
333 N. Main Street
South Bend, Indiana 46601
Phone: (574) 904-4957
info@upperroomrecovery.org

# Application for Acceptance

Date:_____

Client First Name:_____ Middle Name:_____ Last:_____

Date of Birth:_____ Age:_____ Social Security Number:_____

☐ State ID ☐ Driver's License Number:_____

☐ Homeless OR ☐ Current Address:_____

_____

Telephone Number:_____

Email Address:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Relationship

Significant Other Name:_____ Length of Relationship:_____

Names of People in Previous Residence:_____

Relationships to Those in the Home:_____

Emergency Contact Name:_____

Emergency Contact Relationship:_____ Phone Number:_____

Referring Agency:_____

Referring Agency Contact Name:_____ Phone Number:_____

Reason for Request to be Accepted:_____

Primary Physician:_____ Phone Number:_____

Medical Diagnosis:_____

Prescriptions

| Name: | Prescriber: |
| --- | --- |
| | |
| | |
| | |
| | |
| | |

Have You Ever Been Convicted of an Offense: ☐ Yes ☐ No

Have You Ever Been Convicted of a Violence or Sex Offence: ☐ Yes ☐ No

| Offense: | County/State: |
| --- | --- |
| | |
| | |
| | |
| | |

Substance(s) of Abuse (check all that apply)

☐ Alcohol ☐ Cocaine ☐ Heroin ☐ Inhalants ☐ Marijuana ☐ Methamphetamine

☐ Nicotine ☐ Prescription Amphetamines ☐ Prescription Benzodiazepines ☐ Prescription Opiates

☐ Synthetic Substances ☐ Other:_____

Last Use Date:_____ Substance(s):_____

Current or Past Treatment History: ☐ Yes ☐ No

Where:_____ When:_____

Where:_____ When:_____

Where:_____ When:_____

History of Gambling: ☐ Yes ☐ No Treatment History: ☐ Yes ☐ No Location:_____

For Office Use Only: ☐ Approved ☐ Denied Reason:_____

Date:_____ Staff Name:_____

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# Client Questionnaire

Admission Date:_____ Method of Interview: ☐ Phone ☐ In Person

Date:_____

Staff Performing Evaluation:_____

Client Name: _____

Date of Birth:_____ Age:_____ Social Security Number:_____

Phone Number:_____ Email Address:_____

Diagnosis/Impression:_____

Reason for Residential Housing Stay at the Upper Room:_____

_____

Prescriptions

| Name: | Prescriber: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

History of Trauma or Abuse: ☐ Yes ☐ No Details:_____

_____

Physical Health Conditions: ☐ Yes ☐ No Details:_____

_____

Mental Health Diagnosis: ☐ Yes ☐ No Details:_____

_____

Substance Use History:

| Substance | Age of First Use | Last Use | Recent Frequency of Use | Recent Quantity of Substance | Longest Length of Absence | Tolerance, Loss of Control, Black Outs, Withdrawal, DT's |
|---|---|---|---|---|---|---|
| Alcohol | | | | | | |
| Cocaine | | | | | | |
| Heroin | | | | | | |
| Inhalants | | | | | | |
| Marijuana | | | | | | |
| Meth | | | | | | |
| Nicotine | | | | | | |
| Rx Amph | | | | | | |
| Rx Benzo | | | | | | |
| Rx Opiates | | | | | | |
| Synthetic | | | | | | |
| Other: | | | | | | |

| History/Symptom | Yes | No | History/Symptom | Yes | No |
|---|---|---|---|---|---|
| Use to Manage Withdrawal | | | History of Withdrawal Seizures | | |
| Recent Use of Sedative Drugs | | | History of Delirium Tremens (DT's) | | |
| Resident in Past Six Months | | | Unable to Safely Evacuate Building | | |
| Employed in Past Six Months | | | Learning/Developmental Disabilities | | |
| Arrested in Past Six Months | | | Depression/Anger/Sleep Problems | | |
| Sexuality/Aggression Issues | | | IV Drug Use | | |

Allergies: ☐ Yes ☐ No Details: _____

_____

Past or Current Suicidal Thoughts: ☐ Yes ☐ No Details: _____

_____

History of Gambling: ☐ Yes ☐ No Details:_____

Currently in Treatment: ☐ Yes ☐ No
Location:

_____

_____

_____

Past History of Treatment: ☐ Yes ☐ No
When:

_____

_____

_____

Describe Relationship with Family:_____

Community Support(s): ☐ AA ☐ NA ☐ Church ☐ Other:_____

Details:_____

History of Victimization: ☐ Yes ☐ No Details:_____

Strengths:_____

Weaknesses:_____

Ability/Reasons to Remain Abstinent:_____

_____

Other Comments:_____

_____

_____

_____

_____

_____

_____

_____

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# Release of Information - Emergency Contact

Client First Name: _____ Middle: _____ Last: _____ Date: _____

Client Date of Birth: _____ Age: _____ Emergency Contact: _____

Contact Phone Number: _____ Relationship: _____

Contact Street Address: _____

City, State & Zip Code: _____

The above-named client authorizes the Upper Room Recovery Community to release the following information either verbally, in writing, digitally, and/or electronically to each other regarding my evaluation and/or treatment, including diagnosis or treatment of use disorder.

Upper Room will release:

☐ Alcohol/Drug/Gambling Information ☐ Attendance & Progress ☐ Discharge Summary
☐ Diagnosis ☐ Drug Screens ☐ Medication
☐ Weekly/Monthly Report ☐ Assessment ☐ Treatment Plan
☐ Other: _____

Requested from the Above Referral Agency and Case Manager:

☐ Alcohol/Drug/Gambling Information ☐ Attendance & Progress ☐ Discharge Summary
☐ Diagnosis ☐ Drug Screens ☐ Medication
☐ Weekly/Monthly Report ☐ Assessment ☐ Treatment Plan
☐ Other: _____

Purpose of Disclosure(s):

☐ Aid in Treatment ☐ Comply with Court Order ☐ Follow-Up Care
☐ To Keep the Following Involved and Informed:
☐ Gatekeeper ☐ Family ☐ Probation Officer ☐ Employer
☐ Attorney ☐ Referral ☐ Legal Authorities ☐ Other: _____

I understand that my records are protected under the Federal and specific State confidentiality laws and regulations 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 (e.g., the provision of treatment upon consent to disclosure to third-party payers) and that in any event this consent automatically as described below. It is understood that this consent expires within one (1) year from the date signed unless otherwise specified here:

Expiration Date (beyond one year from date signed): _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Notice to Recipient of the Upper Room Recovery Community Information

The information that has been disclosed to you from records is protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for 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 client.

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# Release of Information - General

Client First Name: _____ Middle: _____ Last: _____ Date: _____

Client Date of Birth: _____ Age: _____ Release to: _____

Phone Number: _____ Relationship: _____

Street Address: _____

City, State & Zip Code: _____

The above-named client authorizes the Upper Room Recovery Community to release the following information either verbally, in writing, digitally, and/or electronically to each other regarding my evaluation and/or treatment, including diagnosis or treatment of use disorder.

Upper Room will release:

☐ Alcohol/Drug/Gambling Information ☐ Attendance & Progress ☐ Discharge Summary
☐ Diagnosis ☐ Drug Screens ☐ Medication
☐ Weekly/Monthly Report ☐ Assessment ☐ Treatment Plan
☐ Other: _____

Requested from the Above Referral Agency and Case Manager:

☐ Alcohol/Drug/Gambling Information ☐ Attendance & Progress ☐ Discharge Summary
☐ Diagnosis ☐ Drug Screens ☐ Medication
☐ Weekly/Monthly Report ☐ Assessment ☐ Treatment Plan
☐ Other: _____

Purpose of Disclosure(s):

☐ Aid in Treatment ☐ Comply with Court Order ☐ Follow-Up Care
☐ To Keep the Following Involved and Informed:
☐ Gatekeeper ☐ Family ☐ Probation Officer ☐ Employer
☐ Attorney ☐ Referral ☐ Legal Authorities ☐ Other: _____

I understand that my records are protected under the Federal and specific State confidentiality laws and regulations 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 (e.g., the provision of treatment upon consent to disclosure to third-party payers) and that in any event this consent automatically as described below. It is understood that this consent expires within one (1) year from the date signed unless otherwise specified here:

Expiration Date (beyond one year from date signed): _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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# Release of Information - Oaklawn

Client First Name: _____ Middle: _____ Last: _____ Date: _____

Client Date of Birth: _____ Age: _____ Referral Source: Oaklawn

Referral Phone Number: _____ Referral Case Manager: _____

Referral Street Address: _____

City, State & Zip Code: _____

The above-named client authorizes the Upper Room Recovery Community to release the following information either verbally, in writing, digitally, and/or electronically to each other regarding my evaluation and/or treatment, including diagnosis or treatment of use disorder.

Upper Room will release:

| | | |
|---|---|---|
| ☐ Alcohol/Drug/Gambling Information | ☐ Attendance & Progress | ☐ Discharge Summary |
| ☐ Diagnosis | ☐ Drug Screens | ☐ Medication |
| ☐ Weekly/Monthly Report | ☐ Assessment | ☐ Treatment Plan |

☐ Other: _____

Requested from the Above Referral Agency and Case Manager:

| | | |
|---|---|---|
| ☐ Alcohol/Drug/Gambling Information | ☐ Attendance & Progress | ☐ Discharge Summary |
| ☐ Diagnosis | ☐ Drug Screens | ☐ Medication |
| ☐ Weekly/Monthly Report | ☐ Assessment | ☐ Treatment Plan |

☐ Other: _____

Purpose of Disclosure(s):

☐ Aid in Treatment ☐ Comply with Court Order ☐ Follow-Up Care

☐ To Keep the Following Involved and Informed:

| | | | |
|---|---|---|---|
| ☐ Gatekeeper | ☐ Family | ☐ Probation Officer | ☐ Employer |
| ☐ Attorney | ☐ Referral | ☐ Legal Authorities | ☐ Other: _____ |

I understand that my records are protected under the Federal and specific State confidentiality laws and regulations 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 (e.g., the provision of treatment upon consent to disclosure to third-party payers) and that in any event this consent automatically as described below. It is understood that this consent expires within one (1) year from the date signed unless otherwise specified here:

Expiration Date (beyond one year from date signed): _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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# Release of Information - Referral Source

Client First Name: _____ Middle: _____ Last: _____ Date: _____

Client Date of Birth: _____ Age: _____ Referral Agency: _____

Referral Phone Number: _____ Referral Case Manager: _____

Referral Street Address: _____

City, State & Zip Code: _____

The above-named client authorizes the Upper Room Recovery Community to release the following information either verbally, in writing, digitally, and/or electronically to each other regarding my evaluation and/or treatment, including diagnosis or treatment of use disorder.

Upper Room will release:

☐ Alcohol/Drug/Gambling Information ☐ Attendance & Progress ☐ Discharge Summary
☐ Diagnosis ☐ Drug Screens ☐ Medication
☐ Weekly/Monthly Report ☐ Assessment ☐ Treatment Plan
☐ Other: _____

Requested from the Above Referral Agency and Case Manager:

☐ Alcohol/Drug/Gambling Information ☐ Attendance & Progress ☐ Discharge Summary
☐ Diagnosis ☐ Drug Screens ☐ Medication
☐ Weekly/Monthly Report ☐ Assessment ☐ Treatment Plan
☐ Other: _____

Purpose of Disclosure(s):

☐ Aid in Treatment ☐ Comply with Court Order ☐ Follow-Up Care
☐ To Keep the Following Involved and Informed:
☐ Gatekeeper ☐ Family ☐ Probation Officer ☐ Employer
☐ Attorney ☐ Referral ☐ Legal Authorities ☐ Other: _____

I understand that my records are protected under the Federal and specific State confidentiality laws and regulations 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 (e.g., the provision of treatment upon consent to disclosure to third-party payers) and that in any event this consent automatically as described below. It is understood that this consent expires within one (1) year from the date signed unless otherwise specified here:

Expiration Date (beyond one year from date signed): _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Notice to Recipient of the Upper Room Recovery Community Information

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# Resident Housing Guidelines

## Admission

1. Upon admission, there is a probationary period of 14 days. During this time, only recovery related activities such as treatment appointments, AA/NA meetings, and drug screens are permitted to be attended, in addition to legal system appointments and other appointments permitted by the case manager.
2. Curfew and overnight passes do not apply during this time.
3. A daily to weekly schedule of social support meetings, including encouragement of worship services, will be determined by the case manager.
4. Anonymity is always respected.
5. If any of these prevention of relapse tools does not prove to be successful, a warning, write-up, or discharge summary will be completed.

## Substance Use

1. Must remain free from possession or use of any substance of abuse and submit to any substance testing upon request.
2. When a resident is suspected of substance or alcohol use, the resident is given the option to make a statement about the allegation and a drug screen will be completed. Results of the drug screen and/or toxicology will be presented to any requesting agency, when a release of information has been obtained, and to the resident.
3. When the resident admits to returning to substance or alcohol use and/or the drug screen is positive for a prohibited substance or alcohol, the resident will be presented with either a warning, write-up, or discharge summary.
4. The resident will have 10 days after leaving the facility to remove all property. Any property after the 10 days will be discarded.

## Gambling

1. Gambling within or outside the facility is prohibited.

## Smoking

1. Smoking is prohibited anywhere in the house, church buildings or on the church property. Any violation of this policy will result in completion of a warning, write-up, or discharge from the facility.

## Elevator

1. The facility elevator is prohibited unless otherwise authorized by the case manager.

## Personal Relationships

1. Residents are prohibited from being in close or intimate relationships with any Upper Room residents. This includes romantic or sexual relationships and any type of relationship that includes significant time together.

## Personal Belongings

1. Candles and items with an open flame are not permitted.
2. Borrowing of money between clients and/or staff is prohibited.

3. Residents are restricted from touching or looking through any property that is not their own.
4. Residents should restrict the storage of valuable items in the facility. The Upper Room is not responsible for any lost or stolen property.
5. Residents have 10 days after leaving the facility to remove all property. It will be discarded after that deadline and the Upper Room is not responsible for items.

Employment

1. Residents who are not at documented employment must attend devotions at 8:00am each weekday. Residents must not return to bed after devotions.
2. Obtain employment within 60 days of admission, or as determined by the case manager.
3. Residents who are not working are required to engage in community service, which may be determined by the case manager.

Treatment

1. Residents must register for treatment assessments three (3) days of admission or sooner. Residents must agree to participate in treatment appointments.

Case Management

1. Residents are expected to schedule regular meetings with their case manager in one-to-three-week intervals, as determined by the case manager.

Curfew

1. Curfew is 10:30pm Sunday through Thursday and 11:30pm Friday and Saturday.
2. Sign-in and out on the provided form near the door when leaving and returning.

Medications/Prescriptions

1. Residents are permitted to take approved medications as appropriately prescribed by a medical professional and may be accepted by staff. A prohibited medication list is available from any staff member.
2. All prescription and over-the-counter drugs must be kept in the resident's locked storage space. Residents are responsible for the safety and administration of any medications they may have. Any new prescriptions must be approved by staff. A list of all prohibited medications is available from any staff member.
3. Any approved controlled prescription must be locked in the safe and prescribed doses picked up daily from a staff member, unless otherwise scheduled.
4. Naloxone/Narcan is available on site and training will be made available to any resident.

Respect

1. Residents must clean up after themselves and be respectful of the property of others, including the facility.
2. Participate in rotating household and church chores each day to week.
3. Residents must be respectful of neighbors with regard to loitering, noise and smoking.
4. Headphones will be worn when any form of electronics are used, with exception to the communal TV in the dayroom.

5. Full clothing, including a top, bottoms and shoes will be worn at all times, with exception being in the resident's own dorm and bathroom.

Rent

1. Rent is billed at $100 per week.
2. Any third-party payors will be billed weekly, with $0 rent owed from the residents that qualify.
3. Deposits of rent funds to the case manager or Executive Director will result in a receipt given to the resident and funds will be deposited at the appropriate fiduciary monthly.
4. Any additional paid work arrangements will be confirmed with the resident and that resident's rent is waived in the month when work was performed.
5. Refunds of rent will be made when appropriate as deemed by the Executive Director, when a mistake has been made with billing, such as charges made after separation of residence.
6. Accrual of three (3) months of past due rent will result in Upper Room discharge.

Vehicles

1. All motor vehicles used by residents must be properly licensed and insured. A valid driver's license is required. A copy of these documents will be kept in the resident file.
2. Parking restrictions must be followed. Resident parking is restricted to the rear of the main parking lot or street.

Searches

1. Privacy will be provided but searches of property will be conducted by staff when reasonable suspicion arises. Reasonable suspicion is when a hazardous item or illegal substance or alcohol is suspected and either a warning, write-up or discharge summary will be made upon search completion when an item was found.

Grievances

1. Any grievances that arise between residents, or between residents and staff, will be handled through the grievance procedure, which is provided by the case manager and documented in the Resident Handbook.

Rights

1. All residents will receive a copy of the Resident's Rights and INARR Code of Ethics.

Emergencies

1. A staff member is always on call for emergencies.
2. Resident assistants live in the house to assist residents with evening and overnight minor and routine issues.

Exposure of Bodily Fluids

1. Staff shall refer any resident experiencing symptoms of a communicable disease to a local healthcare facility.
2. If the resident is positive, the resident will be isolated as recommended by local health officials.
3. Any required announcement of the communicable disease will be made when appropriate.

4. Before returning to the facility, staff must receive release of care from the healthcare official.
5. If a resident or staff member handled and/or was exposed to any bodily fluid, the resident or staff member will seek medical attention and any appropriate recommended measures by a medical professional will be taken inside the facility or a discharge summary will be completed for the safety and security of the residents and/or staff.

Social Media

1. Residents and staff are permitted to consent to participate in interviews, the use of quotes and the taking of photographs, movies or video tapes of the resident or staff members by signing a consent.
2. The consent, which is available from staff, grants the Upper Room to edit, use, and reuse interviews for non-profit purposes including use in print, on the internet, and posting and/or sharing to any and/or all forms of social media.
3. By signing the consent, the resident or staff member understands protection from unauthorized posting or sharing of residence on social media.
4. The consent allows for release by the Upper Room Recovery Community and its agents and employees from all claims, demands, and liabilities in connection with the above.
5. The consent requires a signature, and if the signature is not obtained, the interview will not be used in any way.

Drug Screening

1. The Upper Room may drug screen residents or staff members at time of suspicion and/or on a random basis for consistency and to maintain a safe and sober living environment.
2. Drug screens are initially presumptive and may be sent out to a partnering screening company when either positive for any substance or alcohol, or when requested.
3. Results will be shared with any requesting agency, when a release of information has been obtained, and to the resident or staff member.

Chores

1. Daily completion of Upper Room and church chores are mandatory.
2. Daily chores will be assigned by a panel of Resident Assistants.
3. The assigned chore description will be kept with the resident and signed once the chore has been completed. The signed copy will be submitted to an RA, which will verify completion of the task.

Non-Compliance

1. Any non-compliance which is observed by an RA may result in a write-up, which is then forwarded to the case manager and/or Executive Director, without verbal reprimand by the RA to the resident at the time of violation.
2. The case manager and/or Executive Director will decide the outcome of the write-up, either being without a reprimand, a warning, or discharge.
3. Any three write-ups within three months shall result in discharge.
4. Residents may be discharged without being given prior notice.

The Housing Guidelines for Upper Room residents must be read and signed by all being admitted to the Upper Room Recovery Community.

By signing, I affirm that I have read, understand, and agree to abide by all the guidelines outlined above.

Name (print): _____ Date: _____

Signature: _____

Staff Witness: _____ Date: _____