Restore House

Residential Treatment Program Application
PO Box 1191, Bemidji, MN 56619
218-444-9420 (phone) 218-444-9212 (fax)
Mary Greer, Program/Treatment Director
218-760-4209 (phone)

Date_____

Personal Information:

Full Name:_____
(First) (Middle) (Last)

Address: _____
(Street, PO Box) (City) (State) (Zip Code)

Date of Birth: _____Social Security Number _____-_____-_____

Marital Status: ____Single____ Married____ Divorced____ Separated ____Engaged ____Widowed

Phone #_____

Emergency Contact Person:_____**Relationship:**_____
(Name)

_____
(Street Address) (City) (State) (Zip Code) (Phone Number)

2nd Emergency Contact Person:_____**Relationship:**_____
(Name)

_____
(Street Address) (City) (State) (Zip Code) (Phone Number)

Rule 25 Assessor: _____ _____
(Name) (Phone Number)

Date of last Rule 25/Chemical Dependency Assessment: _____

Corrections Agent *(if applicable)*:

_____ _____
(Name) (Phone)

Attorney/Public Defender Information *(if applicable)*:

_____ _____
(Name) (Phone)

Next Court Date *(if applicable)*:_____ **Where:** _____

Have you ever been classified as a sex offender in Minnesota or any other state?

_____**Yes** _____ **No**

If yes please Explain:

Date last used alcohol/illicit drugs: _____

Write a brief biography of your life, including your spiritual experiences:

_____

_____

_____

_____

Why are you interested in being a part of a Residential Treatment Program? _____

_____

_____

_____

Who has encouraged you to become a part of Restore House? _____

_____

Dismissal:

I understand that any violation of Restore House program rules could result in my immediate discharge and eviction from the program/home. No financial refund will be given.

I authorize Restore House staff to contact any individuals named in this application. Also, I authorize Restore House staff to exchange information with board and committee members regarding application and acceptance.

_____ _____

Signature **Date**

Submitted to the committee: _____ (Date)

Committee decision: _____

_____

_____

RESTORE HOUSE INC.
Residential Treatment Facility
CONSENT FOR RELEASE OF INFORMATION

51756 229th Avenue
Bemidji, Minnesota 56601
Phone: 218-444-9420

P.O. Box 1191
Bemidji, MN 56619-1191
Fax: 218-444-9212

1001 Mississippi Ave. NW
Bemidji, MN 56601
Phone: 218-444-9102

Name: (Last)_____(First)_____(M.I.)_____

Phone: (_____)_____Date of Birth: _____

I hereby do give consent and authorize: Restore House Inc

X To release information to:

X Obtain information from:

Company/Individual Name: **Restore House Treatment Team**

Address: _____

City:_____State:_____Zip:_____

Phone:_____ Fax:_____

Information can be communicated: **X** Verbally, **X** Written, and/or **X** Facsimile.

I understand the purpose of this release is to:

X facilitate the assessment, treatment planning, and discharge planning regarding the client who has accessed the Restore House Inc. for treatment services.

X other purposes, please specify:_____

I understand the specific information to be disclosed includes information on the items with an "x" below:

X Discharge Summary
X Chemical Dependency Evaluation
X Progress in Treatment/Progress Notes
X Acknowledgement of Client's access of service
X History and Physical
X Doctor's consult results
X Assessment/Admission Intake
X Treatment Plan/Recommendations
X Lab: Urine Drug Screens
X Psychological/Psychiatric Consults
X Communication
____Other: _____

Effective this date _____to expire _____unless revoked by me.
NOTE: This authorization, except for action already taken, can be revoked at any time.

I understand that information in confidential records cannot be released without my written consent unless otherwise provided for in legal statutes and judicial orders. My signature below indicates that I understand the conditions of this release and that I give my authorization voluntarily.

SIGNATURE:_____**DATE:**_____

NOTICE: Further disclosure of confidential information without the specific written consent of the person to whom it pertains is prohibited by state and federal statutes.

NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS: This information has been disclosed to you from records protected by Federal Confidentiality Rules 42 CFR Part 2. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I revoke this authorization for Release of Information on _____20___for the above designated person or persons.

Signature_____ Witness Initials_____

FOR YOUR PUBLIC DEFENDER/ATTORNEY

RESTORE HOUSE INC.
Residential Treatment Facility
CONSENT FOR RELEASE OF INFORMATION

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Bemidji, Minnesota 56601
Phone: 218-444-9420

P.O. Box 1191
Bemidji, MN 56619-1191
Fax: 218-444-9212

1001 Mississippi Ave. NW
Bemidji, MN 56601
Phone: 218-444-9102

Name: (Last)_____(First)_____(M.I.)_____

Phone: (_____)_____Date of Birth: _____

I hereby do give consent and authorize: Restore House Inc

X To release information to:

X Obtain information from:

Company/Individual Name: Public defender_____

Address: _____

City: **Bemidji** State: **MN** Zip:**56601**

Phone:_____ Fax:_____

Information can be communicated: **X**Verbally, **X**Written, and/or **X**Facsimile.

I understand the purpose of this release is to:

X facilitate the assessment, treatment planning, and discharge planning regarding the client who has accessed the Restore House Inc. for treatment services.

X other purposes, please specify:_____

I understand the specific information to be disclosed includes information on the items with an "x" below:

____ Discharge Summary	____Assessment/Admission Intake
____ Chemical Dependency Evaluation	X___Treatment Plan/Recommendations
____ Progress in Treatment/Progress Notes	X___Lab: Urine Drug Screens
____ Acknowledgement of Client's access of service	____Psychological/Psychiatric Consults
X___ History and Physical	X___Communication
X___ Doctor's consult results	____Other: _____

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FOR YOUR RULE 25 ASSESSOR

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Residential Treatment Facility
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Bemidji, Minnesota 56601
Phone: 218-444-9420

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Bemidji, MN 56619-1191
Fax: 218-444-9212

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Bemidji, MN 56601
Phone: 218-444-9102

Name: (Last)_____(First)_____(M.I.)_____

Phone: (_____)_____Date of Birth: _____

I hereby do give consent and authorize: Restore House Inc

X To release information to:

X Obtain information from:

Company/Individual Name: **Rule 25 Asessor**

Address: _____City:_____State:_____

Phone:_____Fax:_____

Information can be communicated: X___Verbally, X___Written, and/or X__Facsimile.

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____ Progress in Treatment/Progress Notes
____ Acknowledgement of Client's access of service
____ History and Physical
____ Doctor's consult results
X___Assessment/Admission Intake
X___Treatment Plan/Recommendations
____Lab: Urine Drug Screens
____Psychological/Psychiatric Consults
X___Communication
____Other: _____

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Phone: (_____)_____Date of Birth: _____

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_____ To release information to:

_____ Obtain information from:

Company/Individual Name:_____

Address:_____ City:_____State:_____Zip:_____

Phone:_____ Fax:_____

Information can be communicated: ____Verbally, ____Written, and/or ___Facsimile.

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____Other: _____

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