left of each statement and by signing at the bottom of the form. The rare exceptions to any of these conditions must be expressly coordinated and approved in advance. We do not discriminate against race, color, or national origin.

_____ I understand that the Substance Abuse Unit is up to a 1 month treatment in duration for clients who are adult age (18 and above) and I will be expected to remain on the unit until my discharge date.. I understand that only special visitation with primary family can be arranged during my last week of treatment.

_____ I understand that I need to arrange transportation to treatment by a means other than by driving myself, and that I will not be permitted to have a vehicle on the grounds of the Substance Abuse Unit during my treatment stay.

_____ I understand that I will not be permitted to bring any controlled substances (including prescribed opiates or benzodiazepines) or alcohol into the Substance Abuse Unit. I further understand and consent that should I bring these items to treatment, they will be confiscated as contraband and destroyed.

_____ I understand that I will not be permitted to have weapons, including firearms and knives, while at the Substance Abuse Unit. Possession of firearms is prohibited on the property of the Substance Abuse Unit. Common possessions that may be considered potential weapons must be surrendered and stored during treatment.

_____ I understand that use of electronic devices such as pagers or cell phones are not permitted during the treatment stay. If these are not left at home, the staff will secure them until discharge. I also understand that the use of headphones of any type is not permitted.

_____ **AS OF JANUARY 1, 2018 TOBACCO USE WILL NOT BE PERMITTED IN THE FACILITY.**

_____ I understand that Substance Abuse Unit will not divulge that I am a client at the Unit without my written consent, and that if I want people to know where I am, I will need to inform them myself of my whereabouts prior to admission.

_____ I understand that phone use is not permitted during the first 72 hours after admission for a number of therapeutic reasons. I also understand that, after 72 hours, I will be permitted one 10-minute phone call per day during designated evening phone times.

_____ I am aware that I will forfeit the opportunity for future voluntary admissions for a minimum of 120 days if, once admitted, I choose to leave treatment against medical advice (AMA).

_____ I understand that even though I am entering treatment voluntarily, my release may not be voluntary, if I am found to be a danger to myself or others the Substance Abuse Unit Staff may seek to involuntarily commit me. I further understand that I may request release from the Unit at any time (WV 27-4-4).

By signing below, I acknowledge that I understand and consent to the conditions of admission and treatment described in this document.

Client Name (PRINT)

Referrer Name (PRINT)

Client Signature & Initials

Referrer Signature

Date

Date

Referrer Contact #

TO REFERRAL SOURCE: *This form must be reviewed by/with the potential client prior to acceptance of the client by the Substance Abuse Unit. The client must agree to all conditions, signified by client initials next to each condition, and signature above, for acceptance to the Unit. You, as the referrer, must also sign this form, indicating that you have assisted the potential client in understanding these conditions.*

BOB MAYS ADMISSION ITEMS: 3 MONTH TREATMENT PROGRAM

CAN'T HAVE:

ELECTRONIC DEVICES/CELL PHONES

SNACKS, CANDY, DRINKS, ECT.OVER THE COUNTER MEDICATIONS

TOBACCO PRODUCTS

OWN PILLOW/BLANKETS

BOOKS

PIERCINGS

PERFUME/BODY SPRAY

BRING WITH YOU:

6+ CHANGE OF CLOTHES/LIMITED STORAGE

MONEY FOR GUM: (NOTHING OVER \$20)

PICTURE ID/MEDICAL CARD/INSURANCE CARD

HYGEINE ITEMS/ NO PERFUME OR BODY SPRAY

COMFORTABLE CLOTHES/NO REVEALING CLOTHES

WE FURNISH: BED LINENS, PILLOW,
TOWELS/WASHCLOTHS, LAUNDRY PODS.

NO VISITATION THE FIRST TWO MONTHS, AFTER THAT SPECIAL VISITATION WITH PRIMARY FAMILY ONLY.

PHONE CALL AFTER BEING HERE 3 FULL DAYS/10 MINUTES PER EVENING ON 4TH DAY.

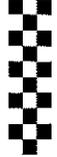
FMRS Health System- Raleigh County
90 day Treatment Facilities

Learn Program - 20 Beds Male only

101 South Eisenhower Drive
Beckley, WV 25801

Contact: Matt Huffman - 304-256-7144 Fax: 304-256-7145

NOTES: This program is located in the Pine Haven Homeless Shelter. (*Call to check availably*)



LEARN Program Pre-Screening and Referral Form

Date: _____

Name: _____ Age: _____ Date of Birth _____

Home Address: _____ City: _____

County: _____ State: _____ Zip: _____

Phone #: _____ Marital Status: _____

Social Security Number: _____ Medicaid: Y or N

Emergency Contact Name: _____ Phone: _____

Drugs of choice: _____
IV Use: Yes No (circle one)

Date of last drug use: _____ Drug used: _____

Date of last drug use: _____ Drug used: _____

Date of last drug use: _____ Drug used: _____

Previous Substance Abuse Treatment—Program name and dates attended:

Currently: court order probation parole CPS DUI

Any legal charges pending? (Explanation)

Current Prescribed Medications: _____

*To expedite admission to LEARN Program, please have your attorney, CPS worker or probation/parole officer contact us at 304-256-7144. Thank you.

Inspires through Southern Highland

(this can be anywhere from 90 days to 6 months. It all depends on their insurance)

7 Male/ 6 Female

1345 Mercer Street
Princeton, WV 24740

Contact: Tina Butler - 304-818-2222

NOTES: Must fill out an application and fax it, then call them.