

## COMPASSION CENTRAL RECOVERY HOUSE

### Resident Fee Agreement (Form 2)

The [enter house name here] fee is [enter fee here \$00.00] per week with a [enter deposit here \$00.00] deposit. The deposit and the first week's fees are [enter fee & deposit here] are due upon admission and are the sole responsibility of the new resident unless a third party payer is involved.

House fees will continue to be due one week in advance (the resident will be paying for the upcoming week.)

Residents who cannot cover their house expenses because they are unemployed or there is an issue with a third-party payer are to immediately bring this to the attention of staff so that we can create a repayment plan for you.

It is understood that changes in employment may take place. Our responsibility is to assist you with your recovery, and financial challenges may arise during your time as a resident of the [enter house name here]. We are here to assist you if this situation comes up. It is especially important that you let staff know of your need for a fee arrangement as soon as possible.

Any form of fee assistance (3<sup>rd</sup> Party) is to be approved by the [enter responsible party here].

A [determine time] notice must be given before moving out of the [enter house name here], or the house fee deposit will be forfeited. No deposit of house fees will be returned for stays less than seven days. If a house recommendation has been made for you to seek alternative living arrangements due to your actions having been found to place the safety of the house or other residents at risk and in noncompliance with house guidelines, the deposit will be forfeited.

Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Recovery Residence Staff: \_\_\_\_\_ Date: \_\_\_\_\_

## COMPASSION CENTRAL RECOVERY HOUSE

### Confidentiality of Personal Identifiable Information (PII) Agreement (Form 3A)

The confidentiality of recovering persons living in a Recovery Residence is protected under Federal Law 42 C.F.R., Part 2 which protects them from anyone outside of the RH knowing their participation in the recovery residence without the resident's specific permission. No information regarding a resident of [enter house name here] may be released to anyone outside of the program unless:

1. The resident has signed a consent form to that person/agency.
2. A court order is issued to [house name] requesting information on the resident.
3. Medical personnel require the information in a medical emergency.
4. The resident threatens to harm him/herself or someone else.

Federal law does not protect a resident if they commit a crime against anyone at [enter house name here]. Also, Federal Law does not restrict the sharing of information regarding reported child abuse/neglect to appropriate State and local authorities.

These laws apply not only to the [enter house name here] owner, staff, and volunteers of [enter house name here] but to the residents as well.

I agree to not reveal to anyone outside of the [enter house name here] the name, identity, or description of another resident. I also agree not to discuss the content of conversations or groups with anyone outside of [enter house name here]. This includes sharing at 12-Step, or any recovery-related meetings that I attend outside of the [enter house name here].

I agree to inform [enter house name here] staff if any of my peers reveal any information about themselves or another resident that may be a cause for concern.

Name of Resident: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

The [house name] Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# COMPASSION CENTRAL RECOVERY HOUSE

## Resident Release of Information (Form 3B)

Client Name:	Date of Birth:	SSN:
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I understand that my express consent is required to release any health care information relating to testing, diagnosis, or treatment of psychiatric disorders/mental health, as well as drug and alcohol use, from the [house name], as well as any other such agency or a medical practice from which I have received services. If I have been tested, diagnosed, and treated for psychiatric disorders, mental health, or drug and alcohol use, I specifically authorize the release of all health care information relating to such testing, diagnosis, and treatment to/from the person or entity listed below.

I am giving this consent voluntarily and have been informed of the type of information requested. Information may be released in either written or verbal format. The benefits and disadvantages of releasing information have been explained to me. I understand that provision of service does not depend on my decision concerning the release of information. However, in certain limited circumstances, due to the legalities of some service providers, I may be denied services if consent is not given. TIME LIMITATION OF RELEASE: This consent is valid until I move out or due to a violation of house guidelines am asked to leave the [house name]. I may revoke this consent at any time by signing the revocation section at the end of this document, except to the extent that information has already been released based upon it. I understand that if I am participating in the program as a formal condition of my parole, probation, or order of the court, I cannot revoke this authorization until the confinement, parole, or probation, is formally released on my behalf by such authority.

### Information to Be Released

- Evaluation/Assessment
- Medication/Laboratory Reports
- Recovery Live History
- Drug/Breathalyzer Results
- Progress Report/Notes
- Immunization Record
- Treatment/Service Plans
- Discharge Information
- Waiting List/Bed Availability

### Purpose of Release

- At the request of the Resident
- Continuity of Care
- External Quality/Utilization Review
- Compliance with Court-Ordered Recovery Services
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Assignment Record Sheet

This information may be  Disclosed To: \_\_\_\_\_  Received From: \_\_\_\_\_

Name of Person and Agency: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Please Check One:

- I agree with the person/entity above being informed that I am no longer a resident of the [enter house name here] if I am discharged or discharge myself from the residence. This information will be given only if the above person contacts this residence.
- I do not agree to the person/entity identified above being informed that I am no longer in the [enter house name here], in the event I am discharged or discharge myself from the residence.

### Signatures

Resident Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff/Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notice to the Recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). Federal regulations prohibit any party from making further disclosure of this information "unless further disclosure is expressly permitted by the written consent of the person to whom it pertains" or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Revocation of Authorization: I hereby revoke the authorization of any information noted on this document to the person or entity listed. I understand that if my residency is a formal condition of my parole, probation, or order of the court, I cannot revoke this authorization until the confinement, parole, or probation is formally released on my behalf by such authority.

Resident Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## COMPASSION CENTRAL RECOVERY HOUSE

Pre-Admission/Admission Applicant Information (Form 4)		
Staff:	Today's Date:	Time:
Desired Move-in Date:	Reason for Move:	
Applicant Name:		
Date of Birth:	Phone:	
Current Address:		
City:	State:	Zip Code:
Own or Rent:	Monthly Payment or Rent:	How long at this address?
Previous Address:		
City:	State:	Zip Code:
Own or Rent:	Monthly Payment or Rent:	How long at this address?
Where have you lived for the past 6 Months:		
Identification:		
<input type="checkbox"/> Valid State I.D.	<input type="checkbox"/> Valid Driver's License	<input type="checkbox"/> Social Security Card
<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Convicted of a Violent Crime?	<input type="checkbox"/> Convicted of a Sexual Offense?
<input type="checkbox"/> SNAP Benefits?		
Marital Status		
Married	Separated	Divorced
Widowed	Registered Partnership	
Do you have Children: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, who is caring for them:
Level of Education:	<input type="checkbox"/> Veteran?	<input type="checkbox"/> Pregnant?
Who referred you to us?		
Recovery and Substance Use History		

Have you been a resident of the [house name] before?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes When:

Have you sought services for a substance use disorder in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please list all:			
Where:	When:	Length of Stay:	
Where:	When:	Length of Stay:	
Substance Use History:			
Drug of use:	Last Use:	How Much:	Method:
Drug of use:	Last Use:	How Much:	Method:
Drug of use:	Last Use:	How Much:	Method:
Alcohol Use <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, How Much:	How Often:	
Probation Parole/Court/Legal Issues			
Pending Charges or Legal Issues: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please explain:	
Upcoming Court Dates: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please explain:	
Are you currently in a Prison or Jail <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, where:	
Are you Court Ordered to the [house name] <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide a copy of Court Order upon arrival			
County:	Judge:	Obtained order <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are report to a Probation Officer <input type="checkbox"/> Yes <input type="checkbox"/> No		Name/Phone:	
Misdemeanor Conviction: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please list:	

Felony Conviction in the past 3yrs: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please list:			
Emergency Contact and Health Information					
Emergency Contact:					
Relation:	Parent <input type="checkbox"/>	Spouse <input type="checkbox"/>	Sibling <input type="checkbox"/>	Friend <input type="checkbox"/>	Other <input type="checkbox"/>
Address:			Phone Number:		
Do you have Medical Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, Please List:					
Please check all that apply:					
Diabetes <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Liver Disease <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	Seizures <input type="checkbox"/>	Other <input type="checkbox"/> _____
Please Describe:					
Please List any Medications you are currently taking:					
				How Long:	
T.B. Skin Test <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date of last test:		Positive <input type="checkbox"/> or Negative <input type="checkbox"/>		
Card: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Positive, were you referred for treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Preventative T.B. medications: <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, where:		
Previous Diagnosis and Treatment History: <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please list diagnosis:					
Mental Health Symptoms or Conditions: <input type="checkbox"/> Yes <input type="checkbox"/> No – If yes, please explain?					
Have you attempted Suicide in the past: <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, how many times?		
Did you have a specific plan?					
Were you under the influence at the time: <input type="checkbox"/> Yes <input type="checkbox"/> No			When was your last attempt?		

According to the Stewart B. McKinney Act, 42 U.S.S. 11301 (1994), a person is considered homeless who "lacks fixed, regular, and adequate nighttime residence and has a primary nighttime residency that is (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations ... (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. "42, U.S.C. 11302 (a) The term "homeless individual does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or state law." 42 U.S.C 11305 (c)

# COMPASSION CENTRAL RECOVERY HOUSE

## Resident Rights (Form 5)

You have the right...

1. To be treated with consideration and respect, without discrimination in eligibility determination.
2. To know, by name, the staff members working in the Recovery House.
3. To give informed consent for services.
4. To privacy and individuality, to be treated with consideration, and respect as it relates to your recovery program.
5. To submit grievances, if needed, to the [enter responsible parties here].
6. To make reasonable requests to support your recovery program.
7. To obtain information regarding [enter house name] and its relationship to other health care related institutions when you are referred for services or programs.
8. To be afforded the opportunity to participate in planning your recovery program and to refuse to participate in human subject experimental research.
9. To be free from verbal, mental, physical, and sexual harassment, or abuse.
10. To have access to house policies and procedures that apply to the residents in the house.
11. To establish a Release of Information (ROI) to approve the release of any information to an individual or entity outside of [enter house name], except as otherwise provided by law.
12. To be assured that Federal Regulations are applied in all disclosures of any confidential information as applicable. Confidential information, without the residents, expressed consent, can be disclosed in the following cases:
  - a. Resident's death – information can be given to the next of kin or others with the next of kin's permission
  - b. Suspected child abuse/neglect
  - c. Threats made by a resident toward self and/or others (the threatened party(ies) and the police will be notified).
  - d. Court order
  - e. Resident's medical emergency
13. To be fully informed as evidenced by your written acknowledgment before or at the time of admission and during your residency at [enter house name], of the rights and responsibilities set forth herein and of all rules and regulations governing client conduct and responsibilities, and client grievance procedures.

Resident Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_