

Name: _____



Spectacular Freedom House
Olympia, WA

Providing Housing, Hope and Healing

APPLICATION PACKET

Contact Person: Jacob – (360) 489-8192

Spectacular Freedom House
RECOVERY HOUSE RESIDENT INTERVIEW

Move In Date Requested: _____ Today's date: _____

Name: _____ Age: _____ Tele: _____

Address: _____
Street City State Zip

Marital Status: _____ Social Security #: _____ Date/Birth: _____

Children's Names & Ages: _____

Next of Kin: _____ Relationship: _____ Tele#: _____

Friend: _____ Tele#: _____

Do you have transportation? _____ Vehicle (Make/Model) _____

Drivers License# _____ State: _____ Ins. Co. & Policy#: _____

Occupation: _____ Employer: _____

Employer Tele#: _____ Source of Income: _____ Amount: _____

Other Income & Source: _____ Are you in Drug Court? _____

Name/location of Outpatient Center: (if any) _____

No. of Outpatient Mtgs. per wk _____ (if any) Counselor: _____ Tele#: _____

Clean & sober date: _____ Drugs of choice: _____

Probation Officer: (if any) _____ Tele#: _____

Name & Address of Physician _____

Medication(s) you are taking _____

Reason Taken _____ How Often? _____

Do you have allergies or any other medical problems? If so list: _____

CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Telephone # _____

Address: _____

TO BE COMPLETED BY STAFF PERSONNEL

Staff Interviewer: _____ Move in Date _____

If moving back in, re-admit date _____ If leaving, reason for leaving: _____

Any balance due? \$ _____

TERMS & CONDITIONS

The following is a list of Terms and Conditions that will be expected of you, should you be accepted by the Spectacular Freedom House leadership:

1. I will submit a non-refundable deposit of \$75.00.
2. I will remit \$_____ per month rent for a shared room (2 or more occupants per room). This amount will be due by the 5th of each month.
3. I will not drink any alcoholic beverage, nor engage in any drug-related activities. I understand that if I engage in alcohol consumption or illicit drug use, I will have (1) hour to vacate the premises. I will not be able to return to Spectacular Freedom clean and sober housing until I have been alcohol/drug free for 30 days.
4. I will not bring any alcohol, illegal drugs, weapons or pornography onto the property.
5. I will obtain authorization from a Spectacular Freedom House representative for any prescribed medications prior to filling the prescription.
6. I will attend a weekly resident house meeting (time to be established).
7. Since pets are not permitted, I will not bring any pets into the house.
8. I will not smoke in the house. If I choose to smoke, it will be in the designated outside smoking area only.
9. I agree to perform housekeeping duties as assigned each week on a rotating basis (i.e. vacuuming, dusting, cleaning bathrooms, kitchen, etc.)
10. I agree to a 30 day probationary period, during which time a curfew of 11:00 PM each night will be observed.
11. I will have a minimum of 30 days clean and sober and will participate in a minimum of (3) support meetings per week, which may include a church service or Bible study.
12. I will submit to urinalysis testing on a random basis, or when requested at my own expense of \$15 per test.
13. I agree that there will be no overnight female guests under any circumstances.
14. Any natural or adopted children I have will be permitted to spend the night, with the agreement of other residents of the house and with the permission of the House Manager.
15. I will respect others personal space, property and belongings. I assume responsibility for my own behavior and attitudes while in the house. I also understand that inappropriate behavior will be confronted. I agree to conduct myself in a polite and respectful manner in and outside of the house. This behavior will show Christian love, compassion, consideration, cooperation and respect for each other.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Spectacular Freedom, 501(C)(3) non-profit
P. O. Box 11403, Olympia, WA 98508 - (360) 790-9637

I _____ of _____ authorize
(Name of Client)

Spectacular Freedom to disclose the following information to/with
(Name of person/organization who is disclosing information)

(Name & address of person/organization to which disclosure is made)

PURPOSE OF INFORMATION

(Patient's initials required preceding each box checked)

- _____ Assist in appropriate treatment placements
- _____ Exchange and verify client case planning information
- Access in emergency situations
- Verification of alcohol/drug abstinence
- Verification of Housing Contract Compliance
- _____ Other _____

TYPE OF INFORMATION TO BE RELEASED

- _____ Diagnostic Impression, Evaluation, Treatment Recommendations for drug/alcohol treatment information
- Dates of attendance at program or self-help group attendance
- Medical or Laboratory Reports (UA results)
- _____ Discharge summary and Aftercare plan
- _____ Reports on patient's progress toward treatment objectives
- Verification of Housing Contract Compliance
- _____ Other: _____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that in any event this Consent will expire as follows:

- _____ 30 days after termination/discharge of treatment, and/or
- Release from Housing Contract (i.e. move, or discharge): _____

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

EXECUTED THIS _____ DAY OF _____ 20____.

Signature of Patient

Signature of parent, guardian or authorized representative

Signature of Program Representative

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 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 general rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.