CENTENNIAL
MENTAL HEALTH CENTER
Moving lives forward

Sober Living Residences Application

Carly's house

MARK'S PLACE

Dear Applicant,

We commend you on your decision to take steps to maintain a sober lifestyle. Realizing that discipline, accountability, self care, and the ability to share in the success of others will be essential to your long term sobriety is no small feat on its own. The purpose of the Centennial Mental Health Center (CMHC) Sober Living Program is to help foster a peer led environment in which you can share in your successes and be supported with a group of people going through their own sobriety journeys. In addition to living in the peer led environment, therapeutic intervention and case management services will be part of your individualized program. Please read through the requirements and expectations before filling out the application so that you can make sure our program is right for you. Also, please have your referring party sign the application as well. If you have any questions, you may call the program manager at 970-473-6316. Please send or fax completed application to:

Mail:
CMHC Sober Living
821 E. Railroad Ave.
Fort Morgan, CO 80701

Fax:
ATTN: Sober Living
844-905-1350

Best Regards,

Sober Living Program Staff

COLORADO
association of recovery residences
CARR

CRITERIA FOR APPLICANTS

- Applicants must be willing to participate in treatment through Centennial Mental Health Center.
- Applicants must be at least 18 years' old
- Applicants must present a negative Covid 19 test result upon move in.
- Be able to traverse a multi level house and complete activities and instrumental activities of daily living (ADLs and IADLs) without assistance.

FINANCIAL RESPONSIBILITY

- There is a $50 application fee to cover the cost of processing criminal background reports.
- There is a $250 refundable deposit due at program entrance.
- Participants are required to pay their full $400 program fee on time, unless otherwise arranged.
- You are required to provide your own food, laundry, and personal care items.
- All utilities have been accounted for in your program fees, including the house phone, television services, and internet service.
- If your insurance does not cover these costs, you will be responsible for the cost of drug and alcohol screenings. This includes instant, lab, and confirmation testing.

EXPECTATIONS AND REQUIREMENTS

- Client must remain abstinent from all substances.
- Clients are required to engage in case management, therapy, and peer specialist services.
- Clients must make a good faith effort to attend all scheduled appointments.
- Attend house meetings with other program participants.
- Participate in household chores/upkeep and maintain clean living spaces. Room checks/searches will be conducted at staff discretion.
- Seek employment/education/volunteer opportunities within the first 30 days. Clients who are able to work must maintain employment and/or full time education enrollment.
- No controlled substances legal or illegal in the house at any time. This includes pain-killers, benzodiazepines, or any other narcotic level medication.
- Clients are required to participate in randomized and for-cause alcohol/substance screenings. Alcohol/substance screening refusals will be counted as positive results.
- Positive UA or BA results require discussion with staff to determine continued eligibility. This may result in same day program discharge.
- All personal visitors must be approved by staff at least 24 hours prior to their visit. All visitors are restricted to common areas only.
- Any violent or verbally abusive behavior toward another program participant, neighbor, or staff is not acceptable.
- No weapons of any type are allowed at the Sober Living Residences.
- There will be a curfew to be determined by staff. Overnight stays require prior staff approval.
- Attend at least two recovery meetings a week either in person or virtually. Clients who are not working/volunteering/seeking education attend four meetings weekly.
- Create a positive support network, including a sponsor or recovery mentor.
- Complete a transition plan, focusing on both voluntary and involuntary program exit scenarios.
- Any items left after 14 days of program exit will be donated or disposed of.

Client Information			
First Name	Middle Name	Last Name	Date of Birth
Social Security #	Maiden Name	Other Names Known By:	

Current Address			
Street	City	State	Zip

Mailing Address			
Street	City	State	Zip

Contact Information			
Cell Phone Number	Other Phone Number	Email	Additional Contact Notes:
Emergency Contact Name	Emergency Contact Phone Number	Emergency Contact Work Phone	Emergency Contact Address

Referring Party Information			
Organization/Facility	Name	Phone Number	Was a Release of Information (ROI) completed for Referring Party? ☐ Yes ☐ No

Please check the response that best applies to you.

COVID-19 Vaccination Status	Marital Status	Sexual Orientation	Veteran Status
☐Fully Vaccinated ☐Partially Vaccinated ☐I can provide proof of exemption status ☐I want to be vaccinated ☐No intention of being vaccinated	☐Divorced ☐Married ☐Married – Separated ☐Never Married ☐Widowed	☐Bisexual ☐Decline to answer ☐Gay/lesbian ☐Heterosexual ☐Other	☐Yes ☐ No

Highest Level of Education Completed

☐Kindergarten
☐ 1st Grade
☐ 2nd Grade
☐ 3rd Grade
☐ 4th Grade
☐ 5th Grade
☐ 6th Grade
☐ 7th Grade
☐ 8th Grade
☐ 9th Grade
☐10th Grade
☐11th Grade
☐ 12th Grade or GED
☐ 13 Some college
☐ 14 Some college
☐ 15 Some college
☐ College degree
☐ Some Masters
☐ Masters Degree
☐ Some Doctoral
☐ Doctoral degree
☐ Less than kindergarten

Employment Status

☐ Disabled
☐ Full time(35+ hrs/week)
☐ Part time (<35 hrs/week)
☐ Homemaker
☐ Inmate
☐ Military
☐ Retired
☐ Student
☐ Supported Employment
☐ Unemployed
☐ Volunteer

Occupation

☐ Accountant
☐ Administrative
☐ Civil Servant
☐ Computer Analyst
☐ Construction Worker
☐ Factory Management
☐ Factory worker
☐ Farmer/rancher
☐ Hair Dresser
☐ Janitor
☐ Lawyer
☐ Medical Doctor
☐ Medical Technician
☐ Nurse
☐ Other
☐ Restaurant employee
☐ Store Clerk
☐ Student
☐ Teacher
☐ Truck Driver
☐ Unemployed
☐ Unknown
☐ Unskilled Laborer

Ethnic Origin

☐ I do not claim to be Hispanic
☐ Yes – Cuban
☐ Yes – Mexican
☐ Yes – Puerto Rican
☐ Yes –Other Hispanic

Do you decline to Identify Race?

☐ Yes
☐ No

Other Races

☐ American Indian/Alaskan Native
☐ Asian
☐ Black
☐ Declined
☐ Native Hawaiian/Pacific Islander
☐ White

Tobacco Use Status

☐ Current Smoker/Tobacco User – Every day
☐ Current Smoker/Tobacco user – Periodically
☐ Former Smoker/Tobacco user
☐ Never Smoker/Tobacco user

Medical Care Provider

Primary Care Provider's Facility	Primary Care Provider's Name	Was a Release of Information (ROI) completed for Primary Care Provider(s)? ☐ Yes ☐ No

Current Living Arrangement			
Number of people in the household?	☐ Alone ☐ Children ☐ Father	☐ Foster Parents ☐ Guardian ☐ Mother ☐ Partner/Significant Other	☐ Relatives(kin) ☐ Sibling(s) ☐ Spouse ☐ Unrelated person

Where are you living now?

☐ Assisted living	☐ Halfway House	☐ Residential Facility(MH Adult)
☐ ATU(Adults Only)	☐ Homeless	☐ Residential Facility(Other)
☐ Boarding Home(Adult)	☐ Independent living	☐ Residential Treatment/Group
☐ Correctional Facility/Jail	☐ Inpatient	☐ Sober Living
☐ Foster home(Youth)	☐ Nursing Home	☐ Supported Housing
☐ Group Home(Adult)		

Other Information

Do you have any major active medical diagnosis? If so, explain.

Do you have a major active mental health diagnosis? If so, explain.

Mental Health Provider's Facility	Mental Health Provider's Name	Was a Release of Information (ROI) completed for Mental Health Provider(s)? ☐ Yes ☐ No

Please list your current medications.
Attach a separate sheet if more room is needed.

Name of Medication	Explain what the medication is used for.

Legal History				
Do you have any Legal Requirements? ☐ None ☐ DHS ☐ Parole ☐ Probation ☐ Court Dates ☐ Community Service ☐ UA Testing ☐ Other	When do you estimate your supervision will end?	Do you have fines or fees you need to budget for? ☐ Yes ☐ No How much are the fees?	Do you agree to the $50 application fee and to allow inquiry through background reporting agencies? ☐ Yes ☐ No	Was a Release of Information (ROI) completed for your legal requirements? ☐ Yes ☐ No

Supervision Provider/Facility	Supervision Contact Name
Supervision County/Jurisdiction	**Supervision Contact Phone Number**

Safety Questions			
Are you a registered sex offender or in current litigation for a sex offense(s)? ☐ Yes ☐ No	Have you been convicted of any violent activity? (Arson, Abuse, Battery, Burglary, Murder, etc.) ☐ Yes ☐ No	Have you been convicted of theft, substance distribution or manufacture, stalking, or similar crimes? ☐ Yes ☐ No	Are these charges over 5 years old? ☐ Yes ☐ No

Do you have any pending, active, or otherwise open cases? If yes, Please explain the nature of the allegations.

☐ Yes, explain.
☐ No

Please explain any charges that may appear on your background report.
Attach an additional sheet if more room is needed.

Charge	Please list dates, county, whether it is a felony or misdemeanor, and offer an explanation

Addiction Recovery			
Substances used in the past 5 years	How often did you use them? (Ex. 3 times a day)	How much would you use per time?	When did you stop using the substance?
Please name any treatment programs you are currently participating in:		List the Names of Self-help/12 Step Groups you currently attend:	
What factors do you believe contribute to your substance use history?			
What do you think was missing in your previous attempts at maintaining sobriety?			
Who do you have as part of your support system?			
What are your current needs?			
What are your main goals for the future?			
Why do you feel this program is appropriate for you and how do you think you will benefit?			

We invite you to use the space below to tell us more about yourself or any information you would like to share or have considered.

Thank you for taking the time to consider sober living as a step in your recovery. For more information about the program such as what to bring, please see the materials on the website.

https://www.centennialmhc.org/services/substance-use-disorders-services/

Our program is voluntary, and by signing this application, you are agreeing to attend and comply with Centennial Mental Health Center services, treatment plans, and program guidelines/rules. You will be expected to remain abstinent from substance use prior to program acceptance and while in the program. If you are discharged from the program for any reason, it is your responsibility to have safe housing to return to.

I have answered all questions on this application honestly and agree that I want to achieve/maintain sobriety.

_____ _____

Applicant Signature Date

CENTENNIAL MENTAL HEALTH CENTER
Release of Information or Authorization
Mental Health and/or Substance Abuse

☐This Release also serves as a Request For Information

Origin of Authorization: ☐Internal ☐External Direction of Authorization: ☐Outgoing ☐Incoming

I, _____ _____ **hereby authorize**
Name of Consumer DOB

Centennial Mental Health Center _____ _____ _____
Name Address City Zip

AND Other Agency: _____ _____ _____ _____
Name Address City Zip

_____
Contact Person

To Release the Following Information: (Check all that apply)

☐All Clinical Records ☐Evaluation/Assessment ☐Physician's Records
☐Lab Reports ☐Service Plans ☐Progress Notes
☐Attendance / Participation / Progress ☐Discharge/Transfer Summary ☐Verbal Discussions
☐Other: _____

For the Purpose of:

☐Treatment (Internal & External) ☐Operations (Administrative) ☐Payment (Reimbursement)
☐Other (Indicates HIPAA Authorization, use only when necessary) Specify: _____

Periods of Treatment: ☐All Treatment Episodes ☐Current Treatment Episode
☐Specific Treatment Episode: Begin Date: _____ End Date: _____

If the purpose of this disclosure is marked as "Other" whether or not Treatment, Payment or Operations are checked, then this is a HIPAA Compliant Authorization. As such, the Center may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this Authorization and must provide me a copy.

I understand that my records or those of the individual listed above are protected under state and federal Substance Abuse and Mental Health confidentially regulations including 42CFR Part 2. Information cannot be disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand and agree that this release form may be sent to the agencies and persons identified above. Copies of this form may be used in lieu of the original.

I understand there is potential for information disclosed as a result of this release/authorization to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken based upon it. This consent expires and cannot be used past the indicated date or event.

Expiration Date: _____ **OR Expiration Event:** _____
Not more than one year

_____ _____
CONSUMER SIGNATURE Date

_____ _____ _____
Parent, Guardian or Authorized Representative Signature Relationship/Authority Date

_____ _____
Staff Member Signature Date

Consent revoked: _____ _____
Consumer or Guardian Signature Date

A COPY OF THIS RELEASE SHOULD BE PROVIDED TO THE CONSUMER C010/03-03

Criminal Background Check Information
Sober Living Residences Program

Please complete this form for use with background reporting systems. Please do not leave any section blank or incomplete.

Legal First Name _____

Legal Middle Name _____

Legal Last Name _____

Other Names Known By _____

Date of Birth _____

Social Security Number _____

Primary Telephone Number _____

Current Street Address _____

Apartment Number _____

City _____

State _____

Zip Code _____

Number of Years at this Address _____

Previous Address _____

Apartment Number _____

City _____

State _____

Zip Code _____

Number of Years at this Address _____

Driver's License Number _____

License State _____

Email Address _____

_____ _____

Signature **Date**