Greetings:

The Wellspring Residential Programs have put together this application packet to get you started with the screening and admission process. All documents need to be filled out completely and returned for Wellspring to communicate with you. You will be scheduled for an initial assessment and then discussion regarding admission and waiting list guidelines. Good communication is our goal to ensure a smooth and efficient process for individuals seeking treatment.

This packet contains the following documents:

- Residential application form (6 pages)
- The AC-OK Screening Questionnaire (1 page)
- Wellspring's Policy on Controlled Substances (medication) (1 page)
- Client Financial Responsibility including Room and Board Policy (2 pages)
- Trauma Informed Care Overview (1 page)
- Overview of Wellspring's Residential Treatment Program (3 pages)
- Connecting w/ Family and the Community (1 page)
- An Authorization to Release Information form (1 page)

Note: The Release of Information form is what will allow Wellspring to communicate with you or authorized referring organization as part of our admission process. Also, please be aware that after the screening process, additional authorization forms may be needed in order to speak with previous treatment providers, lawyers, probation officers, or other entities specific to treatment. This process will identity whether our facility is a good fit for your treatment needs.

The packet of information can be emailed to the program's Administrative Assistant, or via the US Postal Service to the address below. Please specify which program you are applying for:

**Wellspring, Inc.**
**ATTN: Men's House, Women's House, or Infinity House**
**98 Cumberland Street**
**Bangor, Maine 04401**

If you have any questions or need further information, please contact the program Administrative Assistant you are applying to:

- Men's House – Jill Sanborn at 941-1600 ext. 401; jsanborn@wellspringsa.org
- Women's House – Patty Rudge at 941-1639 ext. 301; prudge@wellspringsa.org
- Infinity House – Lacreita Dieter at 217-6550 ext. 501; ldieter@wellspringsa.org

Thank you for your interest in Wellspring! We look forward to supporting you through your journey.
Respectfully,

Lisa Williams

Lisa Williams, LADC, CCS
Director of Residential Services
Wellspring, Inc.

Wellspring Residential Programs
APPLICATION FOR ADMISSION

Rev. 10-17

## I. PERSONAL INFORMATION

Name _____ Date _____
Date of birth _____ Phone _____ Soc Sec # _____
Address _____

Person to contact if you can't be reached:

_____
name address phone
Referral source: _____
name/agency address phone

## II. PRESENTING PROBLEM – Why do you want to come to Wellspring?

_____
_____
_____
_____

## III. BACKGROUND INFORMATION

**Current or Recent Living Arrangement: (prior to incarceration, if applicable)**

_____
_____

**Marital Relationship status:** ☐ **single** ☐ **married** ☐ **divorced** ☐ **separated** ☐ **widowed** ☐ **significant other**

**Children:**

| age | name | who has custody | living with whom | reason |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Is the Department of Human Services involved with your family? yes no
Name of caseworker/office _____
**If applying for Infinity House you must complete the Alternative Child Care Plan on Page 6**

**Nature of Current Family Relationships:** _____
_____
_____

**Family Make-up When Growing Up (parents. step-parents, brothers, sisters, grandparents):** _____
_____
_____

**Relationships with Extended or Other Family Members:** _____
_____
_____

**Significant events, losses, delays, trauma/abuse (physical, emotional, sexual, verbal):** _____
_____
_____

**Education:** (highest grade completed, diploma GED, history of significant problems, current activities, plans/interests)
_____
_____

**Employment/finances:**

If currently employed, list occupation _____
When last employed & occupation _____

Source of income & amount _____

Health insurance: private Blue Cross MaineCare Medicare military coverage/Togus
other – specify _____
Are you a veteran? yes no

**Legal Status: Current**

Legal proceedings pending - what/when _____
Probation – how long _____ name of Probation Officer _____
Parole & Parole Officer: _____
Drug court – where _____
Attorney's name/phone _____

**Legal History:** Number of arrests _____ Charges _____

Convictions: number of OUIs _____ number/types felonies _____

Recreation (hobbies, interests, things you like to do) _____

Spirituality/religion: _____

Social support (friends, neighbors, churches, agencies) _____

## IV. HEALTH INFORMATION

**Current health status:** excellent good fair poor
**Describe current health** (incl sleep, appetite, limitations/spec needs, illness, nutrition – adequate inadequate): _____

**Have you been tested for HIV? If so, when, where** _____ **HIV testing offered** _____

**Have you been tested for Hep C? If positive, when/status:** _____

**Pregnant:** ☐ yes ☐ no **If yes, how long?** _____ **Receiving pre-natal care?** _____

**Significant health history** (health problems, surgery, injuries, head trauma, etc): _____

Current tobacco use: _____ Yes _____ No If yes, amount _____ Interested in quitting? _____
Caffeine use: _____ Yes _____ No If yes, amount _____ Interested in quitting? _____
Last physical: _____ **Current primary care provider:** _____

Allergies (food, meds, other): _____
Limitations or special needs: walking stairs chores lifting hearing vision none
Explain _____

**Current Medications** (Medical and Mental Health/Prescribed and over-the-counter):

**I have read and agreed to Wellspring's medication prescribing policy:** ☐ Yes ☐ No

| name | reason for taking | amount | how often | since when |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## V.SUBSTANCE ABUSE HISTORY

| Drug (List all drugs – be specific) | Check your top 3 drugs of choice (1, 2, 3) | Age when use became regular | Used drugs IV? | How much did you usually use? | How often did you use? | When did you last use? |
|---|---|---|---|---|---|---|
| Alcohol | | | | | | |
| Amphetamines | | | | | | |
| cocaine/crack | | | | | | |
| hallucinogens (LSD, mushrooms, PCP) | | | | | | |
| Heroin | | | | | | |
| inhalants (specify) | | | | | | |
| Marijuana | | | | | | |
| narcotics/opiates other than heroin | | | | | | |
| sedatives/benzodiazapines (Xanax, Klonapin, etc) | | | | | | |
| bath salts | | | | | | |
| steroids (muscle enhancers) | | | | | | |
| other (specify) | | | | | | |

**Problems from AOD use** (check):

| Physical | | Psychological | Social |
|---|---|---|---|
| trauma/accidents | loss of consciousness | mood fluctuations | relationships |
| health | tremors | depression | school |
| blackout | hangovers | anxiety | job |
| DTs | vomiting | anger/rage | legal |
| overdose | tolerance | paranoia | financial |
| hallucination | loss of control | personality changes | fights/quarrels |

Comment on the three things that bother you most: _____

**Previous Substance Use Disorder Treatment:**
Describe any recent (within the last 2 years) any Detox experiences (Alcohol, Opiates, Benzos, Meth, Bath Salts, etc.):

_____

_____

**Outpatient Substance Use Disorder Treatment** (Counseling, IOP, Methadone, Suboxone, DEEP etc.):

| Type of Treatment & Where | When | Length of Stay | Sobriety After |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Residential Substance Use Disorder Treatment** (Wellspring, Cross Roads, Serenity House, St. Francis, Maine Gen., etc.)

| Where | When | Length of Stay | Sobriety After |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Any Period(s) of Abstinence?** ☐ no ☐ yes If yes:

| | When/Length | Quality of Life | What Helped or Motivated |
|---|---|---|---|
| Latest period of abstinence | | | |
| Longest period ofabstinence | | | |

Self-help group experience (type, when, length of involvement, participation): _____

_____

Reasons for/circumstances of relapse: _____

_____

Other compulsive/excessive behaviors – circle and describe (laxatives, sex, eating, spending, shoplifting, Internet, etc):

_____

If you gamble or play scratch tickets, have you ever felt the need to bet more and more? Yes _____ No _____

Have you ever had to lie to people important to you about how much you gambled? Yes _____ No _____

Family history of substance abuse: _____

## VI. MENTAL HEALTH HISTORY

**Current problems:** Have you been given a mental health diagnosis? yes no don't know
Do you know what it is? Please describe: _____

_____

**Psychiatric/Mental Health Hospitalizations** (Acadia Hosp., Spring Harbor, Dorothea Dix, Riverview, AMHI, Mid-Coast, St Mary)

| Where | When | For how long | Reason/Problem |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Residential Mental Health Treatment** (Morrison Place, Maine Stay, The Bridge, Sweetser, etc.):

| Where | When | For how long | Reason/Problem |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Outpatient Psychiatry & Mental Health Treatment** (McGeachey Hall, CHCS, Acadia Hosp., Maine Med., St, Mary, etc.)

| Where | When | For how long | Reason/Problem |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Are you a member of the Consent Decree?** _____

**Have you attempted suicide:** no yes How many times ___ last time _____ how _____
Consequences _____

**Have you engaged in self-harm:** cutting burning hitting self other _____
when _____ how often _____ last time _____

**Have you been a victim of:** domestic violence physical abuse sexual assault
**Have you been charged with:** domestic violence physical abuse sexual assault

**Do you have a family history of mental health problems?** If so, who and what? _____

**Current or recent mental health symptoms of concern** (check, circle, and describe):

Depression (sadness, low self-esteem, lack of interest/pleasure): _____

Anxiety (worry, fear, panic): _____

Anger (irritability, outbursts, reactivity): _____

Sleep (falling asleep, awakening, nightmares, excessive): _____

Cognitive (poor attention, memory problem): _____

Disturbing thoughts/memories: _____

Restlessness, fidgeting: _____

Hallucinations (hearing/seeing things others don't): _____

Other: _____

**Does your drug use make these symptoms worse or better? Please explain:**

**If you have had periods of sobriety or abstinence, were these symptoms worse or better? Please explain**

**Alternative Child Care Plan:** (For those applying for Infinity House)
Who should program staff contact in the event you are unable to provide care to your child (i.e., hospitalization, discharge from program, etc.):

| Name: | Relation: | Telephone # |
|---|---|---|
| | | |
| | | |
| | | |

**Please note:** you must sign a release of information for individuals listed on your alternative care plan upon admittance to the program and are responsible for updating this plan with staff immediately with changes.

## VII. AC-OK SCREENING QUESTIONNAIRE

### PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO

**During the past year:**

| | | |
|---|---|---|
| 1. Have you been preoccupied with drinking alcohol and/or using other drugs? | Yes | No |
| 2. Have you experienced problems caused by drinking alcohol and/or using other drugs, and you kept using? | Yes | No |
| 3. Do you, at times, drink alcohol and/or used other drugs more than you intended? | Yes | No |
| 4. Have you needed to drink more alcohol and/or use more drugs to get the same effect you used to get with less? | Yes | No |
| 5. Do you, at times, drink alcohol and/or used other drugs to alter the way you feel? | Yes | No |
| 6. Have you tried to stop drinking alcohol and/or using other drugs, but couldn't? | Yes | No |
| 7. Have you experienced serious depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)? | Yes | No |
| 8. Have you experienced thoughts of harming yourself? | Yes | No |
| 9. Have you experienced a period of time when your thinking speeds up and you have trouble keeping up with your thoughts? | Yes | No |
| 10. Have you attempted suicide? | Yes | No |
| 11. Have you had periods of time where you felt that you could not trust family or friends. | Yes | No |
| 12. Have you been prescribed medication for any psychological or emotional problem? | Yes | No |
| 13. Have you experienced hallucinations (heard or seen things others do not hear or see)? | Yes | No |
| 14. Have you ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened by someone? | Yes | No |
| 15. Have you experienced a traumatic event and since had repeated nightmares/dreams and/or anxiety which interferes with you leading a normal life? | Yes | No |

_____
Counselor Reviewed - Signature

| MH | SA | T |
|---|---|---|
| | | |

SIGNATURE OF APPLICANT:

_____
Print Your Name

_____
Signature

_____
Date

FINDING STRENGTH

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# CONTROLLED SUBSTANCES AT WELLSPRING

Wellspring provides residential substance abuse treatment and recovery for individuals with co-occurring mental health disorders. We collaborate with Community Health and Counseling Services to provide psychiatric consultation, evaluation, and medication management for our residential clients. As a result of our work together, Wellspring has established the practice that our medical consultants closely review and monitor any on-going prescriptions for controlled substances. A partial list of prescriptions that will be reviewed by our medical consultants include:

Commonly Prescribed Stimulants:

- Ritalin, Concerta (Methylphenidate)
- Adderall (dextroamphetamine)
- Focalin (dexmethylphenidate)
- Vyvanse (lisdexamfetamine)

Commonly Prescribed Benzodiazepines:

- Xanax (Alprazolam)
- Ativan (Lorazepam)
- Valium (Diazepam)
- Klonapin (Clonazepam)

Please be advised as you apply for admission to Wellspring, these medications may or may not be continued while you are a resident at Wellspring. All controlled substances prescribed at admission to Wellspring must either be prescribed by our medical consultant or coordinated for continuation with an established provider.

Medication to treat opioid use disorders utilizing Suboxone will be considered on a case-by-case basis and upon the recommendation of the Clinical Team in consultation with our medical provider, and prescribed in accordance with federal guidelines promulgated by the Substance Abuse and Mental Health Services Administration.

By signing below, you acknowledge that you have read and understand this policy.

_____ _____

Client Date

# NOTICE of Financial Responsibility for treatment at Wellspring's Residential programs

1. I understand that I am financially responsible for any medical and doctor's fees incurred during admissions and treatment. This includes the initial physical exam that happens during the first (5) days of admissions and for all prescription medications purchased while I am a resident at one of Wellspring's Residential Programs (Men's House, Women's House or Infinity House). If I am unable to pay for the medication when it is purchased, I will reimburse Wellspring before I leave the program.

2. I understand that if I am eligible for the *Supplemental Nutrition Assistance Program*, (SNAP) also known as *Food Stamps,* I will submit my SNAP EBT card to Wellspring to use toward my meals while in the treatment program. Upon leaving the treatment program, Wellspring will return my card to me.

NOTE: If I leave the program after the 16th day of the month, I understand that Wellspring will have used all of the monthly allocation amounts on my SNAP benefit allocation EBT card (excluding the amount on the card that you came into the program with at admission). If I leave before the 16th of the month, I will receive my full monthly allocation when my card is returned to me.

Example A:

| | |
|---|---|
| March 31: Arrival and the EBT card has a balance of: | $35.00 |
| April 1st: Monthly SNAP allocation added to card: | $65.00 |
| April 16th: Wellspring draws down monthly allocation: | $-65.00 |
| April 17th: Client leaves program, SNAP card balance is: | $35.00 |

Example B:

| | |
|---|---|
| March 31: Arrival and the EBT card has a balance of: | $35.00 |
| April 1st: Monthly SNAP allocation added to card: | $65.00 |
| April 10th: Client leaves program, SNAP card Balance is: | $100.00 |

NEXT ⟹

3. I understand that I am responsible for the Room and Board Fee for which I will billed for on a per-day basis.

NOTE: This is calculated on a sliding scale based on your income and it ranges between $1.00/day to $10.00/day. The amount you are responsible for will be assessed during the admissions process and a determination of your fiscal responsibility will be discussed then.

**NOTE: Mainecare only covers the treatment portion of your stay. Mainecare <u>DOES NOT</u> pay for the cost of room and board.**

I understand the information outlined in this document regarding my financial responsibilities while I am in treatment in the Wellspring Residential programs.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

# Trauma Informed Care

Trauma Informed Care (TIC) recognizes that traumatic experiences ***terrify, overwhelm and violate*** the individual. TIC is a commitment not to repeat these experiences and, in whatever way possible, to **restore a sense of safety, power and worth**.

## The Foundations of Trauma Informed Care

**Commitment to Trauma Awareness**

**Understanding the Impact of Historical Trauma and Oppression**

Agencies Demonstrate Trauma Informed Care with Policies, Procedures and Practices that:

**Create Safe Context**
**through:**
- Physical safety
- Trustworthiness
- Clear and consistent boundaries
- Transparency
- Predictability
- Choice

**Restore Power**
**through:**
- Choice
- Empowerment
- Strengths perspective
- Skill building

**Build Self-Worth**
**through:**
- Relationship
- Respect
- Compassion
- Acceptance and Nonjudgment
- Mutuality
- Collaboration

**Image Credit:** Trauma Informed Oregon, 2014

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# Overview of Wellspring's Residential Treatment Program for *Substance Use Disorder (SUD).*

The residential treatment programs at Wellspring are designed to provide trauma-informed treatment for people with a history of chronic substance use disorder; including those with co-occurring mental health disorders. The programs are long term - ranging from 4-months to 6-months and focus on supporting and guiding individuals toward gaining sobriety, maintaining sobriety and building the skills needed for independent living. This includes *building strong connections with the recovery community.*

**NOTE: Community Supports are considered vital to successful recovery.** Building connections with the Recovery Community is something that will be there for you long after you leave the highly structured residential treatment program.

To be considered for admission to our treatment in one of our residential programs, you must be:

- Eighteen Years of age or older
- Free of mood-altering substances on the day of admission
- Physically and mentally able to participate in a therapeutic community environment.
- Motivated for treatment.

At each of Wellspring's residential treatment programs we use a combination of treatment modalities along with medication management and daily living education to support overall rehabilitation.

The following trauma-informed services are offered while in residence:

- Individual, family and group SUD counseling sessions
- Educational and vocational counseling

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- Specialized treatment and psychiatric consultation for residents with co-occurring mental health disorder needs.
- Referrals to community support services
- Participation in the Greater Bangor area 12-step community
- Support and education for managing daily living skills

Group Psycho-education topics include:

- Addiction and Recovery
- Relapse Prevention Skills
- Insight processing
- Community Issues
- Family Roles
- Gender specific

Daily Living Skill activities include:

- Completion of scheduled household chores including meal preparation and, cleaning, vacuuming, and mopping floors, etc.
- Maintaining bedrooms in a clear and orderly fashion including beds made daily.
- Personal laundry
- Daily personal hygiene
- Learning time management skills in order to keep up with daily treatment assignments, appointments, chores and other program requirements.

These activities are designed to lend themselves to the development of relapse prevention skills that will go with the client upon graduation of the program and as they transition to independent living.

Our programs also offer daily meditations and house meetings. Participants are expected to actively take part in 12-step support or other types of support groups

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offered in the community in order to build a personalized recovery network that will aid in their recovery, post treatment.

## Q & A:

***1. Will I still get to see my family and children?***

-Absolutely. We encourage everyone to take responsibility for their children and to maintain close contact with their family.

***2. How much contact will I have with the outside world?***

-Recovery is much more than maintaining sobriety. Recovery involves setting goals that will foster a life that allows you to have independence, family connections and supports, self-confidence and a new lifestyle that will lead to success in many areas of life.

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# Connecting with Family and the Community while in Residential Treatment

We believe that it is important for people in recovery to maintain close relationships with their children and positive family supports.

We encourage scheduled visits from spouses and other family members, as long as they are free of mind-altering substances when visiting and also that they do not present any safety issues. All visitors must comply with program rules and regulations.

It is part of the treatment philosophy at Wellspring that residents have opportunities to practice their recovery skills in the community. Examples include the issuance of weekend passes (when eligible and treatment appropriate); as well as obtaining employment and /or continued education. (Residents are encouraged to seek and obtain volunteering opportunities or employment during their latter phases of treatment.)

Additionally, residents are exposed to and meet w/ a variety of community resources such as:

- The Bangor Area Recovery Network (aka *the* BARN)
- Spruce Run for survivors of domestic violence
- Courage Lives: Consortium of services for survivors of human trafficking.
- The Learning Center
- The Career Center

# Authorization to Release/Receive Information

Name: _____

DOB: _____ Date: _____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1966 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. These rules prohibit the recipient of confidential information from further disclosure of it unless that disclosure is expressly permitted by your written consent or as otherwise permitted by 42 C.F.R. Part 2. I understand that generally Wellspring may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I understand that I may request a list of records disclosed to whom, when, and for what purpose at any time during or after treatment. I will be given a copy of this form if I request it.

I, _____, authorize Wellspring and

_____

(name, agency, address, phone)

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

| | | | |
|---|---|---|---|
| ☐ Admission status | ☐ Biopsychosocial History | ☐ Medical Consultation | ☐ Aftercare Plan |
| ☐ Presence in Treatment | ☐ Clinical Assessment | ☐ Treatment Plan | ☐ Discharge Summary |
| ☐ Admission Summary | ☐ Psychological/Psychiatric Eval | ☐ Progress in treatment | ☐ Recommendations |

☐ Other _____

The purpose of this disclosure is to:

| | |
|---|---|
| ☐ Schedule appointments | ☐ Plan or coordinate treatment and services |
| ☐ Facilitate meeting legal obligations | ☐ Obtain/maintain employment, government, other benefits |

☐ Other _____

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken on it. Unless revoked, this consent will automatically expire one year from the date signed, unless otherwise specified below:

_____

(Specify date, event, or condition to expire)

***PCHC and CFM are contracted providers for Wellspring. Wellspring will not release documentation for services provided by these agencies for Wellspring clients. To obtain a copy of those records, please submit your request for records directly. Penobscot Community Health Centers, Medical Records, Union Street, Bangor, ME 04401 TEL 207-404-8200. Northern Light Family Medicine and Residency, 895 Union St, Bangor, ME 04401. TEL 207-973-7979.***

| | | | |
|---|---|---|---|
| I | ☐ do | ☐ do not | authorize information to be faxed. I understand that there are confidentiality risks in fax transmissions. |
| I | ☐ do | ☐ do not | authorize disclosure of information that refers to treatment or diagnosis of drug or alcohol abuse. |
| I | ☐ do | ☐ do not | authorize disclosure of information that refers to treatment or diagnosis of psychiatric illness. |
| I | ☐ do | ☐ do not | authorize disclosure of information that refers to treatment or diagnosis of HIV, ARC or AIDS. |
| I | ☐ do | ☐ do not | authorize redisclosure of this information to _____. |
| I | ☐ do | ☐ do not | wish to review my Wellspring records before their release. If I do, a program director or designee will supervise my review and document the supervision below. |

Client Signature _____ Date _____

Parent/Guardian _____ Relationship _____

To be valid, all sections above must be completed.

Revocation: ☐ by phone ☐ in person ☐ other _____ Date _____ Date written confirmation rec'd _____

(Revised 10/24)