Transitional Living Program Referral Packet

Updated January 2022

The Mountain Center
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Hello!
This is the first step of admission into our transitional living program at The Mountain Center (TMC). This is our referral packet that is filled and signed by licensed professionals as well as the client being admitted. All sections of this document are critical as it best informs us on whether or not the client is a fit for our program and ultimately be able to provide the best care for the client.

About Us - The Transitional Living Program (TLP) at The Mountain Center was established in 2015 as a project of Interfaith LEAP, Inc. under the original name "Sangre de Cristo House". The Mountain Center has been working closely with the program since 2019 and it is now a program within our non-profit organization. The purpose of the TLP is to offer a trauma-informed, substance-free transitional living space for women recovering from substance use disorders. At The Mountain Center, we're able to meet the needs of women in recovery and explore how to balance the demands of life with the goal of long-term recovery. We work to reintegrate our clients back into the community with new self-awareness and stronger coping skills.

About the referral process - The following is mandatory before anyone can be admitted.

- ❑ A **current COVID-19** test result that is **negative**
- ❑ Client confirmation that they have been in **quarantine** while waiting for results
- ❑ Fully vaccinated for COVID-19 **OR** willing to be vaccinated within 14 days of admission
- ❑ Authorization for Release of Information*
- ❑ Current Medical Clearance for Participation*
- ❑ Standing Order for "Bedside" Medication*
- ❑ Behavioral Health Information and Clearance *
- ❑ Client Intake Questionnaire (completed by client)

* **To be completed and signed by a Licensed professional**
Below is the **Screening Requirements Checklist** which will have additional information that will be needed for admission. Please let us know if you have any questions.

Thank you,
The TLP Team

Phone: 505-465-2040
Email: TLPintake@themountaincenter.org

Screening Requirements Checklist

Note: The Mountain Center is a 3-month (90 days) residential program intended to provide a safe, structured, supportive environment during the woman's transition to stable, community-based recovery. Length of stay is determined by an individual treatment plan. It is not intended as a substitute for residential addiction treatment or a detox center.

✔	REQUIREMENTS	Date Received
	1. Stable early recovery, as evidenced by successful completion of a recommended SUD treatment program, a substantial period of abstinence in a controlled setting, or the equivalent. ***Must be completely detoxified.***	
	2. **Signed Authorization for Release(s)** of Information to ensure coordination of services with other providers or authorities involved in the case.	
	3. **Current Medical Clearance for Participation** signed by a qualified licensed healthcare practitioner (MD/Nurse Practitioner). Submission must be no longer than (2) two weeks prior to her entering our program.	
	4. Included in Medical Clearance: TB test and result	
	5. Included in Medical Clearance: HIV test and result	
	6. Included in Medical Clearance: Hepatitis A, B, C tests and results	
	7. Included in Medical Clearance: Behavioral Health Information including current medications **signed by a qualified licensed mental health or psychiatric provider.**	
	8. Standing Order OTC Medication Form ***(must be completed and signed by a Licensed Healthcare Practitioner)***	
	9. Complete Standing Order for "Bedside" Medication Self-Administration (i.e., use of an Inhaler or EPI-PEN)- *(if applicable)* ***(must be completed and signed by a Licensed Healthcare Practitioner)***	
	10. 30 day supply of medications must be in the original container from pharmacy/current prescription with refills as indicated (if applicable). ***Please note: Controlled Substances will not be accepted.***	
	11. Psychological or psychiatric evaluation *(if applicable)*	
	12. Information on the most recent course of treatment (from the provider).	
	13. Any combination of the following evaluations (*must be dated within six months of potential admission*) ● Clinical Interview completed by a licensed therapist ● Biopsychosocial History ● Mental Health Screening ● Other types of screening tools – SASSI, Beck Depression, etc.	
	14. Intake questionnaire completed by potential applicant	

	15.Court Order, Probation/Parole Plan, Charges, Pending *(if applicable)*	
	16.Copy of Social Security Card	
	17.Copy of Identification Card or Valid Driver's License	
	18.Copy of Medicaid Card *(if applicable)*	
	19.Certificate of Indian Blood and Tribal ID card *(if applicable)*	
	20.Other pertinent information (CYFD safety plan / treatment plan of family plan)	
	21. Copy of COVID-19 test result	
	22. Record of COVID-19 vaccination	

Authorization for Release of Information

I, (print name) _____

Date of birth: _____ Social Security #: _____
I hereby agree for reciprocal information to be obtained and release to The Mountain Center to and from

Agency/Provider: _____
Address: _____
Telephone: _____ Fax: _____
Email: _____

I do release The Mountain Center from any and all legal liabilities that may arise from the release of this information pursuant to Evaluation/Assessment and or other coordination and case management treatment efforts on my behalf:

□ **Assessment Report**	□ **History/Intake**	□ **Medication History**
□ **Treatment Summary**	□ **Treatment Plan**	□ **Discharge Summary**
□ **Medical Information**	□ **Treatment Recommendations**	□ **Judicial/Courts /Probation/Parole**
□ **Psychological Evaluation/Test Results**		□ **Diagnostic Report**

□ **Other:** _____

_____

I understand that information regarding my alcohol and / or drug treatment is protected by federal law under the Drug Abuse Prevention, Treatment, and Rehabilitations Act and the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and their implementing regulations. See 42 C.F.R. Part 2; 45 C.F.R. Parts 160, 164. I understand that my health information specified above will be disclosed pursuant to this authorization, that the recipient of the information may re-disclose the information and it may no longer be protected by federal law under HIPAA. Federal law governing confidentiality of alcohol and drug abuse patient information noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that this consent will expire in one (1) year unless otherwise specified below:

Specify below the date, event or condition upon which this consent expires:_____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released):

Authorizing Signature: _____ Date:_____

Witness:_____ Date:_____

Medical Clearance

Patient Name:_____ Date of Examination: _____

DOB: _____ LAST ETOH/DRUG USE: _____

Height: _____ Weight: _____B/P: _____ HEENT:_____

Current Medication/Dosage_____ COVID-19 Vaccination?: Yes ____ No____

Chest:_____

Heart:_____

Abdomen:_____

Genitourinary:_____

Extremities:_____

Neurologic:_____

Laboratory Data:

Hepatitis Test for A, B, C Date obtained: _____Results: A_____ B_____C_____

HIV Test_____ Date Obtained:_____ Results_____

SMAC: _____ RPR_____ HCT: _____ UA: _____

Current Tuberculin Skin Test: Placed: _____Read_____Result: _____

Pregnant? Yes [ ] No [ ] Gestation_____Weeks

Current Medication/Dosage (what and what are the side effects?)

1. _____
2. _____
3. _____
4. _____

Allergies

Medications: _____

Food: _____

Environmental: _____

Other: _____

Does the patient have Epinephrine Yes [ ] No [ ]

Medically Stable, is able to participate in transitional living program without restrictions: Yes [ ] No [ ]

Physically Stable, is able to participate in transitional living program without restrictions: Yes [ ] No [ ]

Note:

Restrictions:_____

_____

_____

Signature of Licenced Medical Provider:_____

Physician's Name:_____Phone: _____

Clinic: _____

Address: _____

Email:_____

***Please complete the attached Standing Order(s) for OTC & Bedside Medication Self-Administration.**

Standing Order
OTC Medication Self-Administration

Resident Name_____

DOB:_____ File Number:_____

The Mountain Center (TMC) permits resident self-administration of Over-the-Counter (OTC) medications as authorized by a licensed healthcare practitioner. This document represents a Standing Order for this resident that shall remain in effect during her stay at TMC unless otherwise indicated. TMC provides limited OTC meds for temporary relief of symptoms. They are not intended to substitute for medical treatment. Residents are instructed to seek medical attention if there appears to be either a sensitivity reaction or significant side effects, or when relief is not forthcoming within a reasonable time-frame.

Please write out a detailed order which includes:

1. Symptoms to be addressed
2. Dose, frequency, schedule of administration
3. Maximum total dose per 24 hours
4. Period medication is to be used
5. ANY KNOWN MEDICATION ALLERGIES (IF APPLICABLE)
6. IF THIS INDIVIDUAL IS NOT TO USE ONE OR MORE OF LISTED MEDICATIONS

ALLERGIC TO:

Please Check/or note below:

Acetaminophen 500mg/Ibuprofen 200 mg – Per Manufacturer's Instructions □

Or_____

Aluminum/Magnesium 225 mg/200 mg Liquid Antacid – Per Manufacturer's instructions □

Or_____

Guaifenesin Cough Syrup – Per Manufacturer's Instructions □

Or_____

Pepto-Bismol – Per Manufacturer's Instructions □

Or_____

Antacid tablets – Per Manufacturer's Instructions □

Or_____

Cough drops – Per Manufacturer's Instructions □

Or_____

Signature of Licensed Medical Practitioner_____

Date_____

Standing Order for "Bedside" Medication

Self-Administration To Whom It May Concern:

The Mountain Center provides residents with self-administration of medication. This individual is required to obtain a BEDSIDE order for medication from a Licensed Practitioner in order to adhere to the self-administration procedure.

Please Note: The BEDSIDE order is applicable only to individuals who have been educated in the use of any bedside medications prescribed i.e., use of an INHALER or EPI-PEN. This order will allow this individual to maintain the medication on their person and in their possession at all times.

The BEDSIDE order pertaining to this resident will remain in effect for the duration of her stay. Residents will seek medical attention when appropriate, i.e., if there appears to be either a sensitivity reaction, significant side effects or when relief is not obtained.

PLEASE NOTE ANY KNOWN ALLERGIES TO MEDICATION:

_____

_____

_____

Please describe in detail below which includes:

1. For what symptoms: _____
2. An exact dose: _____
3. A maximum total dose per 24 hours: _____
4. Instructions on what to do if symptoms persist: _____

The Bedside Order applies **only** to the medication(s) below:

_____

_____

_____

_____

Signature of Licensed Medical Practitioner_____ Date_____

Patient_____ DOB_____

File NO:_____

Behavioral Health Information and Clearance

TO BE COMPLETED BY A LICENSED BEHAVIORAL HEALTH PROVIDER

Name of Client: _____ Date: _____

DOB: _____ Last 4 Digits of SSN: _____ Last ETOH/Drug Use: _____

DIAGNOSES:

PRIMARY: _____

SECONDARY: _____

Current Medications/Dosage/Rx Orders:

_____

_____

Stable on Medication? **[ ] Yes [ ] No** Has the client been suicidal in the last two months? **[ ] Yes [ ] No**

Client is mentally stable and able to participate in a transitional living program such as The Mountain Center without restrictions **[ ] Yes [ ] No**

Note Restrictions: _____

Please attach any combination of the following evaluations (must be dated within six months of referral)

❑ Psychological or Psychiatric Evaluation	❑ Clinical Interview (by a licensed therapist)
❑ Biopsychosocial History	❑ Mental Health Screening
❑ Other Types of Screening Tools ❑ ASI ❑ SASSI ❑ Back Depression	Other: ❑ _____ ❑ _____

Information on most recent course of treatment:

_____

_____

Signature of Licenced Clinical Provider:_____

Name of Licenced Clinical Provider:_____ Phone: _____

Clinic:_____

Address: _____

Email:_____

The Mountain Center

Client Intake Questionnaire

(TO BE COMPLETED BY APPLICANT)

Please Print Clearly

Name: _____ Date of Birth: _____

Today's Date: _____

1. What problems/difficulties were going on in your life that caused you to seek help at TMC? (Include any legal, family, social, employment, or other issues that influenced your decision.)

_____

_____

_____

2. Are you currently receiving any mental health services? If yes, please describe.

_____

_____

_____

3. Are you currently experiencing feelings of depression or anxiety, or thoughts of harming yourself or others? If yes, please describe.

_____

_____

_____

4. Please list any prior treatment episodes. Please include the name of the program or provider, and the approximate date, length of stay, and whether you completed treatment.

   Mental Health treatments (please list dates you discharged)

_____

_____

_____

Substance Abuse treatment (please list dates you discharged)

_____

_____

_____

Have you taken any medications in the last 2 weeks? What medications are currently prescribed for you? If you can, list the Medication Name, Dose, and Frequency of each.

Medication Name	Dosage	Frequency

5. **Medical & Healthcare History:**

(Circle all conditions that apply)

Been hospitalized
Had surgery in last 5 years
Treated after serious accidents
Treated for head injury
Treated for neurological problems
Treated for heart problems
Treated for respiratory problems
Treated for diabetes
Had unusual gains or losses of weight
Stomach problems
Any difficulty with sleep
Changes in eating patterns
Skin problems
Fractured Bone or Joint problems
Communicable disease
Urinary problems
Had a sexually transmitted disease
Difficulties with sexual functioning
Reproductive difficulties
Hearing problems
Vision problems
Had activities restricted due to health problems
Brain Injury/loss of consciousness
Other _____

Please Check All That Apply

❑ Any special dietary restrictions? (i.e. vegetarian/vegan/gluten free/lactose intolerant?) _____

❑ Asthma? Is it mild/moderate/severe? Do you carry an inhaler? _____

❑ ALLERGIES to medicines, foods, materials, or insect bites (please describe)? Do you carry epinephrine? _____

❑ **Is there anything we should know with your health that we should know about that was not mentioned?**

_____

_____

Date of last menstrual cycle: _____

Are you or do you feel you might be pregnant? Yes____ No____

Number of previous pregnancies _____ Live births: _____ Living children_____

6. **Children**

Please list the name and ages of your children and with whom they reside at present:_____

CYFD or Tribal Social Services Involved? Yes____ No____ Name of Providers_____

7. **Substance Use** (list all substances used, number of days used in previous month, how used, and age at 1st use)

_____

_____

8. **Is there a history of substance abuse in your family? If yes, please describe.**

_____

_____

9. **History of Mental Health Diagnosis?**

_____

_____

10. **Criminal Activity?** Yes____ No____ If yes, what was your last charge and date? _____

Have you ever been incarcerated? If yes, for what, where, when, and for how long?

_____

_____

Are you currently on probation or parole? Yes____ No____ If yes, for what offenses?

_____

Was it for Violent Behavior? If yes, please describe:

_____

Client Signature: _____ Date: _____

What to bring with you to The Mountain Center

- **<u>Current</u> driver's license or photo ID (**or we can't admit you.**)**
- **A 30-day supply of any prescribed medication** you're taking, with refills. If this is not possible, please bring in a written prescription so that it may be filled upon arrival.
- **A copy of Medical Clearance and TB test results.** The Medical Clearance form must be filled and signed by your Physician and dated within 10 days of your admission. Please note that admission is not possible without a completed Medical Clearance. Your **TB** test results must be negative and up-to-date (meaning less than a year old). Results of testing for **Hepatitis C** may be pending, although the test date must be noted on the Medical Clearance form.
- **Outside Appointments:** Please complete or reschedule any appointments, personal business, court hearings, etc... **BEFORE** entering the program. TMC staff will help you keep needed appointments current.

<u>And don't forget an adequate supply of items, and back-up for your extended stay</u>

Bring Your Medicaid Card if applicable (including for your children, if any are coming with you)

- Social Security Card
- EBT card
- 1-2 Notebooks
- Pens and/or pencils, colored pencils if desired
- Stamps and envelopes for communicating with family
- Laundry soap
- A modest amount of spending money

Hygiene Items

- At least four towels and washcloths (scrubbies are allowed)
- Soap
- Toothbrush and Toothpaste
- A razor
- Deodorant
- Comb and/or brush
- Hair spray (must be alcohol- free -- check the label)

Clothing Items

- Plastic Hangers (enough for your clothing that should be hung).
- 1 jacket, 2 sweatshirts, or a sweater (even in the summer, desert nights can be cool)
- 3-4 pair of sweatpants
- 5-7 pairs of Jeans or casual pants, including shorts if needed.
- 7-10 Shirts (Modest & appropriate.)
- Socks
- Shower shoes/flip-flops
- Slippers

- Robe
- Underwear
- Bras
- Pajamas
- 1 pair walking shoes

Optional Items
- Books or other reading material
- Hat or sunglasses

Please Do NOT Bring
- Cell phone (you will not be permitted to use it)
- Perfume and/or cologne are not allowed
- Knives/weapons
- Computer
- Camera
- Video Devices
- Bleach
- Personal gaming devices (PSP, Nintendo DS, etc...)
- ANYTHING that connects to the internet via Wi-Fi
- Clothing or personal items that have drug/alcohol/or sexual references, gang logos, etc.
- Pornography
- Hair Dye
- **Food of any kind.** We have plenty.

And Remember...

IF YOU'RE PREGNANT, LET STAFF KNOW IMMEDIATELY!

Additionally:
- A urine analysis (UA) and breathalyzer test (BA) will be required before admission can occur.
- Please, make your transportation aware that they will need to stay until the results of your UA and BA have been admitted.
- **If the Medical Clearance is incomplete, you will not be admitted.**
- **Please stay in touch with the Admissions Coordinator to confirm your arrival time and date.**
- Transportation is not provided for admission to our facility or at discharge. Please make transportation arrangements.

If you have any questions or concerns regarding your admission, please feel free to call the Client Services Coordinator at 505-465-2040, extension 12