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

Application for Acceptance

Date:______________________________________________

First Name: ____________ Middle:__________ Last:____________

☐ Female ☐ Male Date of Birth:______________________

☐ 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:_________________________________________

_________________________________________________________________________

_________________________________________________________________________

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: ______________________________________________

History of Gambling: ☐ Yes ☐ No Details:__________________________________________

Currently in Treatment: ☐ Yes ☐ No Details:________________________________________

Past History of Treatment: ☐ Yes ☐ No Details:_____________________________________

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:_______________________________________________________________________

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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: ________________

Notice to Recipient of the Upper Room Recovery Community Information

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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:__________________

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The **Housing Guidelines** for Upper Room residents must be read and signed by all 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: _____________

**--- Applicant to Keep ---**

Intake Guidelines

Application
1. Any criminal record , including of sexual or violent offense (battery, intimidation, robbery, assault, domestic battery, violent offense, etc.) mayexclude applicant from acceptance.
2. Other disqualification determinations may be explained to the applicant.

Clean Time
1. Applicants should have at least 30 days of clean time. Clean time requirement may be negotiable under certain circumstances.

Treatment
1. Applicants must agree to be assessed at Oaklawn, or other provider if approved, and to participate in any programming or treatment that is recommended.
2. All residents are required to attend 90 social support meetings in 90 days, and three per week thereafter.

Rent
1. Applicants must be able to begin paying rent ($100 per week) within 30 days of admittance.
2. Accrual of three (3) months of past due rent may result in Upper Room discharge.
3. Recovery Works is accepted for approved clients. Approval will be determined between criminal justice provider, the Upper Room, and Recovery Works. Documentation is due to the case manager weekly for billing of Recovery Works, and if this is incomplete, payment may be required.

Goals
1. Applicants must be working toward the goal of independent living and must meet with the Case Manager at least every week to establish and work on other goals.
2. Client must remain substance free.

Intake Paperwork
1. Upper Room intake procedure will be completed within 24 hours of admittance, excluding weekends.

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 are not permitted in the first 30 days of admittance.
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.

Gambling

1. Gambling within or outside the facility is prohibited.

Smoking

1. Smoking and/or vaping is prohibited anywhere in the house, church buildings or on 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. Written medical documentation of necessity of the use of the elevator use may be requested by staff.

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 or personal services 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 are restricted from theft of any item or belonging of another client and/or staff.
5. Residents should restrict the storage of valuable items in the facility. The Upper Room is not responsible for any lost or stolen property.
6. 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 30 days of admission, or as determined appropriate by the case manager.
3. Residents who are not working are required to complete job searches, in which may be determined by the case manager.
4. Residents are also required to fulfill a minimum of five (5) hours of community service within First United Methodist Church and its other outreach ministries.

Treatment

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

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 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 documented by staff.
3. Any approved controlled prescription must be locked in a secure area and prescribed doses picked up from a staff member as 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.
4. 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.
5. 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.
2. Upper Room staff will assist in any searches completed by a local police department.

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 and an acknowledgement will be signed.

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 may 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 for all residents.
2. Daily chores will be assigned by a panel of Resident Assistants and approved by the case manager.
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 may result in discharge.
4. Residents may be discharged without being given prior notice.