Harvest House

FREEDOM SUBSTANCE ABUSE TREATMENT
VA GRANT & PER DIEM
APPLICATION/REQUIREMENTS for ADMISSION

PURPOSE: Our primary goal is to facilitate a stable environment that gives Veterans an opportunity to break the cycle of homelessness and addiction as they rebuild their lives and re-enter society as an active contributing member by achieving residential stability, increasing their skill level, and obtaining greater understanding of their strengths and purpose.

PROGRAM: Harvest House provides an opportunity for a new life conforming to right moral standards in a home-like, faith-based environment.

COST: Per Diem funds cover cost of housing, treatment, basic food items, and access to public transportation.

ACCOUNTABILITY: Residents develop a character of respect, integrity, and humility as they honor the program structure of Harvest House; i.e. *Progressive Four Phase Program, Daily Schedule, House Rules, Cause for Disciplinary Discharge, etc.* as well as staff directives.

GUIDELINES:

A. Commit to nine months of residency with the goals of independent & sober living.
B. Honor House Rules and staff directives with diligence and respect.
C. Break from dysfunctional people, places, and things that brought you to Harvest House.
D. Agree to a search of your person and possessions upon arrival, or at anytime thereafter, while a resident of Harvest House. Agree to random urinalysis and upon request.
E. Resident will set up escrow account with the purpose of saving towards independent living.
F. Harvest House reserves the right to discharge any resident at anytime for not complying with the Code of Conduct or Program Description. If discharged, agree to leave without disruption to staff or other residents.

If you share the perspective offered by Harvest House, you are welcome to make official application for admission by signing below. Your signature denotes that you have voluntarily and free of coercion, read and agree to submit to the authority of Harvest House as referenced in this document. Upon the review of your completed application and the available bed space you will be notified as to acceptance. To contact HHTC call (941) 953-3154.

Please remember to enclose the proper release form from your contact person (lawyer, case worker, probation officer, Chaplain, counselor, family member, friend, other).

Applicant's Name (PRINT):____

Applicant's Signature:_________________________________ Date:____________________

Anticipated Admission Date:_____________________________ Time:___________________

Staff Approval:____ Date:____________________

IDENTIFICATION INFORMATION

Date:_________________________

First Name:__________________________ Last Name:________________________ M.I.:______

Currently Homeless: Y N If No, Address:_______________________________________

City:______________ State:________ Zip:__________ Phone:___________________________

SS#:_______________________ Sex:___________ Citizenship:___________________________

Age:________ D.O.B.:______________ Marital Status:_________ Race:____________

Living with:_____________________________ Relationship:____________________________

Spouses Name:___________________________ Address:_______________________________

No. of Children:__________________________ Are you a veteran?_____________________

Level of Education:______________________

Do you have a FL I.D./D.L.: Y N Birth Certificate: Y N SS Card: Y N

What languages do you speak?:____

Give a one word description of your life now:____

FINANCIAL ASSISTANCE

Please circle the following financial assistance you are currently receiving and the amount per month:

SSI $_______.____ Other? ________ $_______.____

SSDI $_______.____

Food Stamps $_______.____

WIC $_______.____

HUD $_______.____

Cash Assistance $_______.____

If you are unable to pay your program fee who will be your guarantor to insure that it is paid?_______

____

PREVIOUS COUNSELING HISTORY

Have you ever gone for counseling?:__________ When?:________________________________

Where?:____

For what?:____

Are you currently receiving help from another professional?:______ Who?:_________________

Have you ever attempted suicide?:_________ Has anyone in your family?:__________________

Has anyone in your family ever been diagnosed mentally ill?:_____________________________

CRIMINAL JUSTICE SYSTEM

Charges Pending:____

City:___________________ Judge:____________________ Next hearing date:_____________

Are you n Probation or Parole? (circle one) Date of Sentencing:______________

Probation Officer:________________________ Phone No. of PO:_____________________

Address of PO:____

Terms of Probation/Parole:____

Ever violated?:______________________________________ When?:_____________________

Prior Criminal History:

Date	City	Charge	Disposition

Attorney/Public Defender's Name:____________________________

Address:____

Appointed or Retained (circle one)____

Have you ever been required to register as a sex offender?____________________________

If yes, when was it and what were the charges? (use space provided below)

SUBSTANCE ABUSE HISTORY

Check all that you have abused and when:

DRUG	USED Past	USED Present	HOW OFTEN Frequency	HOW LONG Duration
Alcohol	____	______	______________	_______________
Marijuana	____	______	______________	_______________
Hallucinogenic	____	______	______________	_______________
Barbiturates	____	______	______________	_______________
Amphetamine	____	______	______________	_______________
Methamphetamine	____	______	______________	_______________
Heroin	____	______	______________	_______________
Methadone	____	______	______________	_______________
Cocaine	____	______	______________	_______________
Opiates	____	______	______________	_______________
K2/Spice	____	______	______________	_______________
Other?_____________	____	______	______________	_______________

Have you used alcohol in the last 7 days?:________ When?:___________________

Is alcohol your drug of choice?:___________

Have you used a drug in the last 7 days?:__________ What?:____________ When?:__________

What is your drug of choice (excluding alcohol)?:________________________

QUESTIONS:

Do you feel alcohol/drugs are a problem for you?	Y	N
Have you ever been arrested under the influence/high?	Y	N
Have you ever needed more alcohol/drugs to get the same affect?	Y	N
Has anyone ever complained about your behavior?	Y	N
How old were you when you first noticed your problem?	_______________	
Have you ever tried to cut down or stop using alcohol/drugs?	Y	N

When?:______________________

MENTAL HEALTH HISTORY

Have you ever been diagnosed with a mental illness? ______ If so, what was the diagnosis? _____________
____

When was the diagnosis? _________________ Who made the diagnosis?____________________________

What medication was prescribed? ____

What medication are you currently taking for diagnosis?____

EMPLOYMENT HISTORY

Are you currently employed?________ If yes, where?:_______________________________________

Position/Title:_____________________ Name/Number of Supervisor:_________________________

LIST YOUR 3 MOST RECENT JOBS:

Employer	Position	Time Frame (dates)	Reason for leaving	Attitude toward job

What kind of work are trained to do?:____

What kind of work are you interested in?:____

HEALTH AND MEDICAL INFORMATION

Doctor's Name: ________________________________ Doctor's Phone #: _____________________
Medical Insurance: Yes or No Policy #: _______________________________

When did you last see a Doctor? __________________ For What? ____________________________
____
Have you ever used needles? ___________
Have you had an HIV test? _____________ When? _____/______/_____ Result?:_______________

Have you had any other S.T.D. tests? _________ When? ____/____/____ Result?:_______________
Treatment history? ____

Is it possible that you are pregnant?:_______ Are you currently taking medication? _____________

**List medications: ____

____

Are you on a special diet? _____________ If so, what?______________________________________

Check symptoms you **currently** have:

_____Allergies
_____Asthma
_____Mental Illness
_____Chronic cough
_____Dermatitis
_____Dental problems
_____Diarrhea
_____High blood pressure
_____Difficulty breathing
_____Open sores
_____Constipation
_____Dizziness
_____Insomnia
_____Digestive problems
_____DT's
_____Rapid weight loss
_____VD or Herpes
_____HIV (AIDS)
_____Liver problems
_____Tuberculosis
_____Bone or joint pain
_____Chest pain
_____Upset stomach
_____Bleeding
_____Excess fatigue
_____Depression
_____Epilepsy
_____Back problems
_____Hearing loss
_____Hepatitis
_____Heart disease
_____Vision problems
_____other

Explain above symptoms:

____

____

____

Please list any current allergies or physical complaints/problems:______________________________

____

____

How did you hear of Harvest House?____

List 3 goals you hope to achieve by participating in this program:

1)____

2)____

3)____

Additional notes you'd like Harvest House to know:

*****It is a requirement for applicants to complete the following VA Release Medical Information form in order to determine eligibility*****

All questions and sections must be completed for this application to be processed. Please return your application Admissions at 209 N Lime Ave Sarasota, FL 34237, via fax (941) 954-2349, scan & email to info@harvesthousecenters.com, or in person.

Thank you for your interest in our program. Your application will be processed within 48 hours from the time we receive it. If you do not here from our Admissions department regarding your application please feel free to contact us.

"Your Freedom Starts Now"

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

DRUG ABUSE ALCOHOLISM OR ALCOHOL ABUSE TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

COPY OF HOSPITAL SUMMARY COPY OF OUTPATIENT TREATMENT NOTE(S) OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on ______ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY