
CROSSROADS
A Residence for Addiction Recovery

Crossroads Aftercare Program

Intake Information

I, _____, have been given a copy of my rights and responsibilities as a resident of the Crossroads Aftercare Program.

I understand that in signing this document, I agree to abide by these rules during my stay in the Crossroads Aftercare Program. If I do not adhere to these rules and regulations during my residency at Crossroads, I understand that I will be at risk of dismissal from the program. If I have any questions or concerns I have the right to seek clarification from staff. I will not rely on other residents to interpret the rules.

I understand and will adhere to and be held accountable for knowing and following these rules and all other rules governing my residency in the program.

Printed Name: _____

Signature: _____

Date: _____

Resident Information

Today's Date: _____ Name: _____

Preferred Name: _____ Date of Birth: _____

Cell Phone Number: _____ Email Address: _____

May we send unencrypted email to this address? Yes ____ No_____

Gender Identity (please check): Male ☐, Female ☐, Nonbinary ☐, Transgender ☐,

Other: _____ ☐, Decline to specify ☐

Racial and Ethnic Background (please check all that apply): White ☐, Black/African American ☐,

Native American or Alaskan Native ☐, Asian ☐, Native Hawaiian or Other Pacific Islander ☐,

Hispanic ☐, Latinx ☐, Other ☐ _____, Decline to specify ☐

Date of Last Use: _____ Date of Last Gamble: _____

Drug, Gambling, or Mental Health Treatment History:

Treatment Center/Hospital _____ Date:_____

_____ Date:_____

_____ Date:_____

Name of most recent treatment center Counselor: _____

Have you been seen by a psychiatrist, psychologist, or other therapist? Yes____ No____

If yes, for what reason?_____

Have you ever been hospitalized for mental health? Yes____ No____

If yes, for what reason?

_____

_____

Have you ever engaged in self-injurious behaviors (cutting, burning etc)? _____

If so, when_____

Have you ever attempted suicide? _____ If so, how and when _____

_____

Do you have a history of an eating disorder? Yes____ No____

If so, have you received help for this? Yes____ No____

Are you open to receiving help for this if needed? Yes____ No____

Have you struggled with other mental health or addiction disorders? Yes____ No____

Have they been diagnosed? Yes____ No____

If yes, explain: _____

What prescription drugs are you **currently taking**?

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Medication: _____ For: _____

Do you have a prescriber that can refill your medication? Yes____ No____

Do you have medical, dental, nutritional, or hygienic problems that require attention? Yes ___ No ____

If yes, explain:

_____

Do you snore? Yes_____ No_____

ADDICTION HISTORY

When did your addiction become a concern for you? _____

What mood-altering chemicals or types of gambling did you use/engage in most often?

Please list: _____

_____

Describe your addiction behaviors: _____

_____

Have you had previous periods of abstinence from mood-altering substances or compulsive gambling?

Yes____ No____ If yes, when and for how long?_____

_____

Did any of the following help initiate treatment? Legal____ Family ____ Employer ____ Other ____

Do you currently work with a sponsor/mentor? Yes ____ No ____

If not, are you open to working with a sponsor/mentor? Yes____ No____

PERSONAL HISTORY

What are your strengths?_____

_____

What areas would you like to improve or work on while at Crossroads?

_____

_____

What are your hobbies/passions?_____

_____

Who are the individuals in your life that are closest to you and can hold your accountable in your recovery?

_____

How do they support you?

_____

_____

In what relationships do you need to set and maintain healthy boundaries?

_____

_____

Why have you chosen Crossroads? Please be specific:

_____

_____

What are your expectations of Crossroads?

_____

_____

Anything else you would like us to know about you?

_____

_____

JOB/EDUCATION HISTORY

Are you currently employed? Yes ____ No ____

If yes, what is your current occupation: _____

If no, are you seeking employment? Yes _____ No _____

If applicable, what was your occupation prior to treatment: _____

Do you see yourself changing occupations? Yes ____ No ____

If so, to what? _____

CURRENT LEGAL INVOLVEMENT

Do you have any current legal issues? Yes ___ No ____

If so, please describe: _____

Are your currently on probation? Yes ___ No ____

If yes:

P. O.'s Name _____ Phone: _____

Are you willing to sign a release between Crossroads and your P.O.? Yes____ No___

FINANCIAL HEALTH

Are you someone who struggles with money management? Yes____ No___

If so, are you interested in working with a financial coach at Crossroads? Yes____ No__

Consent for Participation in Follow Up Study

Purpose and Background: Crossroads follows up with residents that leave Crossroads with staff approval to determine the effectiveness of the Crossroads Aftercare program.

Procedure/Process: One of the Crossroads staff will contact you to ask you some questions related to your Crossroads experience, your length of sobriety/gambling free time, your recovery program, chemical use/gambling activity, and other basic information to include your age, race, sex, education, occupation, previous treatment, etc.

Confidentiality: The information gathered during this follow up study will remain confidential. No identifying information will be released in any reports or publications resulting from this study.

Voluntary: Please understand that your participation is voluntary and you have a right to withdraw your consent at any time. Your decision whether or not to participate in this follow up study will not affect the treatment you receive at Crossroads.

Consent Expiration: This consent will expire two years from your discharge from Crossroads.

Resident Name (Please print): _____

Phone Number: _____ **Email:**_____

In the event I cannot be contacted, I grant permission for a Crossroads staff member to contact the following person for information regarding my current or any future email address and telephone number.

Contact Person: (Please print): _____

Phone Number: _____

Email:_____

I agree to participate in the study and to be added to the alumni association list after successful completion of the Crossroad Aftercare Program.

Date: _____

Signature: _____

Crossroads Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Here at **Crossroads Aftercare Program** we are dedicated to confidentiality and privacy. We follow all requirements of the 1996 Health Insurance Portability and Accountability Act (HIPAA) regarding protected health information and the Federal confidentiality regulations (42 CFR Part 2) pertaining to individuals receiving treatment for alcohol and drugs and related issues. As a client of the Crossroads Aftercare Program you will be providing the staff with Protected Health Information (PHI), and this document outlines what constitutes PHI, the way in which your PHI is protected, in what circumstances your PHI can be shared with other individuals, groups, or facilities, and your rights concerning your health information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was developed to provide guidelines for health practitioners to appropriately handle individual's health information. Protected Health Information (PHI) is the term HIPAA outlined as a description of all identifiable information provided to a health practitioner during the course of that person's treatment and any follow up care. Your PHI here at **Crossroads** would include such things as your name, address, age etc., but also your drug of choice, treatment program you attended, the mental health diagnosis you may have, your legal status etc. The simplest way of looking at PHI is any information that could be used to identify you.

The **Crossroads Aftercare Program** and its staff are dedicated to protecting your confidentiality. We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Federal confidentiality regulations (42 CFR Part 2) to: (1) maintain the privacy of protected health information (PHI) (2) provide you with this Notice of our legal duties and privacy practices with respect to protected health information (3) notify you of any changes made to these policies (4) abide by the terms of this Notice.

HOW YOUR CONFIDENTIAL HEALTH INFORMATION WILL BE USED AND DISCLOSED:

We will use your protected health information (PHI) as part of your care here at **Crossroads**. Your (PHI) will be used by the counseling staff to appropriately treat you, to address your issues during staffings and consultations between the counseling staff members, by the business office to process your payment for the services rendered, and by the program director when reviewing the quality of the care you receive. We may also contact you for fundraising efforts, but you can tell us not to contact you again.

The other ways in which your confidential health information may be used and disclosed without your consent or authorization are outlined below:

Business Associates: We may disclose your health information to the auditor for Crossroads. This disclosure will be limited to your name, the length of your stay here at Crossroads, and your payments of program fees.
Medical Emergencies: If you have a life threatening physical emergency that requires immediate attention, we will disclose limited information about you to assist medical personnel in addressing your emergency.
Abuse or Neglect: We may disclose your (PHI), if you acknowledge to the staff or if the staff suspects that you have abused or neglected a child.
Court Order: Your (PHI) may be disclosed if the staff receives a court order and a subpoena appropriately developed under Federal law which demand disclosure of your records.

<u>Crime within Crossroads Premises or Against Program Personnel</u>: Your (PHI) may be released if the staff needs to report a crime you have committed or threatened to commit on Crossroads property or against Crossroads staff.

AUTHORIZATIONS: We will not use or disclose your protected health information (PHI) for any other purpose other than those listed above, without your written consent or authorization. Once given, you may revoke your consent or authorization in writing at any time by completing a Revocation of Authorization form. These forms will be made available to you from the Crossroads staff upon your request. Be aware that any disclosures made prior to this revocation cannot be rescinded. You may contact **John Rundquist**, counseling staff member and privacy officer, at 612-374-0506 for any further information.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION: You have the following rights with respect to your protected health information (PHI):

- You may ask us to restrict certain uses and disclosures of your PHI. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your PHI. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by Crossroads during the last six years (or following April 14, 2003), except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact:

John Rundquist, Crossroads Executive Director at 612-374-0506

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:

John Rundquist, Crossroads Executive Director at 612-374-0506

THIS NOTICE IS EFFECTIVE AS OF 6/5/18

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice and will make paper copies of the revised Notice of Privacy Practices available upon request.

ACKNOWLEDGMENT:

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Crossroads Aftercare Notice of Privacy Practices.

Resident Signature: _____ **Date Signed:** _____

Mail and Package Delivery

The Crossroads staff is willing to sign and accept your package deliveries during business hours. Crossroads and staff do not assume responsibility for delivery, loss, damage theft. It is up to you to check daily to see if anything has arrived.

The post office will not forward mail from this address when you move out. Before you move, please make arrangements with the Administrative Assistant to hold your mail so you may pick it up. Please note: mail will not be held beyond 30 days unless previously arranged.

I understand the above statement and **WANT** staff to sign for and accept packages and mail on my behalf:

☐ Yes ☐ No

Client Signature: _____ Date: _____

Financial Agreement

I understand that I will forfeit all fees paid to Crossroads if I do not give written notice 30 days prior to leaving the program or if I am discharged because of rules or behavioral infractions. Note: this applies regardless of who pays the fee. I also understand that my deposit will be mailed to me contingent on the following: completion of a satisfactory room inspection by a staff member or resident manager, a return of my building key, my room key, as well as my parking card (if applicable). I must request my deposit return or I will leave a forwarding address with staff or a resident manager.

If I am struggling to pay my program fees, I understand that it is my responsibility to discuss this with staff as soon as possible. Financial coaching is available to me at any time during my stay and is included in my program fee.

I understand these terms and accept these terms with the knowledge that there are no exceptions.

Signature: _____

Name (please print): _____

Date: _____

Vehicle Registration

If you plan on keeping a vehicle here at Crossroads, you must register it. All vehicles (bikes and/or cars) will be towed/confiscated if they are not registered to a Crossroads resident.

Resident Name: _____

CAR
You are automatically entitled to park in the surface parking lot while you are a resident here at Crossroads. Based on availability, you may have the option of parking in the underground garage. There is a one-time $25.00 fee that is refundable when you return the garage access key.

Make:_____

Model:_____

Year: _____

Color: _____

License Plate Number: _____ State: _____

BIKE/MOTORCYCLE
Bicycles and Motorcycles MUST be kept in the underground garage. Per fire marshall, bikes are not allowed to be stored in resident rooms. Bikes are not allowed to be left unattended ANYWHERE on Crossroads property. There is a one-time $25.00 fee that is refundable when you return the garage access key. Have a bike at Crossroads does not automatically guarantee a spot for a vehicle in the garage.

Make: _____ Color: _____

Description: _____

Crossroads Aftercare Program

Consent for Release of Information

Client Name: _____ **Date of birth:** _____

I authorize the disclosure of records and information about me between:

Name	Crossroads Aftercare Program
Address	2823 Wayzata Blvd. Minneapolis, MN 55405
Phone	612-374-0504
Fax	651-323-2051
Relationship	Aftercare Provider

And

Name of treatment program referred from: _____

Referring counselors name: _____

Date entered treatment: _____ **Date completed treatment:** _____

Information to be Released			
X	Physician Discharge Summary	X	Counselor Discharge Summary
X	Psychological Test Results	X	Social History
X	Reason for Discharge	X	Progress Updates

The purpose of this release of information is for the continuation of care for alcohol, drug, and/or gambling addiction and related issues. I, the undersigned, understand that I may revoke this consent at any time and that this consent will expire without my express revocation three months following my discharge from the Crossroads Aftercare Program. The care I receive at Crossroads will not be conditioned on my agreement to sign this release of information. To revoke this consent I will contact the Crossroads Aftercare Program at 2823 Wayzata Blvd. Minneapolis, MN 55405. I also understand that that any disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. However, HIPAA requires Crossroads to notify me of the potential that information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by the HIPAA rules.

Client Signature: _____ **Date:** _____