Please send application to:
707 N. 7th Ave., Ste. D
Pocatello, ID 83201
Phone: 208.242.3044
Fax: 208.904.0494

CR
COGNITIVE RESTRUCTURING, LLC

# Foundations of Recovery Housing Application

| | | | |
|---|---|---|---|
| Today's Date | | IDOC # | |
| Name | | SSN | |
| Address | | Date of Birth | |
| City, State, Zip Code | | Age | |
| Telephone | | Marital Status | |
| Ethnicity/Race | | Gender | |
| Employment Status | | Employer | |
| Who Referred You? | | Funding Source | |

## *HOUSING REQUEST*

| | |
|---|---|
| Housing need by? (Date) | |
| If a future date, please explain why: | |
| | |
| | |

## *LEGAL HISTORY*

| | | | | | |
|---|---|---|---|---|---|
| Legal Status | | | | | |
| Number of arrests in the last 30 days? | | For | | | |
| Parole/Probation | PO's Name: | | | Phone | |
| CPS | Case Worker: | | | Phone | |
| Will you be on probation/parole while in housing? | Yes | | No | | |
| Have you ever been convicted of a misdemeanor or felony? | Yes | | No | | |
| Were you under the influence of drugs/alcohol when the crime was committed | Yes | | No | | |
| List Charges: | | | | | |
| | | | | | |
| | | | | | |

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## *PERSONAL INFORMATION*

| *Please fill out the following information for each substance used:* | | | | | | | |
|---|---|---|---|---|---|---|---|
| Substance | | Last Used | | Method | | Age first Used | |
| Substance | | Last Used | | Method | | Age First Used | |
| Substance | | Last Used | | Method | | Age First Used | |
| Substance | | Last Used | | Method | | Age First Used | |
| Substance | | Last Used | | Method | | Age First Used | |

| | |
|---|---|
| Do you have any major health concerns? | |
| Are you able to climb stairs without assistance? | |
| Have you ever used any aliases or other names? | |

## RESIDENCY REQUIREMENTS

*Foundations of Recovery is a recovery home that requires its residents to be in recovery from alcohol and/or substance abuse. Please indicate below the type of program you are participating in for your recovery:*

| | | | |
|---|---|---|---|
| Are you currently in treatment? | | | |
| *If BPA/Magellan funded, please list outpatient treatment provider information:* | | | |
| Company | | | |
| Address | | | |
| Phone | | | |
| 12-Step Program | | Frequency Attending | |
| Other (Please describe) | | | |
| *Recently completed residential treatment (Please include location and length of stay):* | | | |
| | | | |
| | | | |
| Is your treatment court-ordered? | | Are you involved in drug court? | |
| Are you involved in mental health court? | | | |

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## FINANCIAL

*Each member staying at Foundations to Recovery is required to pay his share of the housing expenses. Please provide accurate information for the following questions.*

| | |
|---|---|
| What is your source of income? | |
| Are you currently employed? | |
| *If you answered yes to the above question, please complete the following questions:* | |
| Approximately how many hours a week will you work? | |
| Will you ever be required to work past curfew (9:00 PM)? | |
| ** If employed you will be required to turn in a weekly work schedule to the House Manager and curfew exceptions may be made at the discretion of the House Manager for conflicting work schedules.* | |

***I have completed this application to the best of my abilities and have answered all questions honestly. My signature below attests to my having read all materials provided and I agree to follow all rules and policies. I hold harmless Cognitive Restructuring, the corporate officers, property owners, independent service contractors and all service providers from all claims, actions and liabilities.***

***I authorize Foundations of Recovery to exchange information as needed with all government and/or private parties and/or their representatives as it relates to the application process and housing status while living at the Foundations of Recovery house.***

***I have read both statements above, understand its content and voluntarily agree to these terms and conditions.***

_____ _____

Applicant Signature Date

_____

Printed Applicant Name

CR

COGNITIVE RESTRUCTURING, LLC

# Foundations of Recovery House Rules

1. Absolutely no alcohol and/or drugs on or off the premises while at ***Foundations of Recovery***.
2. Overnight passes off of the premises are allowed. House Guests on probation/parole will need written permission from their Probation Officer. Only three (**3**) overnight passes are allowed in a 30 **day cycle**.
3. Nightly Curfew is **10:00 PM - 7:00 AM.**
4. House Guests violating the curfew will be required to pass a drug test upon return. The late test fee is **$20.00** paid by the house guest.
5. There will be random drug testing. If you refuse a test it will be considered a positive test and you will be required to leave ***Foundations of Recovery*** until a negative sample can be provided. Testing will take place at Cognitive Restructuring. You will be given a time period to UA and if you fail to do so during the designated time, disciplinary action will occur on an individual basis. Persistent positive UA's will be addressed on a case by case basis and may lead to being discharged from ***Freedom of Recovery***.
6. House Guests agree to random searches of personal property with the house guest and **2** staff members present.
7. ***Foundations of Recovery*** is not responsible for the loss, damage, or stolen property. There will be one locked cabinet provided per house guest.
8. There will be a **$20.00** fee if Cognitive Restructuring has to pack up and store personal belongings. I understand my belongings will be donated after 30 days.
9. All common areas at Foundations of Recovery are to be treated with respect and remain clean at all times.
10. No personal refrigerators, microwaves, coffee pots, heaters, furniture, candles or excessive personal property allowed. You will be given designated storage areas, all belongings must fit in the specified storage areas. House guests will receive 2 dresser drawers, 1 under bed storage bin and 1 locked cabinet drawer.
11. Any house guest caught **stealing** will immediately be discharged from ***Foundations of Recovery***.
12. We have an open door policy with Law Enforcement, Probation/Parole, and Court Service Programs. All house guests agree to be respectful to all outside agencies.
13. Smoking and Vaping is allowed outside only in designated areas as a privilege. Cigarette butts must be disposed of properly, if not disposed of properly this privilege may be revoked for an undetermined length of time. **Client Initials**_____
14. Visitors are not allowed on the Property to ensure it remains safe for all house guests and staff.
15. If you are being picked up by transportation, the driver may ring the doorbell and wait outside. If during business hours the driver may be allowed to wait in the main lobby area.
16. Only house guests and staff are allowed to enter the living quarters at ***Foundations of Recovery***.

17. **Verbal** or **Physical** violence towards another house guest or staff will not be tolerated and will result in a disciplinary action, up to and including being discharged from Foundations of Recovery.
18. Each house guest will be given a daily chore to ensure the house stays in good living conditions. This chore must be completed before leaving each day, as well as your bed being made and personal areas cleaned up.
19. House guests are not allowed to borrow money from staff or other house guests.
20. House guests will not be allowed to borrow cigarettes, food, clothing or personal hygiene products. If you need help finding resources please speak with the program director or case manager to assist with these community resources.
21. Romantic/ Intimate relationships **will not** be permitted between house guests or staff.
22. Always be kind and considerate when speaking to other house guests, staff, outside agencies or community resources.
23. No **pets** of any kind are allowed at Foundations of Recovery or on the premises unless it is a certified service animal or emotional support animal.
24. Narcotics and controlled substances are not allowed. We practice **TOTAL ABSTINENCE** from all mind-alternating substances, legal or illegal.
25. House Guests are responsible for the storage, maintenance and following their prescription as ordered by the physician. (**All medications must be locked in a secured cabinet at all times.**)
26. All medications need to be in the original containers with current prescription dates on the label. There will not be any sharing of medications of any kind (prescription, over the counter or otherwise).
27. If you are prescribed a pain medication while a resident of the house due to an accident or injury, please be sure to request a non-narcotic medication to avoid any interruption of housing services. If you fill a prescription for a narcotic while a resident of the ***Foundations of Recovery*** house and test **positive** during a drug screen a negative test result will be required before reentering the house. We understand that a physician may prescribe a pain medication out of necessity, however due to our total abstinence policy you will be required to make other living arrangements until you are able to pass a drug screening. If you wish to keep your bed during this time you are still responsible to pay your Housing fee. If you decide to move out during this time, your rent is **non-refundable**. We practice **total abstinence** from all substances, legal and illegal.
28. Suspicion of drugs/ alcohol use by another house guest should be reported to the Program Manager immediately (24/7), please call **208-576-5235**. You will remain anonymous and the house guest accused will be removed if unable/ unwilling to submit a negative drug/ alcohol test
29. Internet, cable TV, and phone services are provided. Any abuse of data usage or calls made to 411 will cause an interruption in services.
30. House guests are not allowed to service their vehicles on the property. All vehicles must be in good working order and registered to a ***Foundations of Recovery*** house guest. A limit of one vehicle per house guest. **Client Initials**_____
31. ***Foundations of Recovery*** is an approved housing provider for SUD (**substance use disorder**) through the Department of Health and Welfare. If you are approved through the Magellan Healthcare Non-Medicaid funding, please contact the main office to verify the referral has been received. All clients funded through Magellan Healthcare Non-Medicaid funding source pay a

**$100/monthly program fee.** The $100.00/monthly program fee is waived for house guests attending Cognitive Restructuring's Partial Hospitalization Program.

32. I understand that I am solely responsible to know when my housing fee & program fee is due and agree to pay on time. I will be given additional information on the housing agreement upon my move in date.
33. If a house guest violates any house rules or policies, they agree to meet with the program director to discuss the consequence or consequences.
34. ***Foundations of Recovery*** requires a **one** month commitment for a housing minimum.
35. When I am accepted into ***Foundations of Recovery*** and take up residency, I agree to hold harmless Cognitive Restructuring, the property owners, and any and all service providers/contractors against any and all claims, demands, suits or loss.
36. No cooking after **10:00 pm** and the kitchen and all dishes need to be cleaned by **10:00 pm.**
37. ***Foundations of Recovery*** is not responsible for any injury I may sustain from using the downstairs gym equipment. I must sign the gym waiver *before* using *any* of the gym equipment.

Applicant Signature Date

Staff Signature Date

COGNITIVE RESTRUCTURING, LLC

# Housing Agreement

**343 E. Bonneville**
**Pocatello, ID. 83201**

**Landlord:** Cognitive Restructuring-Foundations of Recovery
**Landlord Address:** 707 N. 7th Ave., Ste. D, Pocatello, ID. 83201
**Landlord Phone:** 208-242-3044
**Monthly Rent Total:** $350.00 **

**Monthly Program Fee:** $100.00**

**Prorated Amount: $** _____

***Payment in full is due by the 5th of each month, failure to pay will result in late fees or possible program discharge. After the 5th of each month if payment is not received there will be a late fee charge of $5.00 per day. Optional payment arrangements can be made with the House Manager. House Guest is responsible for keeping a record of monthly rent receipts. Monthly rent and program fees are non-refundable.*

☐ Monthly ☐ Payment Plan (see attached)

## *Funding Source*

*(Please select the residents funding source, determined prior to applicant's acceptance into the program)*

| | |
|---|---|
| | *Self-Pay* |
| | *Idaho Department Of Corrections* |
| | *Magellan Safe and Sober Housing* |
| | *Housing Assistance from BPA* |

I understand that while a resident at Foundations of Recovery I will be required to comply with the mandatory drug testing as conditions of my residency. Failure to comply with the housing requirements will result in disciplinary actions up to and including immediate discharge from the program.

***I understand that Foundations of Recovery Program is not part of the Idaho Housing Authority and therefore is not subject to the Idaho Fair Housing Act. Foundations of Recovery is not long-term housing and may include a maximum occupancy time limit.***

By signing below, I acknowledge my understanding of the Housing Agreement. I agree to comply with the program requirements and to pay the housing fees on or before their due date unless otherwise noted in a resident specific Payment Plan that has been predetermined with the House Manager.

_____

Applicant Printed Name Signature Date

_____

Witness Printed Name Signature Date

Last Update: February 2023

# Consent to Release Protected Health Information (PHI)

Magellan Healthcare, Inc.
Attention Privacy Officer, Collaborative Care
14100 Magellan Plaza, Mail Stop MO41
Maryland Heights, MO 63043

Managing the Collaborative Care Program for:
**Community Health Development, Inc.**

**Protected Health Information (PHI)** means information about your health. Federal and state laws protect the privacy of your PHI. The laws say we cannot give anyone other than your doctors at Community Health Development, Inc. your PHI unless you say it is **OK**. By signing this paper, you give us your **OK.** We will only give out the PHI that you say we can share. And, we will only give it to the people or agencies that you list. Do you have questions? We can help. Call Magellan Healthcare, Inc. (Magellan) at 1-800-201-3957, Option 3 or read the separate instructions page for more information on how to complete this form.

## Part 1 Who is the patient?

| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

| ID Number | Date of Birth (MM/DD/YYYY) | Phone Number (with area code) |
|---|---|---|
| | | |

| Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

**Check One** (to tell us who is filling out this form):

☐ I am the patient OR

☐ I have the legal right to act for this person. (Check one below; if "Guardian/Other" fill your name in blank)

I am his or her: ☐ Parent OR

☐ Guardian/Other (Legal Proof Required) _____

## Part 2 Who can give out the PHI?

Magellan may give out your PHI. Magellan manages your mental health and/or drug and alcohol treatment through the Collaborative Care program for Community Health Development, Inc.

## Part 3 Who can the PHI be given to?

| Name (a person, like a family member or doctor, or a place like a clinic or hospital): Cognitive Restructuring | Phone Number (with area code) (208) 242-3044 |
|---|---|
| Address: 707 North 7th Avenue, Suite D | City, State, and Zip Code Pocatello, Idaho 83201 |

## Part 4 What PHI can we share?

We will **only** share the PHI that you **OK.** This **OK** includes facts about your medicine. It also includes facts about your mental health and/or your alcohol and drug treatment that are in your records. It does not cover psychotherapy notes that <u>are not</u> in your records. Tell us the health information from your records that can be shared. _____

_____

If you give us your **OK** to share <u>this</u> kind of health information in the above PHI, check the boxes that apply:

☐ HIV/AIDS ☐ Alcohol/Substance Abuse Records

## Part 5 Why are you giving out this PHI?

Tell us why you want us to share your PHI? _____

_____

**Turn this page over.**

## Part 6 When does my OK end?

Your **OK** will end when you tell us it does. **Tell us when you want your OK to end:**

☐ **My OK ends on this date:** _____ (It cannot be more than one year from your **OK**)

OR

☐ **My OK ends when this happens:** _____

(It can be something like "you can share my PHI this one time.") If you do not tell us when your **OK** ends, then we will end your **OK** in one year from when you sign. After one year, we will need a new **OK.**

## Part 7 Your Rights and Important Facts

- Giving your **OK** is up to you. You do not have to share your information.
- You do not have to **OK** this paper. You will still get benefits and treatment.
- You can take back your **OK.** You must tell us in writing. Mail it to: Magellan Healthcare / Attention Privacy Officer, Collaborative Care / 14100 Magellan Plaza, Mailstop MO41 / Maryland Heights, MO 63043. Or you may fax it to 1-888-656-4769.
- What if you take back your **OK?** This will not take back the PHI that we have already shared. But, we **will not** share any more of your PHI.
- If we share your PHI with the people or agencies that you named, they may share it with others. Not everyone has to follow privacy rules.
- You have a right to get a copy of this signed **OK.** If you need another copy, call Magellan at 1-800-201-3957, Option 3.
- If you do not understand, or have questions, we can help. Call Magellan at 1-800-201-3957, Option 3.
- If you decide to complete this form and give your **OK**, send it to us at the address or fax # listed above.
- You should keep a copy of this signed paper. Remember, Protected Health Information (PHI) means any information about your health in the past, present, or future. It includes facts like your address and date of birth. A full definition of PHI is at 45 CFR §160.103.

## Part 8 Signature of Patient

I give my **OK** to share the information listed in this paper.

_____ _____

Signature or Mark of Patient Date (required)

## Part 9 Signature of Authorized Representative (if any)

**Authorized Representative** means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If the patient is less than 18 years old, a parent or guardian should sign for the minor. If you have legal proof that you can act for this person, please send a copy of the proof with this form.

_____ _____

Signature of Person signing on behalf of patient Date (required)

Printed Name: _____ Phone: _____

Address: _____

## NOTICE TO ANYONE OTHER THAN THE PATIENT

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited 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 federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**BPA Clients Only**

**Idaho Substance Abuse Treatment and Recovering Support Services**

| **Consent for Release of Information** |
|---|
| I, _____, am requesting substance abuse services from Idaho's publicly funded substance system of care. As such I voluntarily authorize BPA Health, those Substance Abuse Treatment and Recovery Support Services (RSS) providers who are contracted to provide Treatment and RSS under Idaho's publicly funded substance abuse system of care, and the Department of Health and Welfare (Department) to disclose my name, all necessary treatment information and my social security number to each other and the Department. This information will be disclosed for the following purposes: **1)** To assist with referring me to appropriate types of care and guiding my treatment and recovery support; **2)** To be entered into the Department's common client database so that I will have one client number for any services received from the Department; **3)** To process payment of costs for my treatment and recovery support services; **4)** For monitoring compliance in the program; **5)** For programming audit and research including independent peer reviewers, contract monitors or researchers appointment by the Department; **6)** For investigations related to fraud.<br><br>Furthermore, I authorize the disclosure of personal substance abuse treatment and recovery outcomes data collected by contracted Substance Abuse Treatment and RSS Providers, BPA Health and the Department to the Federal Center for Substance Abuse Treatment and its contracted data collections Agents.____, **Client initials** |
| **Informed and Voluntary Consent for Treatment** |
| The purpose of my participation, as a client, in the Idaho publicly funded substance abuse treatment program is to acquire knowledge, skills and attitudes supportive of a sober and more satisfying lifestyle. In addition to the potential positive outcomes likely to occur as a result of my participation, the following reasonably foreseen risks may occur, as they would in any other alcohol and drug treatment program: breach of confidentiality; negative reactions of group members; emotional stress from requirements of group interaction, self-disclosure; stress to relationships resulting from open discussion of issues, past traumas; and stress to relationships resulting from participant behavioral changes, positive or negative, need to attend recovery support meetings, spend time in group and doing assignments.<br><br>Providers will take steps to minimize or protect participants against potential risks by adhering to standards of confidentiality found both in Federal and State Code, and by informing and verifying client understanding of group rules. And, by intervening in and guiding appropriate disclosure, confrontation and resolution in group and in family conflict. Providers will assist clients in accessing sober support services and self-help groups where acceptance and stress reducing support is available. _____, **Client initials.** |
| **Revocation Clause** |
| This release may be revoked at any time either orally or in some writing, except to the extent that action has already been taken in reliance on the release. I acknowledge that some information may include material that is protected by State and Federal regulations including Confidentiality of Alcohol and Drug Abuse Patient Record, 42 C.F.R. Part 2 and the Health Information Portability and Accountability Act (HIPAA). Unless revoked as stated above, this consent expires automatically on: _____. _____, **Client initials.** |

Direct any and all questions or concerns to: Cognitive Restr ucturing, LLC

I have read above and Consent to Release of Information, Informed and Voluntary Consent for Treatment and the Revocation Clause. I agree I have been given the opportunity to question the above disclosures and consent for care and hereby do agree to the above identified Disclosure and Consent to Treatment.

| | | |
|---|---|---|
| Client Printed Name | Client Signature | Date |
| Parent/Guardian Printed Name | Parent/Guardian Signature | Date |
| Witness Printed Name | Witness Signature | Date |