Sitka Counseling

113 Metlakatla St
Sitka, AK 99835

T 907-747-3636
F 907-747-5316

info@scpsak.org
sitkacounseling.org

Residential Application Checklist

Admission into Sitka Counseling's residential substance misuse treatment program is a multiple step process that involves the client, the client's referral source, chemical dependency counselor, clinician, Clinical Director, and any other involved party (such as Office of Children Services, Parole/Probation, etc.,). In order to apply to Sitka Counseling Residential Program the following items are required:

A completed application packet is to include the following items:

- ☐ 1. Residential Treatment Application
- ☐ 2. Clinical Assessment – completed within past 90 days.

  Comprehensive Biopsychosocial Substance Abuse and Mental Health evaluation to include DSM 5 Diagnosis, ASAM Criteria level of care, and Treatment Recommendations.
- ☐ 3. Current Medication Log
- ☐ 4. State of Alaska Food Stamps application – you need to submit a food stamps application prior to be accepted into the program. Your application can be in a pending status, or awaiting approval.
- ☐ 5. Physical Clearance of Health Screening with TB test results – completed within past 30 days; if you do not have this, proceed with your application for review and submit as soon as results are available.
- ☐ 6. Releases of Information (ROI) - Include a separate signed ROI for each of the parties involved in the applicant's case, i.e., physician, attorney, parole officer, counselor, OCS, etc. A ***separate ROI*** is required for each person or agency. In order for an ROI to be valid it must be filled out correctly.
- ☐ 7. Presentence Report and signed Release of Information for Probation Officer, if on probation or parole

Fax all the above completed paperwork to Sitka Counseling at (907) 747-5316, or mail to Sitka Counseling, 113 Metlakatla Street, Sitka, AK 99835.

Thank you,

Intake Staff, Sitka Counseling Residential

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Residential Information & Responsibilities

Thank you for choosing Sitka Counseling's Residential Treatment Program as a step toward a life free from addiction to substances. To make your transition and admission into treatment go smoothly, there are a few things you need to know about our Treatment facility.

Residential Treatment Overview

- The program serves the integrated treatment needs of adult men and women of Alaska. We focus on assisting clients in: maintaining abstinence; establishing a quality program of recovery; making healthy connections in the community; and achieving economic self-sufficiency.
- Sitka Counseling Residential Treatment is a co-ed program designed to provide a 'family style' environment, with peer support; clients are responsible for cleaning, shopping, and meal preparation; work collaboratively using developing skills; learn to manage conflicts within household relationships; support one another in practicing effective communication and establishing healthy boundaries.
- The objective is to achieve the knowledge, skills, and support needed to successfully re-enter the community equipped with relapse prevention skills to help maintain a sober and fulfilling life outside of a semi-structured environment.
- Each client will be working to develop a Continuing Care Plan to outline practical, measurable and attainable strategies for maintaining Balanced Recovery.

What You Can Expect

- The first 7-10 days of treatment all clients will be in an Orientation Assessment stage. Cell phones and electronics brought for personal use will be collected nightly and stored in the staff office. During the Assessment stage of Orientation these may be used for limited purpose. There will be no visitation during this time and client activity will be limited to treatment activities and medical appointments only.
- Clients will be assigned a bedroom, complete all intake paperwork, count in all prescribed and sealed over-the-counter medications, complete an assessment within the first 24 hours, and develop an initial treatment plan to begin working toward treatment goals.
- From the onset of treatment clients will be working on a Continuing Care Plan. This plan will begin to establish healthy recovery skills, which will be transferable outside treatment, after completion of this program.
- Tobacco use of any kind is not permitted on Sitka Counseling properties.

Program Expectations

- Abstain from all use of alcohol or other illicit drugs.
- Cooperatively engage in the assessment and treatment planning process.
- Fully participate in all treatment activities.
- Respectfully give and accept feedback, or request assistance from staff if facing challenges in communication with others.
- Contribute to household chores and responsibilities.
- All over-the-counter (OTC) medications MUST arrive in unopened packaging. No opened OTC will be accepted for use during treatment at Sitka Counseling. They can however be sealed and returned to the client upon discharge.

- Adhere to all medication policies and understand that program staff is not qualified to give medical advice or alter doctor's recommendations.
- Clients will work cooperatively with the finance department and be accountable for all treatment expenses.

Client accountability is an important part of the treatment process. Honest disclosure and cooperation are an integral component of the therapeutic relationship. Clients will be expected to cooperate and take responsibility for their expenses in the Residential Program.

What to Bring

- One weeks' worth of appropriate clothing for our temperate rainforest environment to include warm, waterproof coat and footwear. Clothing should be comfortable, practical, modest and appropriate for prospective employment.
- A 30-day supply of all current prescription medications. Additionally, any physician approved over-the-counter medications brought with you ***must*** be in factory sealed, unopened containers. Prescription medication ***must*** be labeled by the pharmacy and kept in its original pharmacy container. While in treatment, medications will be stored and clients will be responsible for self-administration of medication.
- Personal hygiene products with alcohol listed as any of the first 3 ingredients will be stored in the staff office, and must be used under staff observation. Be advised some of these products may not be permitted for use, as determined by Coordinator, Program Manager, or Clinical Director.
- An Open Mind.

What Not to Bring

- Alcohol, illicit drugs, and paraphernalia. These items will be confiscated and destroyed.
- Weapons of any sort.
- Pornography or other material that may be considered offensive in nature.
- Clothing displaying liquor or drug logo, images glorifying violence, or that is sexual or provocative in nature.
- Valuable items. Sitka Counseling will not be held responsible for any lost or stolen items.
- E-cigarettes of any kind.
- Opened OTC medications.

Program Rules: *Safety is the number one priority*

- Threats of any kind will not be tolerated. This includes physical violence, sexual assault, intimidation and any other perceived aggression.
- Confidentiality is of the upmost importance. Breaches of confidentiality are a serious violation of rules and are subject up to and including discharge from the program.
- Criminal activity of any kind is prohibited.
- Clients and/or staff are not to engage in exclusive relationships.

Exclusionary Criteria

- Anyone required to register on the Sex Offender Registry is unable to be admitted into our treatment program.
- Chronic history of violent assaults will be evaluated on a case-by-case basis.
- Current active substance use. You must be detoxed and free of all substances for a minimum of 14 days prior to attending our program.

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Residential Treatment Application

Identifying Data

Full Legal Name: _____ SSN: _____ DOB: _____

Maiden/Former Name: _____Age: _____ Sex: ☐ M ☐ F

Current Contact Information

Physical Address: _____ City, State, and Zip: _____

Mailing Address: _____ City, State, and Zip: _____

Home Phone: _____ Can we leave a message? ☐ Yes ☐ No

Cell Phone: _____ Can we leave a message? ☐ Yes ☐ No

Email Address: _____ Do you consent to email? ☐ Yes ☐ No

Referral Contact Information

Referral Agency: _____Contact Name: _____

Referral Direct Line Phone: _____Referral Fax: _____

Has a Release of Information (ROI) been ***signed and witnessed*** for this agency ☐ Yes ☐ No

Race (check all that apply):

☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black/African American
☐ Hispanic ☐ Caucasian ☐ Native Hawaiian ☐ Other: _____

Expected Payment Source (check all that applies):

☐ Private Insurance:_____ ☐ Self-Pay ☐ Sliding Fee Application
☐ Medicaid (includes Denali Kid Care) ☐ Medicare ☐ Other

Medicaid ID Number: _____ Medicare ID Number: _____

Private Policy Number: _____ Group Number: _____

READINESS TO CHANGE

Please describe why you are interested in treatment at this time: _____

_____

_____

Rev. 6/14; 7/14; 10/16; 4/2017; 7/22/17; 9/12/17

Tell us how you think residential treatment is important for your success: _____

_____

_____

What kind of goals do you think are important to set for your recovery? _____

_____

_____

SUBSTANCE USE/WITHDRAWAL POTENTIAL

Drug of choice: _____ Ever use more than intended: ☐ Yes ☐ No Blackouts: ☐ Yes ☐ No

Do you currently use drugs intravenously (IV drug use): ☐ Yes ☐ No

Withdrawal symptoms: ☐ Tremors ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Sweating ☐ Hallucinations
☐ Insomnia ☐ Seizures ☐ Agitation ☐ DT's ☐ Anxiety ☐ Depression
☐ Anger ☐ Irritability ☐ Mood Swings ☐ Muscle Aches

Substance	Age 1st Used	Age 1st Problem Use	Date Last Used	Tolerance Increase	Frequency of Use	Method of Use (oral, smoke, IV, etc.)	Binge Use Patterns
Alcohol				☐ YES ☐ NO			
Cocaine				☐ YES ☐ NO			
Marijuana				☐ YES ☐ NO			
Amphetamines				☐ YES ☐ NO			
Methamphetamines				☐ YES ☐ NO			
Hallucinogen				☐ YES ☐ NO			
Stimulants				☐ YES ☐ NO			
Inhalants				☐ YES ☐ NO			
Opioids				☐ YES ☐ NO			
Sedatives				☐ YES ☐ NO			
Club Drugs				☐ YES ☐ NO			
Tranquilizers				☐ YES ☐ NO			
Nicotine				☐ YES ☐ NO			

BIOMEDICAL CONDITIONS

Describe any chronic medical conditions: _____

_____

Medical history of long-term illness or injury leading to chronic use of pain medication: _____

_____

Do you have any dietary sensitives or restrictions: ☐ Yes ☐ No If yes, explain: _____

_____

Do you think you have or ever been diagnosed with an eating disorder? ☐ Yes ☐ No If yes, explain: _____

_____

_____

Are you prescribed or taking Benzodiazepines: ☐ Yes ☐ No

Are you prescribed or taking Opioids: ☐ Yes ☐ No

WOMEN ONLY: Are you currently pregnant: ☐ Yes ☐ No If yes, describe your prenatal care: _____

_____

EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS

Current and historical Mental health diagnosis/treatment: _____

_____

_____

Are you currently Suicidal or Homicidal: ☐ Yes ☐ No; if yes, describe:_____

_____

History of Suicidal or Homicidal ideation or attempts within the past 45 days: _____

_____

_____

History of trauma, loss, or abuse ☐ Yes ☐ No; if yes, describe:_____

_____

_____

_____

Education History: (attitude, grade completed, learning disabilities, etc.) _____

_____

_____

Military Service: ☐ Yes ☐ No; Describe substance use or mental health issues while in the service: _____

_____

_____

LEGAL HISTORY (start with most current charges)

Charge	Year	Disposition	AOD Involved
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

Are you required to register on a state or national sex offender or child kidnapping registry: ☐ Yes ☐ No; if Yes, please explain: _____

Do you have history of violence, arson, or Felony Assault charges: ☐ Yes ☐ No; if Yes, please explain: _____

_____

Describe any current/pending legal involvement: _____

_____

_____

TREATMENT & RELAPSE HISTORY

PREVIOUS SUBSTANCE ABUSE TREATMENT HISTORY:

Where	Year	Type (Res, OP, IOP)	Days/Months Completed	Completed	Length of Clean Time
				☐ YES ☐ NO	
				☐ YES ☐ NO	
				☐ YES ☐ NO	

Identified substance abuse/mental health risk factors & relapse triggers: _____

_____

_____

Describe your knowledge of the relapse process? _____

_____

_____

RECOVERY ENVIRONMENT

Describe current living situation: (living with whom, where, housing) _____

_____

_____

Others' substance use and/or mental health issues in the home: (who, frequency, problems) _____

_____

_____

Other current life stressors: (financial, transportation, child care, etc) _____

_____

_____

Please describe your plans for after you complete the treatment program _____

_____

_____

Any current barriers that would prevent client from accessing treatment at this time: _____

_____

CONFLICT OF INTERESTS

Do you have any family or friends working at Sitka Counseling: ☐ Yes ☐ No; if Yes, please explain:_____

_____

Do you have any family or friends in treatment at Sitka Counseling: ☐ Yes ☐ No; if Yes, please explain:_____

_____

Please tell us anything you would like us to consider about your application for Residential Treatment _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Your Signature Date

Comprehensive Medication Log

Prescription Medications

Name of Medication	Reason Taken	Dosage	Time(s) of Day

Over the Counter Medicines or Supplements

Name of OTC/Supplement	Reason Taken	Dosage	Time(s) of Day