Alaska Addiction Rehabilitation Services (AARS)

26731 W. Point MacKenzie Road
Wasilla, Alaska 99623

RESIDENTIAL TREATMENT PROGRAM

APPLICATION PROCESS:

1. **An application packet is available**
   - **On-line:** www.aarsrecovery.org
   - **By fax:** 907.376.2348
   - **By phone:** 907.376.4534 / 1.800.376.4535 (in-state only)
   - **In person:** 26731 W. Point MacKenzie Road, Wasilla, Alaska

2. **Applicant completes the packet and returns it to the Ranch**
   - **In person:** 26731 W. Point MacKenzie Road, Wasilla, AK
   - **Mail:** P.O. Box 871545, Wasilla, AK 99687
   - **Fax:** 907.376.2348

3. **Treatment Team will review the application and respond to the applicant**

A completed application packet includes:

1. application form,
2. substance use assessment,
3. completed Alaska Screening Tool,
4. Release of Information (ROI),
5. physical exam and current TB test results,
6. criminal history, and
7. a recent psych evaluation for persons with co-occurring disorders.

Additional information may be requested.

If you any questions, please contact us at 907.376.4534 / 1.800.376.4535 (in state) or info@aarsrecovery.org

GENERAL INFORMATION FOR APPLICANTS

ABOUT THE RESIDENTIAL PROGRAM AT AARS

Alcoholism and drug addiction are chronic and progressive diseases. Persons admitted to AARS are alcohol / drug dependent individuals; many have co-occurring disorders (dependent on drugs/alcohol with a mental illness). After years of using illicit drugs and alcohol, a person's ability to function on the job, within a family or even to care for themselves deteriorates. Residential treatment provides the necessary place and time to learn or relearn basic life and social skills. It provides an opportunity for the brain to recover from years of being assaulted by chemicals and life situations. As a rehabilitation program, AARS focuses on those skills necessary to become a productive member of a community and a contributing member of the family.

Rehabilitation is the process that "restores the client to good health" (the body-mind-spirit connection), commonly referred to as "recovery". It is a multi-dimensional process. Three distinctly different but uniquely coordinated services are available to clients in treatment at the AARS.

1. The unique blend of therapeutic interventions provided by the counseling staff address individual issues.

2. The support of the recovery community guides the client through the 12 Steps of AA / NA and demonstrates the power of the recovery process in a very unique way.

3. AARS has a ranch that is active with animals to care for, gardens to attend, greenhouse and kitchen opportunities, each providing an opportunity to return to structured living by relearning work skills.

To assist the client in attaining and maintaining sobriety, the following services are available while in treatment:

1. Professional medical / psychiatric services provided by a doctor, a psychiatrist, nurses, and a dietitian,

2. Therapeutic services provided by counselors to include:

    A. scheduled 1x1 counseling sessions and frequent informal counselor-client interactions,

    B. group sessions,

    C. psycho-educational classes,

    D. case management assistance,

    E. family education and participation in the recovery process, and

F. transition and aftercare services.

3. Community recovery support from sponsors (mentors) and local AA / NA fellowships,

4. Sober social / recreational activities, and

5. Participation in self-care and community living skills.

AARS uses an extended orientation process; a process that invites self-awareness (through assessment) and becomes the foundation for an individualized treatment plan. Clients are active participants in treatment planning activities; clients identify and prioritize their strengths and their needs.

The completed assessment will:

1. Determine the extent and nature of the client's needs,
2. Identify the capacity of the client to address these needs,
3. Identify the strengths and weaknesses of the client, his/her social support system and family network and its capacity to support the client in the recovery process, and
4. Assess the services available to assist the client from within the program and through collateral services within the community.

THE COMPONENTS OF TREATMENT

The treatment program is a finely balanced program that incorporates the 12 Step recovery philosophy of AA / NA, the search for personal spirituality (reconnecting with important people and activities in one's life), and the development of a healthier self-concept that supports sober living. Each component is supported through the client's treatment plan and all services are available to all clients.

1. Housing

A. All clients are housed dormitory-style in the main building of AARS.

2. Food

A. Three meals per day are prepared for the clients by the cooking staff.

B. Meals are planned by a certified nutritionist.

C. Special dietary needs are addressed individually.

3. Health and Pharmaceutical Care

A. A nurse is available each day.

B. A doctor and a psychiatrist are available each week to address health and/or mental health concerns of the clients.

1. All medications are managed by the medical staff.

4. Social and Interpersonal Relationships

A. The therapeutic milieu of AARS provides unlimited opportunities for clients to develop and maintain interpersonal relationships.

1. The benefits of healthy social interactions can be to:

a) expand the concept of intimacy,

b) learn ways to manage the pervasive aloneness underlying addiction,

c) provide nurturance of self and others,

d) recognize one's worth, and

e) ask for and get help from others (Weiss).

(1) Family and friends visit with clients at AARS at scheduled times each week.

5. Mental Health

A. Being free of alcohol and drugs, depression and anxiety, and enjoying a positive outlook regarding self and life are essential aspects of being mentally healthy.

1. The acquisition of life-sustaining and life-enhancing skills through creative, meaningful, and productive activities influence the self-esteem, self-concept, and affect of the client.

2. Addressing mental health and wellness through an integrated approach to both substance use disorders and mental illness is the most effective way of helping individuals learn to manage both illnesses.

a) So much of managing life is about managing choices.

6. Chores and Responsibilities

A. The recovery process focuses on reclaiming "life" from past addictive behaviors.

1. A portion of each day is spent participating in assigned chores and normal housekeeping tasks.

    a) Many chores teach new skills, reinforce time-management skills, and encourage group cohesiveness and cooperation.

    b) Chores are related to animal husbandry, greenhouse work, planting and maintaining vegetable gardens, and general housekeeping.

7. Recreation and Leisure

A. Beyond the treatment day, clients have time to socialize and engage in hobbies and / or recreational activities.

1. Clients participate in:

    a) special AA / NA activities,

    b) community theater presentations,

    c) native Pow-Wows,

    d) shopping trips,

    e) Saturday Night Live social gatherings, and

    f) do special activities with their sponsors.

B. The annual June Fun Day at AARS is a family-centered social event that provides a day of games, food, music, and family activities.

8. Cultural and Spiritual Growth

A. Recovery is a process of reconnecting with family, friends, sports, hobbies, and other special interests and talents lost during the years spent using mind- altering chemicals.

1. Clients bring with them histories rich in cultural rituals, celebrations, and beliefs.

2. Encouraging clients to incorporate their culture into their recovery lifestyle is, for many, a lasting spiritual experience.

9. Outpatient / Aftercare / Transition

A. Several transitional activities take place prior to completing the treatment experience.

1. During this transition period, the client develops:

    a) a relapse prevention plan,

    b) learns job application skills,

    c) attends local job fairs,

    d) creates an up-dated resume,

    e) attends classes at the local Job Service,

    f) perhaps seeks assistance from the Division of Vocational Rehab,

    g) takes college entrance exams and some apply to colleges,

    h) perhaps earn their GEDs,

    i) focus on budgeting skills,

    j) locate sober housing, and

    k) attend aftercare groups.

It is a busy time. A time that uses all the skills learned during treatment.

SUCESSFUL TREATMENT COMPLETION

1. Completion of Treatment

A. Treatment is successfully completed when a client has:

1. finished their treatment plan,

2. met the ASAM criteria for discharge,

3. completed the 12 steps of AA / NA,

4. has displayed significant changes in behavior and attitude that has been observed by staff and peers, and

5. is functioning such that they can become productive members of their communities.

ALASKA ADDICTION REHABILITATION SERVICES, INC.
APPLICATION
RESIDENTIAL SUBSTANCE DEPENDENCE TREATMENT

Please mail or fax this information to:

Alaska Addiction Rehabilitation Services, Inc. (AARS).
Intake Coordinator 907-357-7356
PO Box 871545 1.800.376.4535 (In-state only)
Wasilla, AK 99654 Fax: 907-376-2348

APPLICANT INFORMATION: (Please print)

☐ Male ☐ Female ☐ Transgender

Medicaid # _____

Name _____ _____ _____
Last First Middle

Maiden _____
Last

Address _____ State _____ Zip _____

Mailing _____ State _____ Zip _____

Phone _____ _____ _____

_____ / _____ / _____ _____
Date of Birth Sex

SSN: _____ - _____ - _____ Medicaid # _____

Driver's License #: _____

REFERRAL INFORMATION: (Agency/Individual)

Name _____ _____
First and Last Name Relationship to applicant

Address _____ State _____ Zip _____

Phone _____ FAX _____

SUBSTANCE USE INFORMATION:

Primary substance: _____

Frequency of use: daily weekly 1-3 times/month

Age of first use: _____

Method of use: Inhalation IV injection Oral/smoking

Secondary substance: _____

Frequency of use: daily weekly 1-3 times/month

Age of first use: _____

Method of use: Inhalation IV injection Oral/smoking

Tertiary substance: _____

Frequency of use: daily weekly 1-3 times/month

Age of first use: _____

Method of use: Inhalation IV injection Oral/smoking

Does the applicant currently use tobacco products? Yes / No

DUAL DIAGNOSIS:

Does the applicant have a DSM 5 diagnosis of a mental illness? YES / NO

If YES, what is the diagnosis? _____

Identify the current medications taken to stabilize the mental illness:

_____

Who currently provides the applicant's psychiatric care?

Name: _____ Phone: _____

Is the applicant eligible for SSI/SSDI benefits? YES / NO

Is he/she currently receiving these benefits? YES / NO

Is the applicant receiving Interim Assistance? YES / NO

APPLICANT DATA:

Is the applicant: single married divorced separated co-habituating

Is the applicant: (Please circle all that currently apply)

An IV user Pregnant Involved with the Office of Children's Services (OCS) Homeless

A veteran Assigned to the Alcohol Safety Action Program (ASAP) Currently incarcerated

Involved with Department of Corrections (expecting Nygren Credit for treatment time)

Court ordered to treatment On Probation/Parole

Identify chronic health concerns that require on-going medical and /or dental care:

_____

_____

Has the applicant experienced head or body trauma that required medical attention? YES / NO

If YES, describe: _____

_____

_____

Does that trauma still require medical care? YES / NO

Identify previous substance abuse treatment programs the applicant has participated in:

Year	Program Name	City/State	Length	Completed
				Yes/ No
				Yes /No
				Yes/ No
				Yes / No
				Yes/ No

How many times during the past 5 years has the applicant detoxed in either a detox center or a hospital? ____

What medical complications has the applicant experienced while detoxing? _____

_____

_____

Is the applicant currently employed? YES / NO

If **yes**, what is his/her occupation? _____

Does the applicant have persons dependent on him/her for financial support? YES / NO

Is the applicant eligible for State / Federal entitlements? YES / NO

If **Yes**, identify the programs the applicant currently receives assistance from: _____

_____

Circle: The highest degree of education you completed:

1 2 3 4 5 6 7 8 9 10 11 12 GED 12+ Degree _____

How many times has the applicant been arrested: a) in his/her lifetime? _____
b) in last 30 days? _____

Does the applicant have an open legal case? YES / NO

If yes, please provide a Release of Information for the attorney assigned to the case.

In the space provided, please write a brief description of:

1) The progression of your substance use,

2) The consequences of your substance use,

By my signature, I attest to the fact that the information provided in this application is accurate and supportable.

APPLICANT'S PRINTED NAME

APPLICANT'S SIGNATURE DATE

When all the requested information has been received, your application for long-term residential treatment will be reviewed by the members of the Treatment Team. Please make sure that you have completed and submitted all of the information requested on the information / cover letter.

ALASKA SCREENING TOOL

Client Name: _____ **Client Number:** _____

Staff Name: _____ **Date:** _____

Info received from: (include relationship to client) _____

Please answer these questions to make sure your needs are identified. Your answers are important to help us serve you better. If you are filling this out for someone else, please answer **from their view**. Parents or guardians usually complete the survey on behalf of children under age 13.

SECTION I – Please estimate the number of days in the **last 2 weeks** (enter a number from 0-14 days): **0-14 days**

1. Over the last two weeks, how many days have you felt little interest or pleasure in doing things? ..... _____
2. How many days have you felt down, depressed or hopeless? ..... _____
3. Had trouble falling asleep or staying asleep or sleeping too much? ..... _____
4. Felt tired or had little energy? ..... _____
5. Had a poor appetite or ate too much? ..... _____
6. Felt bad about yourself or that you were a failure or had let yourself or your family down? ..... _____
7. Had trouble concentrating on things, such as reading the newspaper or watching TV? ..... _____
8. Moved or spoken so slowly that other people could have noticed?..... _____
9. Been so fidgety or restless that you were moving around a lot more than usual? ..... _____
10. Remembered things that were extremely unpleasant? ..... _____
11. Were barely able to control your anger? ..... _____
12. Felt numb, detached, or disconnected? ..... _____
13. Felt distant or cut off from other people? ..... _____

SECTION II – Please check the answer to the following questions based **on your lifetime.**

14. I have lived where I often or very often felt like I didn't have enough to eat, had to wear dirty clothes, or was not safe ..... ☐Yes ☐No
15. I have lived with someone who was a problem drinker or alcoholic, or who used street drugs ..... ☐Yes ☐No
16. I have lived with someone who was seriously depressed or seriously mentally ill ..... ☐Yes ☐No
17. I have lived with someone who attempted suicide or completed suicide ..... ☐Yes ☐No
18. I have lived with someone who was sent to prison ..... ☐Yes ☐No
19. I, or a close family member, was placed in foster care ..... ☐Yes ☐No
20. I have lived with someone while they were physically mistreated or seriously threatened ..... ☐Yes ☐No
21. I have been physically mistreated or seriously threatened ..... ☐Yes ☐No
    a. If you answered **"Yes"**, did this involve your intimate partner (spouse, girlfriend, or boyfriend)? ..... ☐Yes ☐No

ALASKA SCREENING TOOL

SECTION III – Please answer the following questions based **on your lifetime.** (D/N = Don't Know)

22. I have had a blow to the head that was severe enough to make me lose consciousness ..... ☐Yes ☐No ☐ D/N

23. I have had a blow to the head that was severe enough to cause a concussion . ☐Yes ☐No ☐ D/N

If you answered "Yes" to 22 or 23, please answer a-c:

a. Did you receive treatment for the head injury? ..... ☐ Yes ☐ No

b. After the head injury, was there a permanent change in anything? ..... ☐Yes ☐No ☐ D/N

c. Did you receive treatment for anything that changed? ..... ☐Yes ☐No

24. Did your mother ever consume alcohol? ..... ☐Yes ☐No ☐ D/N

a. **If Yes**, did she continue to drink during her pregnancy with you? .....☐Yes ☐No ☐ D/N

SECTION IV – Please answer the following questions based on the **past 12 months.**

25. Have you had a major life change like death of a loved one, moving, or loss of a job? .... ☐Yes ☐No

26. Do you sometimes feel afraid, panicky, nervous or scared? ..... ☐Yes ☐No

27. Do you often find yourself in situations where your heart pounds and you feel anxious and want to get away? ..... ☐Yes ☐No

28. Have you tried to hurt yourself or commit suicide? ..... ☐Yes ☐No

29. Have you destroyed property or set a fire that caused damage?..... ☐Yes ☐No

30. Have you physically harmed or threatened to harm an animal or person on purpose? ... ☐Yes ☐No

31. Do you ever hear voices or see things that other people tell you they don't see or hear? ..... ☐Yes ☐No

32. Do you think people are out to get you and you have to watch your step? ..... ☐Yes ☐No

SECTION V – Please answer the following questions based on the **past 12 months.**

33. Have you gotten into trouble at home, at school, or in the community, because of using alcohol, drugs, or inhalants? ..... ☐Yes ☐No

34. Have you missed school or work because of using alcohol, drugs, or inhalants? ..... ☐Yes ☐No

35. In the past year have you ever had 6 or more drinks at any one time? ..... ☐Yes ☐No

36. Does it make you angry if someone tells you that you drink or use drugs, or inhalants too much? ..... ☐Yes ☐No

37. Do you think you might have a problem with alcohol, drug or inhalant use? ..... ☐Yes ☐No

THANK YOU for providing this information! Your answers are important to help us serve you better.

SHARED CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ **, authorize the following agencies/individuals**:

AARS		(Name) _____
P.O Box 871545		(Address) _____
Wasilla, AK 99687	**AND**	(City, State, Zip) _____
(907) 376-4534		(Phone) _____
Fax: (907) 376-2348		(Fax) _____

to communicate with and disclose to one another the following information:

(Initial each category that applies)

_____ My name and other personal identifying information
_____ My status as a patient including drug and alcohol treatment
_____ Assessments and/or evaluation results
_____ Summary of treatment plan /mental health service plan(s), reviews, and progress
_____ Attendance and compliance with intervention strategies
_____ Results of medical interventions and/or UA results
_____ Discharge summary and plan(s)
_____ Legal/criminal history records
_____ Other: _____

The purpose of the disclosure authorized in this consent is to:

(Initial all that applies)

_____ Obtain intake information
_____ Enable the agencies identified above to refer and coordinate treatment services
_____ Coordinate aftercare (continuing care) services
_____ Collect follow-up information
_____ Other: _____

Disclosure is to be: (**check** all that apply) written verbal audio electronic testimony

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that the agencies identified above may not condition my treatment on whether I sign a consent form, but that in certain circumstances I may be denied treatment if I do not sign a consent form.

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken on it, and that in any event this consent expires as indicated:

_____

(Specify date, event, or condition upon which this consent expires)

Date _____/ _____/ _____

_____

Print Name of Participant or Guardian

_____ _____

Signature of Participant or Guardian Date

_____

Print Name of Witness

_____ _____

Signature of Witness Date

Recipients: If the information released pertains to drug and alcohol abuse, the confidentiality of the information is protected by federal law (CFR 42, Part 2) prohibiting you from making any further disclosures of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

MEDICAL EXAMINATION FORM

SECTION I

File # _____

Name _____ _____ _____
Last First Middle

Address _____ State _____ Zip _____

_____ / _____ / _____ _____
Birth Date Sex

Last time hospitalized - Date _____ / _____ / _____

Reason for hospitalization _____

Name and location of hospital _____

Presently under care of physician? _____ If yes, give name _____

and address _____

_____

_____

Chronic illness/Conditions _____

Allergies _____

SECTION II

PHYSICAL EXAMINATION - TO BE FILLED OUT BY A PHYSICIAN.

Use check (x) for items found normal, note deviations from normal. If items need further information, record on extra sheet. It is important that complete medical information be recorded, fill in form as fully as possible from exam and previous records. Need to have information to determine extent of physical deterioration, to identify possible handicapping conditions, and to determine appropriateness for long term alcoholism treatment.

Height _____ ft. Weight _____ lbs. Temperature _____ F

Eyes: Right _____ Left _____

Distant vision: Without glasses - R. 20/ ___ L.20/ ___ With glasses - R. 20/ ___ L.20/ ___

Ears: Right _____ Left _____ (at 20 ft.)

Name _____ _____ _____
Last First File #

Other Findings: Right _____ Left _____

Nose _____ Throat _____

Lymphatic system _____ Breasts _____

Lungs _____ Heart _____

Blood pressure _____ Pulse _____ Dyspnoea _____

Cyanosis _____ Edema _____

Abdomen _____

Hernia _____

Genito-Urinary _____

Gynecological _____
(prolapse, cystocele, rectocele, cervix)

Last Monthly Period _____

Ano-rectal (including prostate) _____

Neurological _____

Psychiatric _____

Skin _____ Feet _____ Varicosity _____

Orthopedic Impairments, describe _____

_____

Optional Lab Tests

(HTLV & HEPATITIS - OPTIONAL

HTLV - Date _____ / _____ / _____ Results _____

HEPATITUS - Date _____ / _____ / _____ Results _____

Serologic test for Syphilis:- Date _____ / _____ / _____

Name of test _____ Results _____

Diphtheria/Tetanus Booster:
Current immunization required – Date given _____ / _____ / _____

Name _____ _____ _____
Last First File #

Required Lab Tests

TB-Skin Test: - Date _____ / _____ / _____ Results _____

Or

Chest X-ray: - Date _____ / _____ / _____ Results _____

RECOMMENDATIONS

Is examination by a specialist advisable? if so, please specify specialty

_____

Other diagnostic procedures or services (specify) _____

_____

Hospitalization (reasons and estimate duration) _____

_____

Treatment (type and estimate duration) _____

_____

_____

_____

Re-examination or Re-evaluation, how soon? _____

_____

SECTION III

PHYSICIAN'S CONCLUSIONS AND COMMENTS

PLEASE CHECK ALL ACTIVITIES CLIENT CAN DO

perform daily hygienic routines		dress unassisted		lifting		pulling	
control body eliminations		feed self		climbing		walking	
communicate with others		move about freely		pushing		standing	

Name _____ _____ _____

Last First File #

Please include other activities client should avoid or cannot do _____

Does client exhibit Psychosis or Psychoneurosis? explain (DSM IV) _____

Current medications _____

History of Inhalant abuse, head injury? explain _____

Potential danger to self or others? explain _____

Suicidal? _____

Communicable Disease? explain _____

Any special accommendations needed? _____

_____
PHYSICIAN'S PRINTED NAME

_____ _____
PHYSICIAN'S SIGNATURE DATE

_____
ADDRESS

Name _____ _____ _____
Last First File #