Program Entry Application

Date

Personal Information

Name

Date of Birth		ID#	SS# - -	Referred by
Phone Number	Mobile Number	Emergency contact		
Are You A U.S. Citizen? Yes ☐ No ☐		Have You Ever Been Convicted of a Felony or a Misdemeanor? Yes ☐ No ☐ Details:		

I am Willing to Submit to any Random Drug Screening Test required by Time For Change In Action

Yes ☐ No ☐

Legal

Are you currently on parole or Probation? Yes ☐ No ☐	Charges:	Probation time?

Phone number:

Name of probation office and officer?

Employment / Income

Employer or Source of income: Phone

Other Financial Resources: Paid schedule: Weekly ☐ Bi-Weekly ☐ Monthly ☐

References

Name	Title	Company	Phone

Alcohol and Drug Use

Substance			Frequency of Use	(oral, smoke, inhaled, injected, other)
Alcohol	Yes ☐	No ☐		
Marijuana	Yes ☐	No ☐		
Methamphetamine	Yes ☐	No ☐		
Opioids	Yes ☐	No ☐		
Spice	Yes ☐	No ☐		
Pharmaceuticals	Yes ☐	No ☐		
Drug of choice	Yes ☐	No ☐		
Heroin	Yes ☐	No ☐		

Other _____

Recovery Plan Checklist

Are you willing to attend five Recovery Meetings each week? YES / NO If attending a Group, are you willing to work with a sponsor each week? YES / NO How many attempts have you made to get clean and sober in the past?_____Most clean/sober time attained? _____

How Many Meetings do you attend each week?_____ Do you have a sponsor? Yes ☐ No ☐

Sponsor name and phone? _____

Previous treatment _____

Did you attend other recovery activities? _____

Do you take your Medications every day each week? Yes ☐ No ☐ if no, why?

Do you need to fill your Medications this week? Yes ☐ No ☐ if yes, how?

Are your medications working for you? Yes ☐ No ☐

Do you need to make an appointment with doctor? Yes ☐ No ☐

Do you need to make an appointment with Therapist? Yes ☐ No ☐

Do you have court obligations? Yes ☐ No ☐ Are they being met? Yes / No

Are you currently going to school? Yes ☐ No ☐ if so, name of school _____

Are you planning on going to school? Yes ☐ No ☐ if so, field of study _____

Medical information

General Information

Case manager

Case manager_____ Phone_____

Address _____ City _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other_____ Phone_____

Address _____ City _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sex:

☐ Male ☐ Female

Do you have a DNR? Yes ☐ No ☐

Do you currently have medical insurance? Yes ☐ No ☐ if yes (provider) _____

Member ID:_____Group number:_____

List any other medical or diagnostic test you have had in the past two years: _____

_____

_____

List hospitalizations, including dates of and reasons for hospitalization: _____

_____

List any prescription medications you are now taking: _____

_____

_____

List any self-prescribed medications, dietary supplements, or vitamins you are now taking:_____

_____

_____

Date Name Sign

HIPAA Compliance Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information isprotected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we deem are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. Unless you provide us in writing that you refuse, you agree that this office can share needed information about your treatment plan with your referring family physician and/or physician that you are being referred to.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories, attorneys, collection agencies, law enforcement officials, worker's compensation, etc.), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You, as the patient, have the right to receive one free copy of your medical records from this and any office where you have sought or received treatment. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. You have the right to review our privacy notice, to request restriction, and to revoke consent in writing after you have reviewed our privacy notice. I acknowledge that I have received a HIPAA Compliance Assurance Notification.

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our valued Residents: The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually under go training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us to prevent any inappropriate use of PHI. We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

PURSUANT TO 45 CFR 164.508 TO:

_____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____

Street Address

_____

City, State and Zip Code RE: Patient Name:

_____

Date of Birth:_____Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following: All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

All physical, occupational and rehab requests, consultations and progress notes. All disability, Medicaid or Medicare records including claim forms and record of denial of benefits. All employment, personnel or wage records. All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, my Leo gram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports. All pharmacy/prescription records including NDC numbers and drug information handouts/monographs. All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits while I'm a resident in TIME FOR CHANGE IN ACTION. I understand the information to be released or disclosed may include information relating
to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human Page 1 of 2 immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. This protected health information is disclosed for the following purposes of my recovering and housing TIME FOR CHANGE IN ACTION.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

City, State and Zip Code I understand the following: See CFR §164.508(c)(2) (i-iii) a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Date	Name	Sign

If a personal representative sign this authorization on behalf of the individual, complete the following:

Representative Name: _____

Relationship to the Individual: _____

Guidelines Agreement

Name:

Date Of Birth: SS#

The above-mentioned client has read and understands all the guidelines presented as a condition of participation in the TIME FOR CHANGE IN ACTION. The client agrees to abide by all guidelines presented for the duration of his/her participation in the program at their assigned location (s) or visitation to any other program facilities. The client willingly agrees to vacate the premises immediately upon the request of the management if a violation determination is made and a request to vacate the premises is requested. The client further agrees that the request to vacate the premises is to take place immediately.
Returning to pick up personal property must be made, by appointment with The TIME FOR CHANGE IN ACTION Director, and within 24 hours of the vacate request.

Date Name Sign

Waiver Of Tenant Rights

I,_____, do understand that I am entering the program of TIME FOR CHANGE IN ACTION. I also understand that I can be immediately terminated from the program if I am not compliant with the program-rules of TIME FOR CHANGE IN ACTION, at the discretion of the Executive Directors and Recovery Coaches.

It is with that understanding that I,_____do hereby waive any and all tenant's rights with the understanding that I am in a program and not a resident of any programs properties that TIME FOR CHANGE IN ACTION operates. I agree to leave immediately when requested to leave along with all personal belongings.

Date Name Sign

Program Financial Agreement

Be advised that the above client agrees to $_____weekly/monthly (circle one) for program fees while residingat TIME FOR CHANGE IN ACTION." These program fees are due each and every week/month as agreed upon by the director and client; see section below if the standard agreement is being changed. **Also, upon arrival, there will be a one-time $100 none refundable, application fee. Also, if anyone enters 'Time For Change In Action" between the 1rst and the 4th or the 15th and the 19th of the month, they will be charged the full amount of program fees: ($850) monthly or ($425) bi-weekly.**

Difference in program fee due date:
The above-mentioned client agrees to willingly vacate the premises, immediately upon request by the director, or staff, when program fees are in the arrears, the client uses drugs or alcohol, or the program guidelines are violated in anyway.The policy of " TIME FOR CHANGE IN ACTION " for refunds of prepaid program fees is as follows; money **WILL NOT** be refunded, unless however exceptions can be made on unique circumstances. Exceptions are only made by Director or a member after a case review and if determined a refund can be processed within 10-15 days. Program requires a 15-day written notice prior to resident's intent to vacate the premises. There will be a two-week program fee assessment added to all clients who leave before 30 days.

Resident

Date Name Sign

Staff _____

RESIDENT RESPONSIBILITIES

Respect for Residents and Staff _____

Visitors: 1. NO overnight guests are allowed. If any guest causes dissension on property, that guest will be asked to leave. Visits with sponsors are encouraged. 2. New arrival Curfew: All new residents will return to the house by 10 pm every day. New residents will abide by the standard curfew after employment has been verified. Attaining employment immediately will directly benefit each resident. 3. Standard Curfew: All residents who are working will be expected to return to the house by 11 pm Sunday –Thursday. For those late for curfew, you may be required to drug test and pay a $25test fee and you will be on a 2-week probation. A 10 pm curfew will be in effect while on probation. 4. Noise Levels: We ask that you respect your fellow residents and play radios and televisions at reasonable volume levels. 5. Smoking: Absolutely no smoking in the house due to insurance liabilities. Smoking is allowed in designated smoking areas only.

6. Pets: Residents are not permitted to have any pets not approved by Managing Staff. 7. Sanitation: Program participants have the right to live in a clean and welcoming environment. Resident will keep the premises clean at all times, and upon discharge will leave the premises in

as good of condition as when this agreement was entered. Each resident is requested to eat their food in common areas and wash their own dishes immediately after eating. Residents are responsible for cleaning of all community living areas, such as, kitchen, bathroom, living room, den, patios, backyard and grounds, and laundry room.

Respect for Self _____

Sexual Activity: 1. No sexual activity in the house or on the grounds at any time. 2. Drug and Alcohol Use: Occupancy ismade available on the strict understanding that the house and its residents are to be, at all times, drug and alcohol free.
Alcohol and illegal drugs are not allowed on program premises nor any mind-altering substances at ANY time. Noaddictive psychiatric medications that aren't approved by Doctor and Staff. If you have questions regarding your
recovery, please don't hesitate to ask Staff. Please be aware of other resident's recovery needs. In addition, guests of a resident who are under the influence of any type of mind-altering substances are not permitted, at any time on the grounds.ALL RESIDENTS WILL BE REQUIRED TO SUBMIT TO RANDOM URINE TESTING WHEN REQUESTED BY
STAFF. 3. Medication: The program does not dispense medication. Our policy prohibits abusing mind-altering medications. If we feel that a prescribed medication for a resident is detrimental to other residents, we will ask that residentto go without, or resident will have the option to move out with full explanation to any supervisory agencies. All medications need to be entered in medication log. (See house manager). NO NARCOTIC MEDICATIONS ARE ALLOWED WHILE LIVING IN THE PROGRAM. You must secure your medications. No sharing of any resident's prescribed medications. 4. Dress Code: All residents must be properly attired at all times including while sleeping. 5.
Pornography: NO pornography is allowed in the house.

Respect for Property_____

Alteration to Property: 1. Residents may not make any alterations to the property due to TIME FOR CHANGE IN ACTION lease agreement with the property owners. This includes altercation of cable or internet connections, installation of paneling, flooring, built in decorations, partitions or railing, shades, blinds window guards, in or outside of the premises, or drillingor attaching anything to the floors, walls or ceiling. In addition, residents may not bring in any dish washing, clothes washing, heating, ventilating, or air conditioning units, and may not have any water filled furniture, refrigerator or coffee pot in the bedroom. 2. Vehicles: To operate and/or park a motor vehicle while residing at the facility a valid driver's license, proof of insurance, and registration are required. They will be towed at your expense. Only one motor vehicle per resident is allowed on property. 3. Weapons: No weapons of any kind are allowed on premises.

Legal Accountability _____

Probation/Parole Requirements: 1. If you are on probation/parole or supervision of any kind, you must continue to abide by all rules set down by your supervising agency. 2. Community

Service: Residents can participate in court ordered community service at the property if approved by parole/probation officer. Staff will supervise and sign off on all work.

Basic Resident information _____

Activity/Work Plan: 1. We require all residents to participate to be assigned a case plan; which could involve more addiction recovery programs, employment or volunteer work. All residents that are required to work will be dressed and out of the house at their assigned time. 2. Passes. A minimum of seven days in the house is required before a pass will be considered. The Case Manager along withthe supervisory agency will approve all passes based on performance in the house. All program fees must be current for the pass to be approved. You must have completed a 24-hour pass before being given a 48-hour pass.

3. Sleeping: All residents must be awake, dressed, and areas cleaned by 10:00 am daily. Residents are requested to sleep in their bed and not in the living room. Day sleeping is not allowed unless specifically approved. 4. House activities:All residents are asked to participate in all house activities including weekly house meetings, group sessions, and weekly housekeeping duties.

5. Twelve Step Meeting Attendance: All residents are required to attend at least 3-5 outside 12 step meetings per week or as indicated on treatment plan. 6. Sponsors/Mentors: If you are attending any 12 step Recovery meetings, it is imperative that you get a 12-step sponsor and/or mentor immediately. 7. House Liability: TIME FOR CHANGE IN ACTION is not liable for any personal property during or after the resident's discharge from the house. Please limit what you bring. TIME FOR CHANGE IN ACTION will dispose of all personal property seven days from discharge date. A written notice must be submitted to the case/house manager upon departure for anyone else to pick up personal property.

Second Chance: If a client/house-member violates any of TIME FOR CHANGE IN ACTION's (TFCIA's) rules or policies, that individual will be discharged, but if that individual has been complying with TFCIA's rules and policies for at least sixty to ninety days, that individual could be eligible for a second chance. If the staff decides to give that individual a second chance, it will be as followed: **1.** If an individual commits an infraction in his/her original transitional house, said individual has to be moved to another house if there is one available. **2.** If that individual agrees to be moved to another house, said individual will have to start all over again including curfew and paying program fees. **3.** Severe recovery consequences will be given to said individuals such as: meetings every day for ninety days, getting a home group, getting a sponsor, and getting a service commitment.

RESIDENT RIGHTS _____

Violence Free Environment: Maintaining a violence free environment is critical to establishing a sense of safety. For this reason, violating the rights of others may be grounds for terminating some or all services. Intimidation or violence towards residents or staff is prohibited. Please respect your peers and housing staff. No weapons of any kinds are allowed on property. 2. Spiritual Customs: Residents have a right to practice any cultural, religious or spiritual customs. For the safety and respect of all, please do not impose any of your beliefs, try to recruit anyone to practice your religion, and do not practice any customs that involve fire or smoke inside the house. 3. Privacy: Residents may not enter another person's room without permission. TIME FOR CHANGE IN ACTION will not discuss resident information, including billing agreements or program concerns, with other residents.

Photo Release _____

I hereby grant permission to TIME FOR CHANGE IN ACTION to use photographs and/or video of me taken on any date at any location in publications, news releases, online, and in other communications related to the mission of TIME FOR CHANGE IN ACTION.

I certified that this form has been filled out to the best of my ability and the answers are true and honest. I certified I read and understand the terms on this agreement and agree to follow all terms policies and procedures. I understand that failure to comply with these terms and policies can result in termination from the program with little to no notice.

Date	Name	Sign

Personal Goals and information

Do you ever think about hurting yourself or others? Yes ☐ No ☐

What abilities do you think you possess that will help you be successful at TIME FOR CHANGE IN ACTION?

_____

Please tell us about yourself (your likes & dislikes, etc.):

_____

_____

What would be your dream goal to accomplish?

_____

How would you describe your life right now?

_____

View on Religion?

_____

Hobbies?

_____

Do you believe you are capable of change?

_____

What is your trigger?

_____

What's the one thing you would like to change about yourself?

_____

What was the best phase in your life?

What was the worst phase in your life?

What's your favorite book/movie of all time and why did it speak to you so much?

What's your biggest regret in life?

Long term and short-term goal?

Date Name Sign

For office use only

Date: _____ APPROVED Yes ☐ No ☐ Was interviewee Alert and oriented x3 Yes ☐ No ☐

Intake interview processed by: _____

Signature: _____

Comments: