First Step of Sarasota
Residential Treatment Application

Name (Last, First, Middle): ___

Program(s) of interest:

SS#: DOB: Age:

Race/Ethnicity: Gender:

Do you have children under 18 years old? Yes □ No □

If yes, do you currently have custody of children? Yes □ No □ N/A □

Pregnancy status: Pregnant □ Not pregnant/male □

IV drug user? Yes □ No □

Marital status: Primary Language:

Translator Needed? Yes □ No □

Deaf or Hard of Hearing? Yes □ No □

If yes, do you need any assistive services during treatment? Yes □ No □ N/A □

Insurance information:

Client phone # or contact #:

Client Name Date:

Client address:

County: Email address:

Referral source and contact information:

Emergency contact info (name, address, phone):

Name and phone # of attorney:

Name and phone # of probation officer:

Probation/DOC#: Current location (jail, home, residential program, etc):

If incarcerated, what facility:

Current legal charges:

Arrest date:

Previous legal charges:

History of violent charges: Yes □ No □

History of domestic charges: Yes □ No □

Past/current arson charges: Yes □ No □

History of gang involvement: Yes □ No □

Client Name: Date:

Pending court dates:

Drugs/substances active used within the last 12 months:

Last date of substance use:

Substance abuse diagnosis: Psychiatric diagnosis:

History of suicide attempts (please explain)?

Current psychiatrist:

Current psychiatric medications (include dose):

Past psychiatric medications:

How will you pay for meds while in the program?

Who do you have for financial support:

Are you able to bring 30 days of meds with you upon admission?

Medical diagnoses: Medical medications:

Allergies (food, medication, seasonal, etc.):

Religious food restrictions: Yes □ No □

If yes, explain:

Client Name: Date:

Able to work a 40 hour/week full-time job: Yes □ No □

If no, explain:

Are you currently receiving income from disability or Social Security services?
Yes □ No □

Able to perform Activities of Daily Living (walking, climbing stairs, grooming, feeding, toileting):
Yes □ No □

Client Name Date:

FIRST STEP OF SARASOTA, INC.
A COMPREHENSIVE CENTER FOR ALCOHOL AND DRUG TREATMENT
AUTHORIZATION TO RELEASE INFORMATION TO
STATE OF FLORIDA GOVERNMENTAL AGENCIES
FOR PERSPECTIVE CLIENTS
(In accordance with Federal Law, 42 C.F.R. Part 2)

NAME: DATE:

D.O.B.: S.S.N.:

NOTICE OF FLORDIA LAW GOVERNING ADMISSIONS TO A STATE FUNDED TREATMENT FACILITY

Pursuant to administrative regulations for the State of Florida, any person applying for admission to a State funded treatment facility program must authorize the potential treating facility to provide information to designated state agencies. The notification is limited to notifying the State Agencies that an application has been made for admissions by you to the facility and for the facility to further provide a continuing notification to the state agency of your admissions status. If you refuse consent to First Step of Sarasota, Inc. to provide admission status to authorized State Agencies your treatment at First Step of Sarasota, Inc. may be refused.

NOTICE OF CONFIDENTIALITY RIGHTS

I understand that the confidentiality of any information disclosed, received or used pursuant to this authorization is protected by law and will not be further disclosed by, or to any other party without my express written consent, or as otherwise permitted or required by applicable law. Federal confidentiality rules (42 CFR part 2) prohibits making any further disclosure of this information unless the disclosure is expressly permitted by 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.

I further understand that I have the right to revoke this authorization in writing at any time, except to the extent that any authorized party has already taken action in reliance on it. If not previously revoked by me, this authorization will terminate as of the date that admissions status reporting requirements terminate.

AUTHORIZATION TO PROVIDE ADMISSION STATUS INFORMATION TO AUTHORIZED STATE AGENCIES

This document will authorize First Step of Sarasota, Inc., to provide statistical information to authorized agencies of the State of Florida which shall include the following: my name, date of birth, gender, race, reproductive status and drug abuse status, continuing information regarding my status as an applicant for admissions, the basis for my application for admissions and for my discharge from the admissions list of the health care provider.

I hereby release First Step from any liability which may arise as a result of the use of the information released.

SIGNATURE OF APPLICANT: _____DATE:

REPRESENTATIVE OF APPLICANT: DATE:
(PRINT NAME)

REPRESENTATIVE OF APPLICANT:_____ DATE:
(SIGNATURE)

(Description of Representative's Authority)_____

WITNESS SIGNATURE:_____ DATE:

WITNESS NAME (Print): DATE:

Multiagency Consent Form
AUTHORIZATION AND CONSENT FOR DISCLOSURE, RECEIPT AND USE OF CONFIDENTIAL INFORMATION BY MULTIPLE PARTIES FOR ALCOHOL, SUBSTANCE ABUSE AND/OR MENTAL HEALTH PATIENTS.

CLIENT NAME:_ _____DOB:
I hereby authorize any of the parties designated below to communicate with one another through disclosure, receipt and use of my confidential information for purposes of evaluating my need, coordinating and/or providing services to me. Any disclosure, receipt or use of information by the parties will be limited to the minimum that is reasonably necessary to accomplish the intended purpose.

ADMINISTRATIVE SERVICE ORGANIZATIONS:
_____Central Florida Behavioral Health Network, 719 S US Hwy 301, Tampa
_____Florida Department of Children & Families (DCF)
_____Sarasota County Health and Human Services

ALCOHOL, SUBSTANCE ABUSE AND MENTAL HEALTH PROVIDERS:

_____DACCO
_____Operation PAR
_____Charlotte Behavioral Health Center
_____Coastal Behavioral Healthcare
_____David Lawrence Center
_____Salus Care
_____First Step of Sarasota
_____ACTS (Agency for Community Tx Services)
_____ Bayfront Punta Gorda (Riverside)
_____Goodwill
_____Jewish Family and Children's Services
_____Mental Health Community Centers
_____The Willough at Naples
_____Access Sarasota
_____Other (Specify) _____
_____Other (Specify) _____

_____Phoenix House of Florida
_____Tri-County Human Services
_____Bayside Center for Behavioral Health
_____ Renaissance Manor
_____Safe Children's Coalition
_____Salvation Army - Sarasota
_____Salvation Army - Bradenton
_____Baycare Behavioral Health
_____Suncoast Behavioral Health Center
_____Centerstone of Florida
_____NAMI
_____Serenity Place at Doctors Hospital of Sarasota
_____Transitions at Doctors Hospital of Sarasota
_____CASL Homes

FINANCIAL ASSISTANCE AND RESOURCE OFFICES:

_____Social Security Administration (SSA)
_____Medicaid (AHCA)
_____Food Stamps (DCF)
_____Other (specify): _____

_____Women, Infants and Children (WIC)
_____Temporary Assistance for Needy Families (DCF)
_____ Sunshine Financial Corp.

GENERAL HEALTH CARE PROVIDERS (including but not limited to alcohol, substance abuse and/or mental health treatment services):

_____Charlotte Regional Medical Center
_____DeSoto Memorial Hospital
_____Doctors Hospital
_____
_____Bayfront Punta Gorda
_____Manatee County Rural Health
_____ Manatee Memorial
_____Senior Friendship Center

_____Sarasota Memorial Hospital
_____Armor Correctional
_____FDOH in Sarasota / Manatee County: Location
_____Bayfront (Venice Hospital)
_____ Lakewood Ranch Medical Center
_____ HCA Blake Medical Center

HOMELESSNESS INITIATIVES:

_____SHIFTS
_____HOT Team

LOCAL LAW ENFORCEMENT:

_____ Sarasota County Sheriff's Office
_____ Sarasota Police Department
_____ Lee County Sheriff's Office
_____ DeSoto County Sheriff's Office
_____ Manatee County Sheriff's Office
_____ Bradenton Beach Police Dept.

_____ North Port Police Department
_____ Venice Police Department
_____Charlotte County Sheriff's Office
_____ Probation
_____ Bradenton Police Dept
_____ Holmes Beach Police Dept.

_____ Palmetto Police Dept. _____Other (specify): _____

MENTAL HEALTH COURT:
_____Health Care Court _____Comprehensive Treatment Court
OTHER SERVICE PROVIDERS: _____

This authorization permits disclosure of the following information in the following manner:

□ **Verbal** □**Written**

The nature and amount of information that may be disclosed, received and/or used by the parties pursuant to this authorization is as follows: (Client initials all that apply)

_____ My name and other personal identifying information
_____ My identity as an applicant for, or recipient of substance abuse and/or mental health treatment services.
_____ Initial and subsequent evaluations and assessments of my services needs by the following:
_____ Summaries of substance abuse and/or mental health assessments and history
_____ Summaries of alcohol, substance abuse and/or mental health service plan(s)
_____ Progress and compliance in substance abuse and mental health services
_____ Discharge plan(s) for alcohol, substance abuse and mental health services
_____ Date and status of discharge from substance abuse or mental health services
_____ Psychiatric testing information and diagnosis
_____ Psychosocial history
_____ Other (*specify*:) _____
The purpose for disclosure, receipt and use of information authorized by me in this document is to enable the parties to evaluate my need, coordinate and provide services to me.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned upon my signing this authorization for release of my information. I further understand that I may be required to sign an informed consent for treatment, or other authorizations, in some circumstances, in order to receive treatment or benefits. This release not only covers the provision and receipt of all records maintained by _____, but also authorizes any member of the staff, employee of, or entity contracting with _____ to discuss the case, treatment, and records with the persons authorized to receive information either in private conversations, depositions, or court testimony.

NOTICE TO RECEIPIENTS OF INFORMATION: Any information disclosed to you was taken from the records of which the confidentiality is protected by State (394.459, 397.053, 381.609), (455 and 90) and/or Federal Law (42CFR, Part 2) (45 CFR 160-164). Federal Regulations (42CFR, Part 2) (45 CFR 160-164), prohibits disclosure by provider without my written consent unless otherwise provided for in the regulations. By signing this authorization I acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk of re-disclosure by the recipient and no longer protected by HIPAA.

I further understand that I have the right to revoke this authorization in writing at any time, except to the extent that any authorized party has already taken action in reliance on it. If not previously revoked by me, this authorization expires twelve (12) months from the time it is signed. _____ (specify date, event or condition of termination).

By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily and without coercion, and that I have been given a copy of this authorization, signed by me on the date shown below.

_____ _ _____
Signature of consumer Effective date

_____ _ _____
Consumer's legal guardian or authorized representative Effective date

_____
Description of authority if signed by consumer's authorized representative