HOUSING PLUS CARE

REFERRAL/APPLICATION PACKET

Fairview Recovery Services

Applicant's Name: _____

Date: _____

Referral Source: _____

Received Date: _____

Staff: _____

Fairview Recovery Services helps people with the disease of alcoholism, chemical dependency, and co-occurring conditions live independent, healthy, and productive lives by providing a continuum of individualized services and care.

HOUSING PLUS CARE
REFERRAL/ADMISSION PACKET
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Fairview Recovery Services

Introduction

Thank you for your interest in Fairview Recovery Services' Housing Plus Care Program. The Housing Plus Care Program is an OASAS Medicaid Re-Design Team Permanent Supportive Housing program that assists homeless individuals with disabilities and high Medicaid costs. In order to participate in the Housing Plus Care Program, the client must meet the following criteria:

- Two (2)instances of either: Inpatient Hospital Care for Detoxification from alcohol or any other psychoactive substance, acute psychiatric hospitalization, acute hospitalization for a medical condition, in the last 12 months
  OR Five (5) instances of: Emergency Room Treatment in the last 12 months.
- Be homeless or at risk of homelessness
- Have a Substance Dependence Diagnosis and willing to participate in a recovery plan.
- Pay 30% of income for rent

In order to expedite your application please complete and provide the following:

1. Housing Plus Care Application Form
2. Housing Plus Care Resident Agreement
3. Housing Plus Care Medication Policy
4. Housing Plus Care Vocational Policy
5. Housing Plus Care Overnight Visitor Policy
6. Current Psychosocial evaluation
7. Provide Documentation of Homeless ness
8. Consent for Release of information - funding source, treatment provider, OASAS

After we receive the items listed above, your client will be scheduled for an interview with the Housing Plus Care Manager to determine eligibility.

If you have questions, please contact the Housing Plus Care Manager at (607) 722-8987 ext 232.

Again, thank you for your interest in Fairview Recovery Services.

FAIRVIEW RECOVERY SERVICES, INC.
Fairview and Merrick Community Residences
Supportive Living
Addictions Crisis Center
5 Merrick Street, Binghamton, NY 13904

Consent for Release of Information Concerning Alcoholism/Drug Abuse Patient

Instructions: Prepare one (1) copy for patient's case record. If this form is used for billing purposes, prepare additional copy for Patient Resources Office. If this form is sent to another agency for information, prepare a second copy for patient's case record.

Patient Name: _____
Last First MI

DISCLOSURE WITH PATIENT'S CONSENT

Extent or nature of information to be disclosed:
_____

Purpose or need for the disclosure: **Continuity of Care**
_____
_____

Between name of person or organization disclosing information:
_____

And name of the person or organization to which the disclosure is being made: _____
Fairview Recovery Services, Inc.

I, the undersigned, have read the above and authorized the staff of the disclosing facility name to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire 6 months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure is bound by Title 42 of the Code of Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information is forbidden without written authorization on my part.

Time period, event or condition replacing period specified above: ***6 months following date of discharge***

Note: Any information released through this form will be accompanied by Form A-4400 Prohibition on Re-disclosure of Information Concerning Alcoholism/Drug Abuse Patient.

_____ _____ _____ _____
Patient Signature Date Signature of Parent/Guardian when required Date

_____ _____ _____ _____
Patient Name (Printed) Date Parent/Guardian Name (Printed) Date

FAIRVIEW RECOVERY SERVICES, INC.
Fairview and Merrick Community Residences
Supportive Living
Addictions Crisis Center
5 Merrick Street, Binghamton, NY 13904

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Last First MI

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Time period, event or condition replacing period specified above: ***6 months following date of discharge***

Note: Any information released through this form will be accompanied by Form A-4400 Prohibition on Re-disclosure of Information Concerning Alcoholism/Drug Abuse Patient.

_____ _____ _____ _____
Patient Signature Date Signature of Parent/Guardian when required Date

_____ _____ _____ _____
Patient Name (Printed) Date Parent/Guardian Name (Printed) Date

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING CHEMICAL DEPENDENCE TREATMENT FOR

PERMANENT SUPPORTIVE HOUSING

Applicant's Medicaid Identification Number ( )

☐☐☐☐☐☐☐☐☐☐

Applicant's Last Name First M.I.

Housing Provider's Staff Member's Name:

Housing Provider's Name & Address

INSTRUCTIONS: **1) PROVIDE A COPY OF THIS COMPLETED FORM TO THE APPLICANT;**
2) ADD A COPY OF THIS COMPLETED FORM TO THE APPLICANT'S FILE; AND

1) I, the undersigned, Applicant, hereby **CONSENT** and authorize communication between and among the above named **Housing Provider**, New York State Office of Alcoholism and Substance Abuse Services (OASAS); New York State Department of Health (DOH); and National Center on Addiction and Substance Abuse at Columbia University (CASA).

I **CONSENT** to **DISCLOSURE OF INFORMATION** concerning my: first name; first initial of middle name; last name; maiden name; Medicaid Id number; date of birth; social security number; gender at birth, gender, date supportive housing began, date supportive housing ended, date of this consent and relevant information from the NYS Medicaid system and OASAS client data system.

Such disclosure is for the **PURPOSE** of enabling the entities listed above to communicate as to my treatment needs, activities, history and evaluate my treatment for purposes of monitoring, case management purposes, and for carrying out other official duties;

AND

2) I further **CONSENT** and authorize communication between and among the above named **Housing Provider** and the New York State Office of Alcoholism and Substance Abuse Services (**OASAS**); and OASAS to **DISCLOSE** the above referenced **INFORMATION** to National Center on Addiction and Substance Abuse at Columbia University (**CASA**), for the **PURPOSE** of Medicaid utilization analysis and program evaluation activities. I understand that any reports or studies compiled from my records disclosed pursuant to this release will not include personally identifiable information which will remain confidential and protected from further re-disclosure.

I, the undersigned, have read the above and authorize the staff of the above named disclosing entities to disclose, obtain and share such information as herein specified. I understand that, unless otherwise specified, this consent will remain in effect for five years after I sign this consent OR leave my supportive housing unit, whichever is longer, unless this consent is revoked by me.

I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations 42 CFR Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Pts. 160 &164; and that redisclosure of such information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Chemical Dependence Treatment Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

(Print Name of Applicant)

(Signature of Applicant)

(Date)

CLIENT HOMELESS STATUS: ELIGIBILITY DOCUMENTATION

Client Name: _____ Date of Intake: _____

Check the current status and attach the appropriate documentation to verify homelessness eligibility.

Homeless Status	Type of Documentation	Documentation Attached
Living on the street	A signed and dated general certification from an outreach worker verifying that the services are going to homeless persons, and indicates where the persons served reside.	
Persons living on the street Persons coming from living on the street (and into a place meant for human habitation)	Staff should provide written information obtained from third party regarding the participant's whereabouts, and, then sign and date the statement.	
Persons coming from an emergency Shelter for homeless persons	Written referral from the agency.	
Persons coming from transitional housing for homeless persons	Written verifications to include residency and homeless status prior to program entry.	
Persons being evicted from a private dwelling	Documentation of income, efforts to obtain housing, why participant would be on street, and either documentation of formal eviction proceedings or statement from family evicting participant. (not eligible for acceptance directly into PH from 2005 awards onward.)	
Persons from a short-term stay in an institution who previously resided on the street or in an emergency shelter	Written verification from the institution's staff that the participant has been residing in the institution for less than 31 days, and information on the previous living situation.	
Persons being discharged from a longer stay in an institution	Written verification from the institution of discharge within one week of accepting client into SHP/S+C program AND documentation of income, efforts to obtain housing, and why person would be homeless without assistance.	
Persons fleeing domestic violence	Written, signed and dated verification from the participant.	
Other:	Written verification from client or referring agency.	
CHRONIC HOMELESSNESS Single, disabled Adult + Continuously homeless for 1 yr or more OR.. 4 episodes of homelessness in the past 3 yrs (streets/shelters)	Written verification from outreach workers, shelters AND brief, written statement regarding previous shelter/street stays (dates, locations) AND – documentation of disability	

NOTES:

STAFF MEMBER: _____ Date: _____

CLIENT: I verify this information is true & accurate. I confirm that I have been or am about to be homeless.

_____ Date: _____

Signature of Client

Date:

_____

APPLICATION
Housing Plus Care Program (HPC)

I. APPLICANT INFORMATION

Name

_____

Address City State Zip

_____

Phone Number | How long have you lived at this address?

_____

Type of Housing currently living in (emergency or transitional housing, with friends, own apartment, etc)

Are you presently involved in outpatient treatment? yes no If yes, which type of treatment?

Outpatient Drug and/or Alcohol: Where: _____ Frequency: _____
Outpatient Mental Health: Where: _____ Frequency: _____

II. HOSPITALIZATION HISTORY

Have you been hospitalized within the past twelve (12) months: Inpatient Treatment:

Medical _____ D&A _____

ER Visits _____ Mental Health _____

III. LEGAL HISTORY

Are you or anyone in your household subject to State lifetime registration requirements for sex offenders?
yes no If yes, identify household member

_____

Have you or anyone in your household ever been convicted of a crime?
yes no If yes, identify household member

_____

IV. HOUSING HISTORY

Have you ever been evicted? yes no If yes, please explain reason(s):

_____

How many times have you been homeless in the last four years?

_____

V. FINANCIAL INFORMATION

Present Source of Income	Monthly Amount
Health Insurance: Medicaid #: _____ Medicare Other (specify):	Food Stamps: yes no Amount:

Have you contacted NYSEG within the past 30 days, about potentially setting up services? yes no
Who did you speak with at NYSEG? _____
Do you owe any utility balances? yes no
If yes, how much is your back balance: _____
What is your plan for repayment? _____
_____
_____
_____
_____

_____

VI. APPLICANT CERTIFICATION

I/we certify that if selected to receive assistance, the unit I/we occupy will be my/our only residence. I/we understand that the above information is being collected to determine my/our eligibility. I/we certify that the statements made in this application are true and complete to the best of my/our knowledge and belief.

_____ _____
Signature of Applicant Date

Organization Name:	Program Name:	Date:
Individual's Name *(First MI Last)*:	Record #:	DOB:

Reason for Referral and Chief Complaint/Presenting Problem

Reason for Referral and Chief Complaint/presenting problem-priority and/or emergency issues in individual's own words:

Family/Guardian description of problem (if relevant):

History of Present Psychiatric Illness (Describe course of presenting stressors/symptoms/concerns):

Past Psychiatric History (Previous episodes of current symptoms and any other past psychiatric concerns):

Substance Use/Addictive Behavior Screen

Does individual report problems (historical or current) with any of the following?

☐ Illegal drug ☐ Prescription drug ☐ Non-prescription (OTC) ☐ Alcohol ☐ Gambling ☐ Tobacco ☐ None Reported

Was any evidenced-based screening tool(s) used?: ☐ No ☐ Yes - If Yes, specify:

If yes to any, and required for OASAS, complete Substance Use/Addictive Behavior Assessment.
(OASAS Programs must also have individual complete Communicable Disease Risk Assessment)

Mental Health Treatment History ☐
Addiction Treatment Service History ☐

Treatment Services History Within the Past 5 years ☐ None Reported

Type of Services	Dates of Service	Reason	Name of Provider/Agency:	Completed
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes

Comment further if additional episodes, as indicated:

What was helpful with past treatment?

What was not helpful?

Additional Comments:

Organization Name:	Program Name:	Date:
Individual's Name *(First MI Last)*:	**Record #:**	**DOB:**

OASAS ONLY

Number of prior substance /alcohol abuse treatment episodes, lifetime (Enter 0 – 5):

Has the individual ever been diagnosed with Mental Retardation/Developmental Disability	☐ No	☐ Yes
Co-existing Psychiatric disorder	☐ No	☐ Yes
Ever Treated for a mental illness problem	☐ No	☐ Yes
Ever Hospitalized for mental illness	☐ No	☐ Yes
Ever Hospitalized for 30 or more days for mental illness	☐ No	☐ Yes

Six Months Prior to Admission:
Number Days in Inpatient Detox: Number of Emergency Room Episodes:
Number of Days Hospitalized for Non-Detox Services:
Reason for Hospitalization: ☐ Medical ☐ Psychiatric ☐ Both

Brief Mental Health Screening

Was any evidenced-based screening tool(s) for mental health used?: ☐ No ☐ Yes - If Yes, specify:

Describe results:

Based on tool(s) and/or psychiatric information, Mental Health Screening indicates immediate mental health services needed.
☐ No ☐ Yes - If Yes, specify needs:

Past and Current Social and Developmental Status:

Developmental History (Include individual and family history, motor development and functioning, sensory, speech, hearing and language problems):

Sexual History

Sexual History/Concerns (Include sexual orientation and other relevant information; OMH complete Communicable Disease Assessment as indicated): ☐ NA – Based upon the Individual's age and needs

Vocation/Education/Employment

Highest Grade Completed

☐ *No formal education*
☐ *Pre-K*
☐ *Kindergarten*
☐ *1st*
☐ *2nd*
☐ *3rd*
☐ *4th*
☐ *5th*
☐ *6th*
☐ *7th*
☐ *8th*
☐ *9th*
☐ *10th*
☐ *11th*
☐ *12th, no diploma (OMH Only)*
☐ *High School Diploma*
☐ *General Equivalency Diploma*
☐ *Vocational Cert w/o Diploma/GED*
☐ *Vocational Cert w/ Diploma/GED*
☐ *Some College – No degree*
☐ *Associates Degree*
☐ *Bachelors Degree*
☐ *Graduate Degree*

OASAS Only

Employment Status (Check One)

☐ Employed FullTime-35+ hrs/wk
☐ Employed Part Time-<35 hrs/wk
☐ Employed in Sheltered Workshop
☐ Unemployed, In Treatment
☐ Unemployed, Looking for Work
☐ Unemployed, Not Looking for Work
☐ Not in Labor Force, Child Care
☐ Not in Labor Force, Disabled
☐ Not in Labor Force, In Training
☐ Not in Labor Force, Inmate
☐ Not in Labor Force, Retired
☐ Not in Labor Force, Student
☐ Not in Labor Force, Other
☐ Soc Srvcs Work Exp Program
☐ Soc Srvcs Determined, Not Employed/Able to Work
☐ Soc Srvcs Determined, Unable to Work, Mandated Treatment

Organization Name:	Program Name:	Date:
Individual's Name *(First MI Last)*:	**Record #:**	**DOB:**

OMH Only

Employment Status (Select First that applies)

- ☐ Competitive and integrated employment
- ☐ Other Employment
- ☐ Non-paid work position (volunteer)
- ☐ Unemployed and looking for work
- ☐ Not in Labor Force: unemployed but not looking for work, retired, homemaker, student, incarcerated or psychiatric inpatient

Employment History ☐ NA

Type of Job	How Long	Reason for Leaving
	_____Months / _____ Years	
	_____Months / _____ Years	
	_____Months / _____ Years	
	_____Months / _____ Years	

Approximate Literacy Level (Required for OASAS/CARF-see Manual) and impact on treatment, if any:

Children and Adolescents

Name of School: ***Current Grade:***

Regular Education Classroom *(No Special Services):* ☐ *No* ☐ *Yes - If no, check all that apply below.*

Educational Classification

- ☐ *Autism*
- ☐ *Deafness*
- ☐ *Deaf-Blindness*
- ☐ *Emotional Disturbance*
- ☐ *Hearing Impairment*
- ☐ *Intellectual disability*
- ☐ *Learning disability*
- ☐ *Multiple disabilities*
- ☐ *Orthopedic Impairment*
- ☐ *Other Health Impairment*
- ☐ *Speech or language Impairment*
- ☐ *Traumatic Brain Injury*
- ☐ *Visual Impairment*

Additional Information, if indicated:

Current IEP: ☐ *No* ☐ *Yes*

Current 504 Plan: ☐ *No* ☐ *Yes*

- ☐ *Home Schooled*
- ☐ *Gifted*

Comments on Past and Current Academic Functioning *(include grades, learning ability, learning style and any other relevant indicators):*

Test or Other Evaluation Results *(IQ; achievement; developmental; PT/OT; etc.)* ☐ *No Test Results Reported -*

Attendance: ☐ *Not a Problem -*

Previous Grade Retentions: ☐ *Denied -*

Suspensions/Expulsions: ☐ *Denied -*

Additional Barriers to Learning:

Peer Relationship/Social Functioning:

Organization Name:	Program Name:	Date:
Individual's Name *(First MI Last)*:	**Record #:**	**DOB:**

Vocation/Education/Employment Screen/Summary (For Children/Adolescents and Adults)

Does the individual want help with or desire further discussion of the following? If yes to any area below, comment on history, strengths, weaknesses and aspirations (required for OASAS/COA):

Vocational ☐ No ☐ Yes Comment:

Educational ☐ No ☐ Yes Comment:

Employment ☐ No ☐ Yes Comment:

Military Service Screen

Has the individual ever served in the military? ☐ No ☐ Yes - If Yes, Comment:

If yes, is the individual currently experiencing:
☐ Physical health concerns as a result of military experience?
☐ Pain right now or have experienced chronic pain? ☐ Frequent nausea, stomach upset, and/or deliriums?
☐ Concerns of possible infectious agents, toxins, or radiological exposure?
☐ Psychological Issues related to military service (Flashbacks, Nightmares, etc.)

☐ **Individual has concerns that seeking help may impact his/her career.**

Comments:

Further assessment with the Military Service Assessment can be done *at any point during care.*

Is there someone in the family, or a significant other, in the military? ☐ No ☐ Yes - If Yes, Comment:
If yes, further assessment with the Military Service Assessment for Significant Others can be done *at any point during care.*

LEGAL INVOLVEMENT HISTORY ☐ None Reported

Does the individual have a history of, or current, involvement with the legal system (i.e., legal charges, AOT, Specialized Courts-Drug, Mental Health, Family, Arrests, Incarceration, etc.)? ☐ No ☐ Yes
Is there a family history of, or current involvement with CPS? ☐ No ☐ Yes / APS? ☐ No ☐ Yes
If yes to either of the above, complete and attach the Legal Involvement and History Addendum.

Legal Status

Does Individual Served have a Legal Guardian, Rep Payee or Conservatorship? ☐ No ☐ Yes
If Child, is there a Special Needs Trust other than parent? ☐ No ☐ Yes
If yes to either question above, complete and attach the Legal Status Addendum

Is there a need for a Legal Guardian, Rep Payee, Conservatorship or Special Needs trust? ☐ No ☐ Yes
If yes, explain:

Does the individual have any advance directives? ☐ No ☐ Yes
If yes, what type? ☐ DNR ☐ Health Care Proxy ☐ Living Will ☐ Psychiatric Advance Directive

HOUSING PLUS CARE QUESTIONNAIRE

CLIENT NAME: _____

DATE: _____

TO BE FILLED OUT BY APPLICANT

What do you wish to accomplish while in the Housing Plus Care Program?

_____
_____
_____
_____

Are you currently homeless or at risk of homelessness? _____ Yes _____ No

What is your primary source of income? _____DSS _____SSI/SSD _____OTHER _____NONE

Which support services are you currently involved in?

___Case Management
___Intensive Day Treatment
___Alcohol/Substance Abuse Services
___Mental Health Services
___Health Care
___Probation/Parole
___Education
___Other: (Explain)

_____
_____

Do you owe past utility bills? _____Yes _____No

Have you ever been evicted from an apartment? _____Yes _____No
If so, who was the landlord? _____

I understand that, in order to participate in the Housing Plus Care Program, I must participate in supportive services.

_____

Signature

Fairview Recovery Services
Housing Plus Care

Medication Policy

On admission to Housing Plus Care Residents will review the medications that have been prescribed to them with their case manager. Residents must demonstrate they ability to manage their own medications before admission.

Residents must inform staff when any of the following occurs:

1. Changes in Prescriptions
2. Beginning a new medication
3. Experiencing adverse reactions or side effects to medications
4. Questions regarding medications

I agree to take my medication as prescribed by the doctor, and agree not to abuse my medication.

Resident's Signature _____ Date _____

Counselor's Signature _____ Date _____

Fairview Recovery Services
Housing Plus Care

Overnight Visitor Policy

1. **I understand that I may use my discretion in allowing when I invite an overnight guest(s).**

2. **I agree that all guests will be alcohol and/o drug free.**

3. **I agree to assume full responsibility for my children.**

4. **I agree that Fairview Employees or clients are not to be responsible for my children at any time.**

5. **I understand that guests determined by Fairview staff to be inappropriate will not be allowed in my residence.**

6. **I agree that there will not be guests in my residence when I am not at home (except with prior FRS staff approval)**

7. **I agree that no one but me will have keys to my residence.**

_____ _____
Client Signature **Date**

_____ _____
FRS Staff Signature **Date**

HOUSING PLUS CARE VOCATIONAL POLICY

As a participant of the Housing Plus Care Program, I agree to the following Voc/Ed policy:

1) I agree upon admission to met with a Career Choices Unlimited case-manager to do:
   a) create and or update Vocational Educational plan.
   b) inform of residency changes.

2) I agree to be a participant in one of the following: Employment, volunteer work, GED classes, or college.

3) I agree to follow through with all goals agreed upon with the CCU case-manager until completion of the Voc/ED program.

Residents Signature _____ Date: _____

Counselor's Signature_____Date:_____

Fairview Recovery Services, Inc.
Resident Contract
Housing Plus Care Program

Fairview Recovery Services, Inc. is a private, nonprofit agency with the mission to improve the quality of life and health of persons diagnosed with and recovering from alcoholism, substance abuse and other disabling conditions. Providing you with residential, rehabilitation and support services pursues this goal. The purpose of this contract is to outline what is expected of you and the role of staff to ensure that you have a safe, secure supportive setting in which to live and to work on your rehabilitation goals.

Client Expectations: As a resident of Fairview Recovery Services, Inc. Community Residence, I agree:

1. To treat all community members (other residence and staff) with dignity, and to respect their personal rights and property, their right to privacy and their right to receive support as a member of Fairview Recovery Services, Inc. community.

2. To participate in the development and carrying out of the activities of my individualized rehabilitation program to include:

- Participate in a Recovery Plan.
- Meeting with Fairview Recovery Services, Inc. staff on a minimum 1:1 weekly basis to discuss my plan, services, progress, and changes in my plan, and any other concerns that need to be shared.
- Being involved in a program of goal-oriented activities, therapy, rehabilitation, work and/ or training, for at least 20 hours a week.

  Maintaining regular contact with my primary therapist/ counselor.

3. To assume responsibility for my health and hygiene and for the care and safe keeping of Fairview Recovery Services, Inc. property, personal property, and personal living areas to include:

- Keeping myself in good health and maintaining good personal hygiene.
- Maintenance and cleaning of the apartments.
- Assuming responsibility of apartment keys by insuring against loaning or duplication, and promptly returning all issued keys upon request.
- Assuming financial responsibility for lost or damaged Fairview Recovery Services, Inc. property at replacement value to be established by the Clinical Director.

4. To give 30 days written notice of my intent to leave Fairview Recovery Services, Inc.

5. To insure my physical and emotional well-being and that of the community member

- Supporting fire prevention activities by using smoking materials (candles, incense etc.) only in designated areas and in a safe responsible way.
- Learning the fire evacuation plan and participating in fire drills.
- Refraining from the storage and use of weapons in or around the apartment.
- Informing staff of all prescribed and over-the-counter medications I am taking and immediately reporting changes in dose and frequency, and then taking these medications only as approved by my physician.

- Preparing and storing food in a responsible way that insures my safety and that of others, as well as Fairview Recovery Services, Inc. property and to consume food and beverages only in designated areas to insure a clean environment.
- Informing staff when I will be away from my apartment for longer than two days at a time.
- Welcoming guests within the following guidelines: children need to be carefully supervised during their visit; occasional overnight visitation is permitted. All guests must be clean and sober.
- Agreeing that the staff may enter my apartment without my prior permission to make routine maintenance checks and at any other time, there is a concern for any health or safety issue or when there is a concern that I am not complying with the program expectations.

6. Fairview Recovery Services Inc. is not responsible for Personal belongings. Fairview Recovery Services, Inc. is not responsible to replace lost or damaged Personal property. Personal belongings left behind by a resident who leaves, will be held for a period of seven (7) days. After that time, all belongings will be considered forfeited and will be disposed of at the discretion of Fairview Recovery Services, Inc.

7. To be willing to:

- Pay 30% of income
- Inform staff of all financial changes

Fairview Recovery Services, Inc. Responsibilities: To further your rehabilitation the staff of Fairview Recovery Services, Inc. agree:

1. To provide you with the following services without regard to your sex, race, religion, national origin, sexual preference and mental, emotional, or physical condition:

a) Admission and Discharge planning
b) Training in activities of daily living.
c) Case management
d) Supportive counseling Focusing on relapse prevention and monitoring of sobriety.
e) Crisis management (dealing with difficult situations through counseling or other appropriate interventions)
f) Medication Management

2. To assist you in:

a) Identifying and defining your needs.
b) Developing and individualized rehabilitation plan
c) Identifying appropriate agencies and services to meet your needs
d) Recommending and or referring and coordinating services
e) Identifying and clarifying your satisfaction or dissatisfaction about the services, you are receiving and helping you to find appropriate methods to express your views.
f) Supporting and reviewing progress and changing your rehabilitation plan, as appropriate, through regularly scheduled meetings with your primary counselor.
g) Dealing with difficult situations through crisis counseling or other appropriate interventions

3. To treat you and your fellow clients with dignity and ensuring that your personal rights include, but are not limited to, the:

a) Right to reasonable privacy
b) Right to confidentiality
c) Right to access to your records as described in agency policies.

d) Right to make and receive phone calls
e) Right to receive visitors
f) Right to send and receive mail unopened
g) Right to voice grievances or complaints about the programs, staff and facility, in an appropriate manner, without fear of reprisal
h) Right to exercise all other rights guaranteed to citizens of the community

4. To provide your family members/ significant others with an orientation to the program and ongoing consultation, education and support with the primary purpose of helping them understand and support you while you are in the program.

I understand that Fairview Recovery Services, Inc. staff is responsible for helping me find ways to make my stay a growth experience and to help me address situations with which I am not satisfied.

I understand that I have entered this program voluntarily and may leave voluntarily, having given proper notice.

I understand that if I am satisfied or not satisfied with something, I am encouraged to inform staff. A safe environment will be provided and my views will be taken seriously.

Resident's Signature _____ Date _____

Counselor's Signature _____ Date _____

_____ Chart Copy

_____ Client Copy