TO OUR PROSPECTIVE CLIENTS

Thank you for choosing Rainforest Recovery Center as your first step into a life free from addiction to alcohol and drugs. To make your transition and admission into treatment go smoothly, here are a few things you need to know about Rainforest and what items you should and should not bring with you to treatment.

A FEW THINGS TO KNOW:

- Upon your arrival, you will meet with an RRC staff member who will ask you basic questions and assist in admitting you into the residential program. A Breathalyzer (BAC) test and an observed Urine Drug Screen (UDS) will be completed at the time of admission and randomly throughout your stay.
- You are asked to have a History and Physical completed prior to your admission and have this forwarded to RRC. This must have been completed within the past 90 days. Please take care of medical and dental needs prior to admission.
- Once you have been admitted, if you have not had a recent chemical dependency assessment, this will be completed by your counselor within 24 hours of admission.
- The majority of treatment will consist of group work and meeting with your primary counselor. You are expected to begin your treatment program immediately and participate in all program activities.

WHAT TO BRING:

- Enough clothing for seven days. Limit your clothing to one suitcase and a small personal bag such as a purse or backpack. Your suitcase will be stored for you after you unpack for the duration of your treatment.
- Bring a warm coat, gloves, winter hat and boots for outdoor activities. Waterproof material is preferable.
- Personal clothing for daily wear and loose comfortable clothing and tennis shoes for exercising.
- A bathing suit.
- Hand lotion, shampoo, conditioner, hairdressing gels, deodorant, etc. **THESE ITEMS MUST NOT HAVE ALCOHOL LISTED WITHIN THE FIRST THREE INGREDIENTS.**
- Hairbrush and/or comb, toothbrush and toothpaste. **ANY HAIRSTYLING EQUIPMENT SUCH AS HAIRDRYERS AND CURLING IRONS MUST HAVE A FACTORY-INSTALLED THREE PRONGED ELECTRICAL SAFETY CORD. (AN ADAPTER IS NOT SATISFACTORY.)**
- Paper, pen or pencil, envelopes, and postage stamps
- Small family photographs are welcomed
- Telephone calling card. Cell phones may be brought for use, but will be stored and checked during specified times.
- If you are a tobacco user, you will need to bring enough supplies of nicotine replacement therapy (patches, gum, or lozenges) to last about 5 weeks.
- A 30-day supply of all your medications. Over-the-counter medications must be in factory sealed containers. Medications will be identified and must be approved by RRC Medical Director or Pharmacy staff prior to your being allowed to take these medications. While in treatment, your medication will be stored and you will be responsible for self-administration of medication.

WHAT NOT TO BRING:

- Alcohol, marijuana, street drugs, or tobacco.
- Weapons of any sort
- Pornography or other material offensive in nature
- Clothing that displays liquor or drug logo or is sexual or provocative in nature.
- Your personal vehicle (due to limited parking availability).
- Valuable items such as jewelry, valuable personal items, or more than $30 in cash.
- Food from home or personal food items.

Supplemental Questionnaire for Intake Assessment. (STATE and JACHO requirements.)

Name: _____ **Date:** _____

When multiple answers, circle the one that best describes you.

Program Type:
- BO Mental Health/Subs Abuse
- MH Mental Health
- SA Substance Abuse

Admission Type:
- CS Change in service
- FA First admission
- NN None
- RA Readmission
- TR Transfer

Codependent/collateral client? _____

Marital status:
- Single
- Married
- Separated
- Divorced
- Single but living as married.

Client's report of health status:
- EX Excellent
- FR Fair
- GD Good
- PR Poor
- RF Refused
- UN Unknown
- VG Very good

# of prior substance abuse tx episodes: _____

# of mental health treatment episodes: _____

# of substance abuse hospitalizations in past 6 months: _____

# of mental health hospitalizations:_____

Acute/current pain condition? Y N
Location: _____
Description: _____
Intensity: 1 2 3 4 5 6 7 8 9 10
Duration: _____
Radiates? Y N
Location: _____
Relieving technique used: _____
If above answer for Pain is Yes answer the following questions on chronic pain. If No, skip chronic pain questions and proceed to questions on sleep.

Chronic pain condition? Y N
Location: _____
Description: _____
Intensity: 1 2 3 4 5 6 7 8 9 10
Duration: _____
Radiates? Y N
Location: _____
Relieving technique used: _____

Nutrition Screening for Nutrition Consult:

Unplanned, significant weight change?	Y N
Severely overweight or significantly underweight?	Y N
High risk diagnosis?	Y N
Prolonged nausea/vomiting/diarrhea (> 7 days)?	Y N
Special diet?	Y N
Drug(s) for weight control?	Y N

Learning needs:

A	Activity	CI	Current illness
CR	Community resources	D	Diet
HC	Home care	M	Medications
PC	Pain Control	PH	Personal habits
R	Risk factors	T	Treatments

Learning limitations:
- A Age
- AM Altered mentation level
- C Culture
- DL Developmental limits
- L Language
- LE Limited education
- N None
- R Readiness/willingness

Learning style:
- D Demo/return demo
- G Group discussion
- H Handouts
- L Lecture
- 6 One-on-one
- V Videos

Employment status:
- AF In the Armed Forces
- **DI Disabled**
- **FT Employed full time**
- **HM Homemaker**
- NC Not collected
- NI 0 labor-resident/inmate
- **NO 0 labor-other**
- NR No response
- **NS Student**
- **NU 0 labor-unemployed, not seeking**
- **NUS 0 labor-unemployed ,subsistence**
- **NW 0 labor-not seeking work**
- OT Other
- **PT Employed part time**
- **R Retired**
- **SI Seasonal- in-season**
- **SO Seasonal- out of season**
- **UL Unemployed-looking f work**
- UN Unknown

If employed, days absent from work in past 30 days? _____

Primary source of income:

ACD	AK Native Corp Dividends
AL	Alimony
APFD	Alaska PFD
CH	Child support
EM	Employment
IN	Interest and Other
NC	Not collected
NO	None
OT	Other
PA	Any public asst/welfare
PAR	Parent's income
RR	Railroad Retirement
RS	Retire,Surv,Disa Pensions
SD	SS Disability (SSDI)
SE	Self employment
SI	Supplemntl Sec Inc (SSI)
SN	SSI/SSDI Never
SP	SSI/SSDI Previous
SPO	Spouse or S.O.'s income
SS	Social Security
UC	Unemployment compensation
UN	Unknown

Household income:

01	$50,000 and over
L1	$0-$999
L2	$1,000-$4,999
L3	$5,000-$9,999
L4	$10,000-$19,999
L5	$20,000-$29,999
L6	$30,000-$39,999
L7	$40,000-$49,999

Current living situation:

AFC	Adult foster care
ALF	Assted Living Factility
CH	Correctional halfway hous
GH	Group home
H	Homeless
HNP	Hosp/non-psych purposes
HPP	Hosp/psych purposes
IN	Alone
INP	Household w non-related
IR	Household w relatives
JC	Jail/correct. Facility
JD	Juvenile detention
MD	Missing data
NH	Nursing home
OT	Other
PR	Priv resid w/o support
PS	Priv resid w support
RA	Refused to answer
RT	Residential treatment
S	Shelter
SAH	SA halfway house
TH	Transitional housing
UN	Unknown

Household composition:

AL	Lives alone
OT	Other
SO	Lives w spouse/S.O.
WC	Lives w children
WN	Lives w non-relatives
WP	Lives w adolescents
WR	Lives w relatives

# of people living with client: _____
# of children in the household: _____

Legal Status:

30C	30 day commitment
180C	180 day commitment
CJD	Ct ordered Juv: DJJ cust
CDO	Ct ordered for observation /evaluation
CP	Case pending
CTAT	Ct ordered alcohol Tx
DP	Deferred prosecution
DS	Deferred sentence
EDE	Emergency commitment (48 hr hold, 3 Day extension)
INC	Incarcerated XXXXX
NR	No response
PCS	Protective custody (12 hr hold)
PRB	Probation/Parole
UN	Unknown

Potential substance abuse client? Y N

Follow-up steps:

IF	Inappropriate for intervention
IH	In-house assessment
NN	Not necessary/clinician
PR	Provided resource info
RC	Referral created:

Potential mental health client? Y N

Follow-up steps:

IF	Inappropriate for intervention
IH	In-house assessment
NN	Not necessary/clinician
PR	Provided resource info
RC	Referral created:

Does client need FASD assessment? Y N

Follow-up steps:
- IF Inappropriate for intervention
- IH In-house assessment
- NN Not necessary/clinician
- PR Provided resource info
- RC Referral created

Potential dual diagnosed (MH and SA) consumer? Y N

Follow-up steps:
- IF Inappropriate for intervention
- IH In-house assessment
- NN Not necessary/clinician
- PR Provided resource info
- RC Referral created

Evidence of traumatic brain injury? Y N

Follow-up steps:
- IF Inappropriate for intervention
- IH In-house assessment
- NN Not necessary/clinician
- PR Provided resource info
- RC Referral created

Primary ICD9 code: _____ Diagnosis number plus 1 (Continuous) 2 (Episodic) 3 (Remission)

Axis 1.

	291.8	Alcohol Withdrawal
	305.00	Alcohol Abuse
	303.90	Alcohol Dependence
	305.70	Amphetamine Abuse
	304.4	Amphetamine Dependence
	305.20	Cannabis Abuse
	304.30	Cannabis Dependence
	292.0	Cocaine Withdrawal
	305.60	Cocaine Abuse
	304.2	Cocaine Dependence
	305.10	Nicotine Dependence]
	292.0	Opioid Withdrawal
	305.50	Opioid Abuse
	304.0	Opioid Dependence
	292.0	Sedative, Hypnotic, or Anxiolytic Withdrawal
	305.4	Sedative, Hypnotic, or Anxiolytic Abuse
	304.10	Sedative, Hypnotic, or Anxiolytic Dependence
R/O	291.8	Substance induced Mood Disorder
R/O	291.8	Alcohol-Induced Anxiety Disorder
R/O	296.3x	Major Depression Recurrent,
	296.2x	Major Depression Single Episode
R/O	311	Depressive Disorder NOS
R/O	300.4	Dysthymic Disorder
R/O		Bipolar Disorder
R/O	300.0	Anxiety Disorder NOS
R/O	300.1	Panic Disorder without Agoraphobia
R/O	309.81	Posttraumatic Stress Disorder

_____

_____

Axis 2 V71.09 299.9 Deferred

_____

Axis 3 None Deferred _____

_____

Axis 4

1.0	Problems with primary support group
2.0	Problems with social environment.
3.0	Educational problems
4.0	Occupational problems
5.0	Housing problems
6.0	Economic problems
7.0	Problems with access to health care
8.0	Problems with the legal sys/crime
9.0	Other problems with psychosocial/environment.

Dimension 1	0	1	2	3	4	4a	4b
Dimension 2	0	1	2	3	4	4a	4b
Dimension 3	0	1	2	3	4	4a	4b
Dimension 4	0	1	2	3	4	4a	4b
Dimension 5	0	1	2	3	4	4a	4b
Dimension 6	0	1	2	3	4	4a	4b

Axis 5 GAF _____

Recommended level of care
- 0 No Treatment Recommended
- 0.5 Early Intervention
- I.0 Outpatient
- II.1 Intensive Outpatient
- II.5 Day Treatment/Partial Hospitalization
- III.1 Clinically Managed - Low Intensity Residential
- III.3 Clinically Managed - Medium Intensity Residential
- III.5 Clinically Managed - High Intensity Residential
- III.7 Medically Monitored
- IV Medically Managed Inpatient

Actual Level of Care:
- 0 No Treatment Recommended
- 0.5 Early Intervention
- I.0 Outpatient
- II.1 Intensive Outpatient
- II.5 Day Treatment/Partial Hospitalization
- III.1 Clinically Managed - Low Intensity Residential
- III.3 Clinically Managed - Medium Intensity Residential
- III.5 Clinically Managed - High Intensity Residential
- III.7 Medically Monitored
- IV Medically Managed Inpatient

Pharmacotherapy planned? ____

Is client on psychotropics? _____

Was a functional assessment completed? Y N

Rainforest Recovery Center

Assessment (URICA) Scale

Name: _____ **Problem:** _____

This questionnaire is to help us improve our services. Each statement describes how a person might feel when starting therapy. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. For all the statements that refer to your "problem", answer in terms of the problem you have written at the top. And "here" refers to the place of treatment.

There are FIVE possible responses to each of the items in the questionnaire:
Strongly disagree, disagree, undecided, agree, and strongly agree. Circle the number that best describes how much you agree or disagree with each statement.

There are FIVE possible responses:	**Strongly Disagree**	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
1. As far as I'm concerned, I don't have any problems that need changing.	**1**	**2**	**3**	**4**	**5**
2. I think I might be ready for some self-improvement.	**1**	**2**	**3**	**4**	**5**
3. I am doing something about the problems that had been bothering me.	**1**	**2**	**3**	**4**	**5**
4. It might be worthwhile to work on my problem.	**1**	**2**	**3**	**4**	**5**
5. I'm not the problem one. It doesn't make much sense for me to be here.	**1**	**2**	**3**	**4**	**5**
6. It worries me that I might slip back on a problem I have already changed, so I am here to seek help.	**1**	**2**	**3**	**4**	**5**
7. I am finally doing some work on my problem.	**1**	**2**	**3**	**4**	**5**
8. I've been thinking that I might want to change something about myself.	**1**	**2**	**3**	**4**	**5**
9. I have been successful in working on my problem, but I'm not sure I can keep up the effort on my own.	**1**	**2**	**3**	**4**	**5**
10. At times my problem is difficult, but I'm working on it.	**1**	**2**	**3**	**4**	**5**

There are FIVE possible responses:	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
11. Being here is pretty much of a waste of time for me because the problem doesn't have to do with me.	**1**	**2**	**3**	**4**	**5**
12. I'm hoping this place will help me to better understand myself.	**1**	**2**	**3**	**4**	**5**
13. I guess I have faults, but there's nothing that I really need to change.	**1**	**2**	**3**	**4**	**5**
14. I am really working hard to change.	**1**	**2**	**3**	**4**	**5**
15. I have a problem and I really think I should work on it.	**1**	**2**	**3**	**4**	**5**
16. I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem.	**1**	**2**	**3**	**4**	**5**
17. Even though I'm not always successful in changing, I am at least working on my problem.	**1**	**2**	**3**	**4**	**5**
18. I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.	**1**	**2**	**3**	**4**	**5**
19. I wish I had more ideas on how to solve my problem.	**1**	**2**	**3**	**4**	**5**
20. I have started working on my problems but I would like help.	**1**	**2**	**3**	**4**	**5**
21. Maybe this place will be able to help me.	**1**	**2**	**3**	**4**	**5**
22. I may need a boost right now to help me maintain the changes I've already made.	**1**	**2**	**3**	**4**	**5**
23. I may be part of the problem, but I don't really think I am.	**1**	**2**	**3**	**4**	**5**
24. I hope that someone here will have some good advice for me.	**1**	**2**	**3**	**4**	**5**

There are FIVE possible responses:	**Strongly Disagree**	**Disagree**	**Undecided**	**Agree**	**Strongly Agree**
25. Anyone can talk about changing; I'm actually doing something about it.	**1**	**2**	**3**	**4**	**5**
26. All this talk about psychology is boring. Why can't people just forget about their problems?	**1**	**2**	**3**	**4**	**5**
27. I'm here to prevent myself from having a relapse of my problem.	**1**	**2**	**3**	**4**	**5**
28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	**1**	**2**	**3**	**4**	**5**
29. I have worries but so does the next guy. Why spend time thinking about them.	**1**	**2**	**3**	**4**	**5**
30. I am actively working on my problem.	**1**	**2**	**3**	**4**	**5**
31. I would rather cope with my faults then try to change them.	**1**	**2**	**3**	**4**	**5**
32. After all I had done to try and change my problem, every now and again it comes back to haunt me.	**1**	**2**	**3**	**4**	**5**

ROOM RULES

DAILY, YOU ARE EXPECTED TO:

1. Make your bed.
2. Pick up your clothes and personal items from the floor surrounding your part of the room.
3. Use only the bed and space assigned to you.
4. Place all wet towels in the hampers located in the hallways. If you need additional towels, ask the staff in the watch station to get them for you.
5. Use the paper mats for floor mats when getting out of the shower.
6. No food or cell phones are allowed in your room. If they are discovered during the course of cleaning by housekeeping, they will be turned in to the watch station.

ON TUESDAYS, YOU ARE EXPECTED TO:

1. Strip the linens and mattress pads from your bed and place them in the hampers in the hallway. Clean linens will be placed on your bed by housekeeping. Then you are to remake your bed.

DAILY, HOUSEKEEPING WILL:

1. Empty your trash
2. Clean your floor that does not have personal items on the floor.
3. Clean the bathrooms.

HOUSEKEEPING WILL NOT:

1. Make your bed for you.
2. Move any of your personal items in order to clean the room or bathroom.

Rainforest Recovery Center Rules

In addition to your behavioral expectations, the following rules are in place to assure that your stay at Rainforest Recovery Center is safe and healthy.

- No clients of the opposite sex or visitors are allowed in client rooms.
- No food is to be taken from the dining area to client rooms or conference rooms.
- All coffee and beverage cups must be covered with lids whenever taken out of the dining area.
- No sharing of medications either prescription or over-the-counter. Staff will not give out aspirin, Tylenol, or any other medication to clients.
- No ungrounded plugs in client areas.
- Medications are to be taken according to the doctors instructions.
- Staff personal phone numbers, addresses, or e-mail addresses are not to be given to clients.
- No smoking or tobacco use paraphernalia such as lighters are to be in your possession.
- Criminal activity of any kind is prohibited, whether the event occurs on campus or in off campus activities. All illegal drugs or alcohol confiscated will be destroyed.
- No more than $100 will be stored in client lockers. Any money over this amount must be stored in the safe at PAS.
- While participating in off campus activities, you must stay within eye sight of staff at all times. Use the buddy system.
- No smoking or use of tobacco products on or off campus.
- Outpatient clients are not allowed in counselor offices or dining area (IOP clients only)

ALASKA SCREENING TOOL

Client Name: _____ **Client Number:** _____

Staff Name: _____ **Date:** _____

Info received from: (include relationship to client) _____

Please answer these questions to make sure your needs are identified. Your answers are important to help us serve you better. If you are filling this out for someone else, please answer **from their view**. Parents or guardians usually complete the survey on behalf of children under age 13.

SECTION I – Please estimate the number of days in the **last 2 weeks** (enter a number from 0-14 days): **0-14 days**

1. Over the last two weeks, how many days have you felt little interest or pleasure in doing things? ..... _____
2. How many days have you felt down, depressed or hopeless? ..... _____
3. Had trouble falling asleep or staying asleep or sleeping too much? ..... _____
4. Felt tired or had little energy? ..... _____
5. Had a poor appetite or ate too much? ..... _____
6. Felt bad about yourself or that you were a failure or had let yourself or your family down? ..... _____
7. Had trouble concentrating on things, such as reading the newspaper or watching TV? ..... _____
8. Moved or spoken so slowly that other people could have noticed? ..... _____
9. Been so fidgety or restless that you were moving around a lot more than usual? ..... _____
10. Remembered things that were extremely unpleasant? ..... _____
11. Were barely able to control your anger? ..... _____
12. Felt numb, detached, or disconnected? ..... _____
13. Felt distant or cut off from other people? ..... _____

SECTION II – Please check the answer to the following questions based **on your lifetime.**

14. I have lived where I often or very often felt like I didn't have enough to eat, had to wear dirty clothes, or was not safe ..... ☐ Yes ☐ No
15. I have lived with someone who was a problem drinker or alcoholic, or who used street drugs ..... ☐ Yes ☐ No
16. I have lived with someone who was seriously depressed or seriously mentally ill ..... ☐ Yes ☐ No
17. I have lived with someone who attempted suicide or completed suicide ..... ☐ Yes ☐ No
18. I have lived with someone who was sent to prison ..... ☐ Yes ☐ No
19. I, or a close family member, was placed in foster care ..... ☐ Yes ☐ No
20. I have lived with someone while they were physically mistreated or seriously threatened ..... ☐ Yes ☐ No
21. I have been physically mistreated or seriously threatened ..... ☐ Yes ☐ No
    a. If you answered **"Yes"**, did this involve your intimate partner (spouse, girlfriend, or boyfriend)? ..... ☐ Yes ☐ No

ALASKA SCREENING TOOL

SECTION III – Please answer the following questions based **on your lifetime.** (D/N = Don't Know)

22. I have had a blow to the head that was severe enough to make me lose consciousness ..... ☐ Yes ☐ No ☐ D/N
23. I have had a blow to the head that was severe enough to cause a concussion . ☐ Yes ☐ No ☐ D/N

If you answered "Yes" to 22 or 23, please answer a-c:

a. Did you receive treatment for the head injury? ..... ☐ Yes ☐ No
b. After the head injury, was there a permanent change in anything? ..... ☐ Yes ☐ No ☐ D/N
c. Did you receive treatment for anything that changed?..... ☐ Yes ☐ No

24. Did your mother ever consume alcohol? ..... ☐ Yes ☐ No ☐ D/N
    a. **If Yes**, did she continue to drink during her pregnancy with you? ..... ☐ Yes ☐ No ☐ D/N

SECTION IV – Please answer the following questions based on the **past 12 months.**

25. Have you had a major life change like death of a loved one, moving, or loss of a job? .... ☐ Yes ☐ No
26. Do you sometimes feel afraid, panicky, nervous or scared? ..... ☐ Yes ☐ No
27. Do you often find yourself in situations where your heart pounds and you feel anxious and want to get away? ..... ☐ Yes ☐ No
28. Have you tried to hurt yourself or commit suicide? ..... ☐ Yes ☐ No
29. Have you destroyed property or set a fire that caused damage?..... ☐ Yes ☐ No
30. Have you physically harmed or threatened to harm an animal or person on purpose? ... ☐ Yes ☐ No
31. Do you ever hear voices or see things that other people tell you they don't see or hear? ..... ☐ Yes ☐ No
32. Do you think people are out to get you and you have to watch your step?..... ☐ Yes ☐ No

SECTION V – Please answer the following questions based on the **past 12 months.**

33. Have you gotten into trouble at home, at school, or in the community, because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
34. Have you missed school or work because of using alcohol, drugs, or inhalants? ..... ☐ Yes ☐ No
35. In the past year have you ever had 6 or more drinks at any one time? ..... ☐ Yes ☐ No
36. Does it make you angry if someone tells you that you drink or use drugs, or inhalants too much?..... ☐ Yes ☐ No
37. Do you think you might have a problem with alcohol, drug or inhalant use?..... ☐ Yes ☐ No

THANK YOU for providing this information! Your answers are important to help us serve you better.

BARTLETT REGIONAL HOSPITAL- Rainforest Recovery Center

3260 Hospital Drive, Juneau, Alaska 99801 Telephone (907) 796-8900
Fax to: Rainforest Recovery Center (907) 586-5605

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Patient Name:_____ Birth Date:_____ Social Security #_____

Address: _____ City / State/ Zip: _____

I Hereby Authorize Bartlett Regional Hospital to Release Information TO:

Name of Facility/ Organization / Individual: _____

Address: _____

City / State / Zip: _____ Phone Number: _____ FAX: _____

I Hereby Authorize Bartlett Regional Hospital to REQUEST Information FROM:

Name of Facility/ Organization / Individual: _____

Address: _____

City / State / Zip: _____ Phone Number: _____ FAX: _____

- ❑ Dates of treatment: From_____To_____
- ❑ Purpose or need for information being requested:
  Further Treatment _____ Legal Proceedings _____ Insurance Claim _____ Other (specify): _____
  Amount of Information to be used or disclosed

_____Consultation	_____History & Physical	_____Lab Reports	_____ Entire Record
_____Physical Therapy Notes	_____Discharge Summary	_____Operative Report	_____Progress Notes
_____EKG Report	_____Pathology Reports	_____X-Ray Reports	_____X-Ray Films
_____Psychiatric Evaluation	_____ER Report	_____Verbal Exchange	_____e-mail/fax
_____Assessment	_____Treatment Plan	_____Court Disposition	_____Visitation

_____Other: _____

I authorize the release of information relating to:
_____ Chemical Dependency or Abuse Treatment _____ Psychiatric Evaluation / Treatment

This Authorization expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signing.

** I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must submit a written revocation to the BRH Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
** I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment at BRH.
** I consider a photocopy of this authorization to be as valid as the original. I understand that I may upon request inspect the information to be disclosed.
** I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, BRH their employees and physician(s) cannot prevent re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

_____ _____ _____
Signature of Patient or Legally Responsible Party Relationship to Patient Date

_____ _____
Witness Date

FOR OFFICE USE ONLY

ID Verified & Medical Records Released By: _____ Date: _____
MR #: _____ Date Records Mailed/ Faxed/ Picked Up: _____
Amount Charged: _____

Sliding Fee Application

Please note that if the application is not filled out completely, you will not be awarded a sliding fee discount.
Upon determination of your sliding fee scale you will be sent a letter explaining your status.

Please be advised that you will be expected to pay full price for services rendered until your sliding fee is established.

SLIDING FEE REQUIREMENTS and GUIDELINES

Sliding Fee determinations are based on the poverty level income guidelines for the State of Alaska, released by the Federal government. Since these guidelines list income for 12 months to determine poverty level, we must convert income provided with this application to a 12 month amount in order to determine if a client has met the threshold established as "poverty level". Please direct questions to Patient Financial Services at (907) 796-8442. A client must provide the following:

- A Completed Sliding Fee application
- At least 3 months of income verification if employed (generally pay stubs) or previously employed. This will be converted to a 12 month income for comparison to the poverty level guidelines (3 months of income x 4 = 12 months of income). The more months provided, the more accurate the 12-month amount will be. A tax return or a W2 may be provided for a 12 month period **instead** of pay stubs. We will also accept a letter from an employer stating **gross income** and dates of employment.
- Income from all employers in the last 12 month period must be considered. As stated above, the more verification we have of actual income, the more accurate the determination of the sliding fee write-off.
- If self employed, please provide documentation of income received and expenses directly related to the self employment (the same as required for tax purposes).
- If unemployed, complete and sign the unemployment supplement.
- If unemployed for the last three consecutive months but have received income in the last 12 months that would be disqualifying for this program, we will waive the income consideration if unemployment can be documented (unemployment compensation, letter from employer indicating date of termination or lay-off).
- Provide proof of income from Native Corporations, and inheritance money if applicable. Also must include PFD even if garnished
- Unemployment supplement if applicable

If the applicant is married, they MUST provide all the above information on themselves AND their spouse.

Rainforest Recovery Center 3250 Hospital Drive Juneau, AK 99801
Phone: 907.796.8442 Fax: 907.586.5605

SLIDING FEE APPLICATION

Name _____ Date of Birth: _____ Social Security # _____

Mailing Address _____ Phone # _____

Name of Spouse _____

Children (Dependents) living at home

None: _____ or

Employment Information

Employer _____ Name: _____ Age: _____

Work Phone: _____ Name: _____ Age: _____

Spouses Employer _____ Name: _____ Age: _____

Work Phone _____ Name: _____ Age: _____

For categories listed below, please itemize the **TOTAL GROSS** income received for the number of months indicated in the past year. You will need to provide verification for the amounts stated below.

Number of Months for which income is listed: _____

Wages: _____ Self Employment:: _____

Pension/Retirement:: _____ Military Allowance: _____

Unemployment : _____ Disability Income: _____

Child Support:: _____ Public Assistance: _____

Social Security: _____ Longevity Bonus: _____

Other Dividends: _____ Other Income: (List): _____

I understand that this application is made so Rainforest Recovery Center @ Bartlett can determine my eligibility for services under the Sliding Fee Program. If any information I have given is untrue, I understand that Rainforest Recovery Center @ Bartlett may re-evaluate my financial status and take whatever action becomes appropriate.

_____ _____
Applicant's Signature Date

_____ _____
Co-applicant's (Spouse) Signature Date

Sliding Fee Scale Checklist

- The pink sliding fee scale application- filled out and signed
- Twelve months of employment history ad verification- this includes:

Y_____ N_____ -All wages earned- regardless of if it was claimed on taxes or under the table.

Y_____ N_____ -Any dividends (Permanent Fund Dividend or any Alaska Native Corporation Dividends)

Y_____ N_____ -Unemployment compensation

Y_____ N_____ -Pension/Retirement

Y_____ N_____ -Child Support

Y_____ N_____ -Social Security

Y_____ N_____ -Military Allowance

Y_____ N_____ -Disability Income

Y_____ N_____ -Public Assistance

Y_____ N_____ -Longevity Bous

For any lines marked “Y” in the above column- I need some sore of written verification. This verification can be a check stub, bank statement (for anything direct deposited), letter from your employer or if it is an under the table job- we will take an estimation from the patient.

Please remember that if any of the information is found to be untrue we will have the authority to re-evaluate the financial status and take whatever action becomes appropriate.

_____ _____

Patient Signature Date

UNEMPLOYED PERSON SUPPLEMENT

1. Are you looking for work? Describe your efforts.

2. Does someone provide you with housing, food, clothing or cash? If so please list their names:

   Housing:

   Food:

   Clothing:

   Cash:

3. If you have no income and are not receiving help from friends or relatives, Please explain:

   How do you pay rent?

   How do you buy food?

   What do you do for cash?

_____ _____

Patient Signature Date

Rainforest Recovery Center At Bartlett
3250 Hospital Drive
Juneau, Alaska 99801
PAYMENT INSTRUCTIONS

Client Name _____ DOB_____ SSN _____ Date _____

1. Payment is expected at time of service. You may pay for the entire program in advance if you prefer and RRC billing department will estimate your program fee for you. Co-payment is required if you have insurance coverage. Contact the billing department to determine your co-payment amount. If you do not have insurance, you may apply for our discount program ("Sliding Fee Scale"). Contact RRC billing department to see if you qualify. To apply for the discount program, please complete the Sliding Fee application and provide proof of income or disability.

2. Payments must be kept current. Services may be delayed until account is current. Contact our billing department to set up an affordable payment plan.

3. Letters of compliance will be issued upon completion of the program only when account is paid in full or a payment agreement has been made and payments are current.

FINANCIAL INFORMATION
Do you have insurance? Y N *(If yes please answer lines 1-5 below)*
If you have MEDICAID, Skip to line 11
1. Name of insurance company _____ Phone Number _____
2. Address of insurance company _____
3. Subscribers Name: _____ Phone # _____ DOB: _____
4. Subscriber's SSN: _____-_____-_____ Group # _____ Policy # _____
5. Subscriber's Employer: _____ Actively Employed _____ Retired _____

Do you have a secondary insurance company? Y N *(If yes please answer lines 6-10 below)*
6. Name of secondary insurance company _____ Phone Number _____
7. Address of insurance company _____
8. Subscribers Name: _____ Phone # _____ DOB: _____
9. Subscriber's SSN: _____-_____-_____ Group # _____ Policy # _____
10. Subscriber's Employer: _____ Actively Employed _____ Retired _____

11. Are you eligible for Medicaid? Y N
12. If you are eligible for Medicaid:

Have you received services at another treatment facility within the last 12 months? Y N

If Yes Where? _____

If Yes how many days were you there? _____

If you have no means of payment, you are required to complete a separate application for a **sliding fee**. The sliding fee scale application can be obtained online or at RRC reception.

I have read and understand the above payment instructions. I certify that the information I have provided is true and accurate to the best of my knowledge. I give consent to the release of information to my insurance company and authorize payment directly to Rainforest Recovery Center at Bartlett.

Signature: _____ Date: _____

CLIENT STATUS REVIEW

Case Number: _____

Date completed: _____ /_____ /_____ Name _____

If you are filling this out for someone else, please answer from their view.

# of Days

1. How many days during the past 30 days was your physical health (including physical illness and/or injury) **not** good? ..... _____
2. How many days during the past 30 days was your mental health (including depression and/or problems with emotions, behavior, or thinking) **not** good? ..... _____
3. How many days during the past 30 days did poor physical or mental health keep you from doing your usual activities, such as taking care of yourself, work, or recreation? ..... _____
4. How many days during the past 30 days have you had thoughts about suicide or hurting yourself? ..... _____
5. How many days during the past 30 days have you used alcohol? ..... _____
6. How many days during the past 30 days have you used illegal drugs (including medications not as prescribed/directed)? _____
7. In the past 30 days, how many times have you used emergency medical services such as the hospital, emergency room, emergency medical technicians or health aides for physical, substance abuse, or mental health problems? ..... _____
8. Which one of the following best describes your housing situation? (please check one)
   - ☐ Adult in private residence – independent living (house, apartment, trailer, hotel, room, etc.)
   - ☐ Adult in private residence – dependent living (house, apartment, trailer, hotel, room, etc.)
   - ☐ Child living with family/extended family or with non-relative
   - ☐ Foster home/foster care
   - ☐ Homeless or shelter
   - ☐ Jail or correctional facility
   - ☐ Crisis residence (short term stabilization)
   - ☐ Residential care facility (assisted living, halfway house, group homes, board & care)
   - ☐ Residential treatment facility for:
     - ☐ Mental health ☐ Substance abuse ☐ Co-occurring disorder
   - ☐ Institutional care facility – 24 hour, 7 days/week (nursing facilities/homes, psychiatric health facilities, hospitals)
   - ☐ Other (please describe) _____
9. If you are a student (attending elementary through high school), which one of the following best describes your school?
   - ☐ Public/private school ☐ Home schooled

   If you attend a public/private school, how many days have you been absent during the past 30 school days? ..... _____
10. Which one of the following best describes your employment status? (please check one)
    - ☐ Employed full time working for money (30 or more hours per week including supported employment)
    - ☐ Employed part time working for money (less than 30 hours per week including supported employment)
    - ☐ Unemployed (looking for employment during the past 30 days or on layoff from a job)
    - ☐ Not in labor/work force (not looking for employment during the past 30 days); if you checked this box, please check one of the following:
      - ☐ Homemaker ☐ Student ☐ Job training program
      - ☐ Retired ☐ Disabled ☐ Volunteer
      - ☐ Engaged in subsistence activities ☐ Inpatient/inmate (otherwise unable to enter labor force)
      - ☐ Other (please describe) _____
11. In a typical **week** over the past 30 days, how many hours were you engaged in productive activities (e.g., school, employment, volunteering in community service, subsistence activities, etc.)? ..... Total hours: _____
12. In the past 30 days, have you had any legal involvement? (Legal charges, court appearance, arrests, probation, parole) ..... ☐ Yes ☐ No

CLIENT STATUS REVIEW

Case Number: _____

13. In the past 30 days, have you been arrested? ☐ Yes ☐ No
14. In the past 30 days, have you had an intimate partner slap, punch, shove, kick, choke, hurt, or threaten you? ☐ Yes ☐ No
15. In the past 12 months, have you been arrested? ☐ Yes ☐ No

16. Below are questions about your life. Please answer each question by putting an **X** in the space that best describes how you feel about each issue. Please use only **one X** for each question.

How do you feel about:	Terrible 	Unhappy 	Dissatisfied 	Mixed 	Satisfied 	Pleased 	Delighted 
Your housing?							
Your ability to support your basic needs of food, housing, etc.?							
Your safety in your home or where you sleep?							
Your safety outside your home?							
How much people in your life support you?							
Your friendships?							
Your family situation?							
Your sense of spirituality, relationship with a higher power, or meaningfulness of life?							
Your life in general?							

17. Who filled out this survey? (please check one)
    - ☐ I filled this out by myself
    - ☐ I filled this out for a child
    - ☐ Someone helped me fill this out (Person's name) _____

18. Please respond to these statements if you have received services from this agency.

How do you feel about the services you received? (Place an **X** in the space that best describes your level of agreement with each statement)	Terrible 	Unhappy 	Dissatisfied 	Mixed 	Satisfied 	Pleased 	Delighted 
I was treated with respect.							
I was able to get all the services I needed.							
The services improved the quality of my life.							

19. What did you like about the services you received? _____
    _____
    _____

20. What did you dislike about the services you received? _____
    _____
    _____

AKAIMS – Demographics Sheet

Name:_____

Race/Ethnicity (Circle all that apply)
Caucasian/White
African American
American Indian
Native Alaskan
(Athabascan; Tlingit; Haida; Aleut; Inupiat; Yupik; Tsimshian)
Other Alaska Native_____
Asian or Pacific Islander
Hispanic
Other_____

Employment Status (Circle One)
Full time
Part Time
Seasonal (In season)
Seasonal (out of season)
In Armed Forces
Self-Employ-Full-Time
Self-Employ-Part-Time
Not in Labor Force-Homemaker
Not in Labor Force – Student
Not in Labor Force – Retired
Not in Labor Force – Disabled
Not in Labor Force – Resident/Inmate
Not in Labor Force – Subsistence
Not in Labor Force – No seeking
Other:_____

Professional/Occupation (Circle One)
Professional or Technical Mgmt
Sales Worker
Craftsman
Clerical, or Kindred
Transport Operative
Laborer (Except Farmer)
Fisherman
Logger
Farm Laborer
Farm Foreman
Service Worker
Subsistence
Student
Military
Miner
No Occupation
Other:_____

Hispanic Origin (Circle One)
Not Hispanic
Puerto Rican
Mexican
Cuban
Other Hispanic

Education (Circle One)
Highest Grade
Completed:_____
High School Diploma
GED
Associated Degree
B.A./B.S.
Master's Degree
Doctorate
Other:_____

Marital Status (Circle One)
Married
Living as Married
Widowed
Divorced
Separated
Single (Never Married)

Living Situation (Circle One)
Alone
Private Household with Relative
Private Household with Non-Related
Homeless;
Incarcerated
Halfway House
Crisis Shelter
Treatment Center
Other:_____

Military Status (Circle One)
Never in Military
On Active Duty – No Combat
On Active Duty – Combat
Reserves/Nat'l Guard – No Combat
Reserves/Nat'l Guard – Combat;
Vietnam Era Veteran – No Combat
Vietnam Era Veteran – Combat;
Veteran;
Other eras: _____

Primary Source of Income (Circle One)
Employment
Public Assistance
Retirement/Pension
Disability
Social Security
Native Dividends
PDF
Other_____

Legal Status (Circle All That Apply)
Probation/Parole
Informal Probation
Deferred Prosecution
Deferred Sentence
Furlough/Rehabililtive Leave
Incarcerated
No Involvement
Case Pending
Other:_____

Religious Affiliation or Spirituality:

_____

Or when do you feel your best?

_____

For Office Use Only

G#_____ J#_____ Date_____

Rainforest Recovery Center
BARTLETT REGIONAL HOSPITAL

HIV Risk Assessment Survey

Please answer the questions below as carefully and as honestly as you can. All information provided is kept in strictest confidence. Thank you.

1	Have you ever had unprotected vaginal, anal, or oral sex with someone that you know has HIV or you think may have HIV?	Yes	No
2	Have you ever had vaginal, anal, or oral sex with a member of the opposite sex without using a condom?	Yes	No
3	How many different partners have you had unprotected sex with in the past ten years?	0 1 2 3 4 5 or more	
4	Do you think your partner is having sex with someone else?	Yes	No
5	Have you ever shared a needle or syringe with another person to inject drugs or to do tattoos or body piercing on your body?	Yes	No
6	Have you ever had unprotected vaginal, anal or oral sex with someone who uses a needle to shoot drugs?	Yes	No
7	Have you ever had sex while snorting, swallowing, or smoking drugs or drinking alcohol?	Yes	No
8	Did you receive a blood transfusion, or blood products for the treatment of hemophilia, in the United States before 1985?	Yes	No
9	Are you a health care worker who has had unprotected contact with blood or body fluids (needle stick injury, splash to the eye or mouth, etc.) and did not report this at work?	Yes	No
10	If you are a man, have you ever had unprotected oral or anal sex, even once, with another man?	Yes	No
11	If you are a woman, have you ever had unprotected oral sex or shared sexual toys, even once, with another woman?	Yes	No
12	If you are a woman, are you pregnant?	Yes	No
13	Have you ever been infected with any of the following STD's - hepatitis, herpes, gonorrhea, syphilis, Trichomoniasis, Chlamydia, or genital warts?	Yes	No
14	Have you ever been forced to have sex with someone (including your partner) when you did not want to?	Yes	No

Rainforest Recovery Center
BARTLETT REGIONAL HOSPITAL

Hepatitis C Risk Assessment Questionnaire

1. **Have you had a blood transfusion prior to 1992?** Yes No

2. **Currently or in the past, have you:**

   a. Experienced chronic fatigue or tiredness for which your doctor was unable to find an explanation? Yes No

   b. Had surgery, including oral surgery prior to 1992? Yes No

   c. Had a cesarean section or other obstetric or gynecological surgery prior to 1992? Yes No

   d. Been diagnosed as HIV positive? Yes No

   e. Had kidney dialysis? Yes No

   f. Been diagnosed with hepatitis B or hepatitis C? Yes No

3. **Currently or in the past, have you:**

   a. Had a tattoo (with unsterilized equipment) Yes No

   b. Had a body piercing (with unsterilized equipment) Yes No

   c. Served in the military? Yes No

   d. Changed sex partners frequently? Yes No

   e. Inhaled cocaine? Yes No

   f. Been in prison? Yes No

   g. Injected drugs, even once? Yes No

   h. Had unprotected sex with anybody who would fit the above descriptions? Yes No

4. **Do any of the previous categories apply to a member of your immediate family, or has a member of your immediate family been diagnosed with hepatitis B or hepatitis C?** Yes No

5. **Does your work ever put you in to contact with blood, blood products, or needles?** Yes No

RAINFOREST RECOVERY CENTER

HISTORY AND PHYSICAL

Chief Complaint:/Present Illness: _____

_____

Date of Last PPD: _____

(Must be within last year)

Past History: _____

_____

Family History: _____

_____

Social/Occupational: _____

_____

Systemic Review:

Psychiatric _____

_____

Head Injury _____

_____

Resp. _____

_____

Cardio. _____

_____

GI _____

_____

GU _____

_____

CNS (History of Seizures, DT's) _____

_____

Mus-skel _____

_____

Skin _____

_____

Current Medications:_____

Allergies: _____

Patient Name: **MRN:** **Admit#:**

HISTORY AND PHYSICAL (Page 2)

Examination:

WT_____T_____P_____R_____BP_____

Skin:_____

_____

EENT:_____

_____

Chest:_____

_____

Heart:_____

_____

Abdomen:_____

_____

Pelvic and rectal:_____

_____

CNS:_____

_____

Extremities:_____

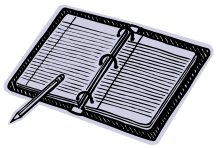
_____

Medical Diagnosis:

Plan of Care:

Physician's Signature: **Date/Time:**

Patient Name: **MRN:** **Admit#:**



What I want from Treatment:

	Yes	Maybe	No
I want to find out whether I have a problem with alcohol or other drugs.			
I want to stop drinking alcohol completely.			
I want help in decreasing my drinking.			
I want help to stop using drugs.			
I want to stop using tobacco.			
I want to decrease my use of tobacco.			
I want to learn more about alcohol or drugs problems.			
I want to decrease my use of caffeine.			
I want to learn some skills to keep from returning to alcohol or drugs.			
I would like to talk about some personal problems (individual sessions).			
I need to fulfill a requirement of the courts.			
I want to learn how to decrease my stress and tension.			
I want help with moodiness.			
I want help with problems in my marriage or relationship.			
I want to learn how to improve my physical health.			
I want to learn to solve problems in my life.			
I want help with feeling angry a lot.			
I want help in having healthier relationships.			
I want to learn to communicate better.			
I want help in overcoming boredom.			
I want help with feelings of loneliness.			
I want to work on having better self-esteem.			
I want help with sleep problems.			
I want to learn how to be a better parent.			
I want help in learning how to manage my time better.			

My main goal in treatment will be:

_____

RAINFOREST RECOVERY CENTER
INITIAL CONTACT

LAST NAME: _____ FIRST NAME:_____ MIDDLE NAME:_____

ALIAS (maiden name or other names you may be known as) _____

Date of Contact: _____ Male _____ Female_____

Date of Birth:_____ Social Security Number: _____

Residence Address: _____
City: _____ State _____ Zip Code_____

Mailing Address (if different than residence):_____
City: _____ State _____ Zip Code_____

Phone: (Home)_____ (Cell) _____ (Work) _____

Referral Source: JASAP ___ Probation/Parole ___ Court___ OCS___ Self___ Family___ Employer___
Name of Referral :_____
Address:_____
_____
Phone: _____

Emergency Contact: Name: _____
Contact Telephone Number _____
Relationship: _____

Why are you seeking services at this time?_____
_____

What type of services are you requesting: Assessment only ____ UA/BA testing ____ Admission to Treatment services (OP, IOP, Residential)

What is your drug of choice (what you most typically drink or use)? _____

What is your method of payment for services?
Self-Pay _____ Requesting a sliding fee scale application Yes No

Insurance: Company: _____
Number: _____
Name on policy: _____
(Bring card to appointment)
Medicare/Medicaid: Number_____
(Bring card to appointment)
Denali Kid Care: Number: _____
(Bring card to appointment)
Therapeutic Court: Yes No

Staff completing: _____

RAINFOREST RECOVERY CENTER

3250 Hospital Drive Juneau, Alaska 99801 907-0796-8690 fax 907-586-5605

CHECK LIST OF ITEMS

- APPLICATION
    1. Initial Contact-Client Information (1 page)
    2. Alaska Screening Tool (2 pages)
    3. Client Status Review (2 pages)
    4. AKAIMS Demographics Sheet (1 page)
    5. Supplemental Questionnaire (3 pages) Client will need counselor to complete shaded areas.
    6. HIV & HEP-C Risk Assessments (2 pages)
- History and Physical (2 pages)
  Can be completed by your local clinic or hospital to include TB Test results

- Copy of Insurance card both sides and or Medicaid number/sticker for pre-approval. Please enlarge when making the copy so it can be read. Payment Instructions (1 page)

- Sliding Fee Scale Application (8 pages). These forms are not required if you have insurance or Medicaid. Please be as detailed as possible, include your last pay stub and or tax return, bank statement and for those that are self-employed please furnish a Profit & Loss Statement.

- ASSESSMENT – Comprehensive Bio/Psycho/Social BH/SA Intake Assessment completed WITHIN THE LAST 30 DAYS and/or furnished with a Current Addendum.
  Please complete the following screening tool:
    - URICA – STAGES OF CHANGE (3 Pages)
    - What I want from Treatment? (1page)

- RELEASES OF INFORMATION (1 furnished)
  Attorney, Counselor/Treatment Center (examples)
  On the ROI's complete both boxes "TO & FROM" with address, phone number, institution/name of facility, initial on the small lines information to be disclosed then sign and date.
  Any questions call for assistance.

- Copy of Rules, Things to Know and Room Rules are included. (3 pages)

Rainforest Recovery Center's residential program is a Level III.5 Clinically Managed High-Intensity Residential Treatment. We offer a specialized Women's Program Level II.1 with a continuing care segment. Our outpatient program is a Level I and meets in the evenings, 3-5 nights a week. Your assessment will determine level of care.

We look forward to meeting you. You will be notified once your application has been reviewed. If you have additional questions please feel free to contact me for assistance. 907-796-8417

Jackie Lewis Ward, MSW, NCACII, CDCS, SAP
Clinical Services Coordinator