CROSSROADS AFTERCARE PROGRAM

RESIDENT AGREEMENT AND ACKNOWLEDGEMENT OF RULES, REGULATIONS, RIGHTS, AND RESPONSIBILITIES

I, _____, have been given a copy of my rights and responsibilities as a resident of the Crossroads Aftercare Program. I have read this policy and understand that the Staff will respect my right to seek clarification and answer questions clearly. **DO NOT RELY ON ANOTHER RESIDENTS' INTERPRETATION OF THE RULES.**

I also understand that in signing this sheet, I am indicating an awareness of Crossroads' Rules and Regulations. I agree to abide by these rules during my stay in the Crossroads Aftercare Program. If I violate any rules or regulations during my residency at Crossroads, I understand that I will be asked to undergo a Staff evaluation with the consequence being my dismissal from the Crossroads Aftercare Program.

All rules and policies are governed and approved by the Crossroads Board of Directors, including the **NO REFUND POLICY FOR RESIDENTS DISMISSED DUE TO RULE INFRACTIONS OR FOR FAILURE TO GIVE A WRITTEN 30 DAY NOTICE.**

_____

Signature

_____

Date

Please note:

In order to be considered for admission your application must be received in our office no later than 10 days after your interview.

CROSSROADS AFTERCARE PROGRAM

APPLICATION FOR ADMISSION

Date_____

Name_____ Date of Birth_____

Cell Phone Number_____ Date of last use/gamble_____

Drug, Gambling, or Mental Health Treatments:

Treatment Center/Hospital _____ Date_____

_____ Date_____

_____ Date _____

_____ Date _____

Most Recent Treatment Center Counselor _____

Date of last physical examination _____ Physician_____

Have you been seen by a psychiatrist, psychologist, or other therapist? Yes____ No____

If yes, for what reason? _____

_____

_____

Have you ever been hospitalized for mental health? Yes____ No____

If yes, for what reason? _____

_____

_____

Do you have any other diagnosed addictions or disorders? Yes____ No____

If yes, explain: _____

_____

_____

Do you snore? Yes_____ No_____

What prescription medications have you used **in the past**?

Medication_____ Purpose _____

Medication_____ Purpose _____

Medication_____ Purpose _____

What prescription drugs are you **currently taking**?

Medication_____ Purpose _____

Medication_____ Purpose _____

Medication_____ Purpose _____

Do you have any medical, dental, nutritional, or hygienic problems that require attention?

_____

_____

ADDICTION HISTORY

When did your addiction become a problem for you? _____

_____

What mood-altering chemicals or types of gambling did you use most often?

Please list: _____

_____

Describe your addiction behavior: _____

_____

_____

Have you had previous periods of abstinence from mood-altering substances or compulsive gambling?

Yes____ No____ If yes, when and for how long? _____

Did any of the following help initiate treatment? DWI ____ Family ____ Employer ____ Other ____

Do you have a sponsor? Yes ____ No ____

PERSONAL HISTORY

What do you like about yourself? _____

_____

_____

What do you dislike about yourself? _____

_____

How would you like to change yourself? _____

_____

What are your recreational interests? _____

_____

Who are the people to whom you feel closest? _____

_____

What is it about your closest relationships that make you feel good? _____

_____

_____

Why have you chosen Crossroads? Be specific: _____

_____

_____

What are your expectations of Crossroads? _____

_____

_____

What can/will you do to help the other residents at Crossroads? _____

_____

JOB/EDUCATION HISTORY

What was your occupation before treatment? _____

Are you currently employed? Yes ____ No ____

Employer _____

Address _____

Phone _____

Do you see yourself changing occupations? Yes ____ No ____

If so, what? _____

Do you have any diplomas or certificates from schools? Yes ____ No ____

If yes, please specify: _____

_____

Please check highest grade achieved:

High School ____ G. E. D. ____ College ____ Grad. School ____

Do you have any special vocational interests? _____

_____

What sort of education/vocational training is necessary to follow these interests? _____

_____

LEGAL HISTORY

Are you in treatment under court leverage? Yes____ No____

Have you ever been arrested? Yes____ No____

If yes, when and for what? _____

_____

_____

_____

Arrest suits pending litigation? Yes____ No____

P. O.'s Name _____ Phone: _____

Are you willing to sign a release form between Crossroads and your P.O.? Yes____ No____

EMERGENCY INFORMATION

In an emergency, whom may we contact:

1. Name _____ Phone _____
   Address _____ Email _____
   _____ Relationship _____
2. Name _____ Phone _____
   Address _____ Email _____
   _____ Relationship _____

NOTE:

If you are discharged from primary treatment before a bed is available at Crossroads, it is your responsibility to keep us informed of your temporary living arrangements. We need to have a telephone number where you can be reached or a message left *during our business hours (8:30 a.m. to 4:00 p.m.).*

Temporary Address: _____

_____

Temporary phone number (during the day): _____

CROSSROADS AFTERCARE PROGRAM

Consent for Participation in Follow Up Study

Purpose and Background: Crossroads follows up with residents that leave Crossroads with staff approval to determine the effectiveness of the Crossroads Aftercare program.

Procedure/Process: One of the Crossroads staff will contact you to ask you some questions related to your Crossroads experience, your length of sobriety/gambling free time, your recovery program, chemical use/gambling activity, and other basic information to include your age, race, sex, education, occupation, previous treatment, etc.

Confidentiality: The information gathered during this follow up study will remain confidential. No identifying information will be released in any reports or publications resulting from this study.

Voluntary: Please understand that your participation is voluntary and you have a right to withdraw your consent at any time. Your decision whether or not to participate in this follow up study will not affect the treatment you receive at Crossroads.

Consent Expiration: This consent will expire one year from your discharge from Crossroads.

Resident Name: (Please print)

_____ _____

Name **Telephone**

_____ _____

Street **Email**

_____

City **State** **Zip**

In the event I cannot be contacted, I grant permission for a Crossroads staff member to contact the following person for information regarding my current or any future address and telephone number.

Contact Person: (Please print)

_____ _____

Name **Telephone**

_____ _____

Street **Relationship**

_____

City **State** **Zip**

☐ **Check here if you would like your contact information released to the Alumni Association.**

_____ _____

Date **Resident's Signature**

Crossroads Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ASSESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Here at **Crossroads Aftercare Program** we are dedicated to confidentiality and privacy. We follow all requirements of the 1996 Health Insurance Portability and Accountability Act (HIPAA) regarding protected health information and the Federal confidentiality regulations (42 CFR Part 2) pertaining to individuals receiving treatment for alcohol and drugs and related issues. As a client of the Crossroads Aftercare Program you will be providing the staff with Protected Health Information (PHI), and this document outlines what constitutes PHI, the way in which your PHI is protected, in what circumstances your PHI can be shared with other individuals, groups, or facilities, and your rights concerning your health information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was developed to provide guidelines for health practitioners to appropriately handle individual's health information. Protected Health Information (PHI) is the term HIPAA outlined as a description of all identifiable information provided to a health practitioner during the course of that person's treatment and any follow up care. Your PHI here at **Crossroads** would include such things as your name, address, age etc., but also your drug of choice, treatment program you attended, the mental health diagnosis you may have, your legal status etc. The simplest way of looking at PHI is any information that could be used to identify you.

The **Crossroads Aftercare Program** and its staff are dedicated to protecting your confidentiality. We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Federal confidentiality regulations (42 CFR Part 2) to: (1) maintain the privacy of protected health information (PHI) (2) provide you with this Notice of our legal duties and privacy practices with respect to protected health information (3) notify you of any changes made to these policies (4) abide by the terms of this Notice.

HOW YOUR CONFIDENTIAL HEALTH INFORMATION WILL BE USED AND DISCLOSED:

We will use your protected health information (PHI) as part of your care here at **Crossroads**. Your (PHI) will be used by the counseling staff to appropriately treat you, to address your issues during staffings and consultations between the counseling staff members, by the business office to process your payment for the services rendered, and by the program director when reviewing the quality of the care you receive.

The other ways in which your confidential health information may be used and disclosed without your consent or authorization are outlined below:

Business Associates

- We may disclose your health information to the auditor for Crossroads. This disclosure will be limited to your name, the length of your stay here at Crossroads, and your payments of program fees.

Medical Emergencies

- If you have a life threatening physical emergency that requires immediate attention, we will disclose limited information about you to assist medical personnel in addressing your emergency.

Abuse or Neglect

- We may disclose your (PHI), if you acknowledge to the staff or if the staff suspects that you have abused or neglected a child.

Court Order

- Your (PHI) may be disclosed if the staff receives a court order and a subpoena appropriately developed under Federal law which demand disclosure of your records.

Crime within Crossroads Premises or Against Program Personnel

- Your (PHI) may be released if the staff needs to report a crime you have committed or threatened to commit on Crossroads property or against Crossroads staff.

AUTHORIZATIONS:

We will not use or disclose your protected health information (PHI) for any other purpose other than those listed above, without your written consent or authorization. Once given, you may revoke your consent or authorization in writing at any time by completing a Revocation of Authorization form. These forms will be made available to you from the Crossroads staff upon your request. Be aware that any disclosures made prior to this revocation cannot be rescinded. You may contact **John Rundquist**, counseling staff member and privacy officer, at 612-374-0506 for any further information.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights with respect to your protected health information (PHI):

- You may ask us to restrict certain uses and disclosures of your PHI. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your PHI. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by Crossroads during the last six years (or following April 14, 2003), except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact:

Sharron Johnson, Crossroads Program Director at 612-374-0504

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:

John Rundquist, Crossroads counselor and Privacy Officer, at 612-374-0506

THIS NOTICE IS EFFECTIVE AS OF 10/28/04

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and will make paper copies of the revised Notice of Privacy Practices available upon request.

ACKNOWLEDGMENT:

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Crossroads Aftercare's Notice of Privacy Practices.

Client Signature: _____ Date Signed: _____