



RESIDENTIAL APPLICATION PACKET

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 & 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 identify 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 programs Administrative Assistant you are applying for:

- Men's House- Jill Sanborn at 207-941-1600 ext. 401 jream@wellspringsa.org
- Women's House- Abbe-Jaye Soohey at 207-941-1639 ext. 301 briley@wellspringsa.org
- Infinity House- Jenna Bragdon at 207-217-6550 ext. 501 jbragdon@wellspringsa.org

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

Respectfully,

Lisa Williams, LADC, CCS
Clinical Director of SUD Services

**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, Klonopin, etc)						
bath salts						
steroids (muscle enhancers)						
other (specify)						

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

trauma/accidents	loss of consciousness
health	tremors
blackout	hangovers
DTs	vomiting
overdose	tolerance
hallucination	loss of control

Psychological

mood fluctuations
depression
anxiety
anger/rage
paranoia
personality changes

Social

relationships
school
job
legal
financial
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 of abstinence		

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 knowDo 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.):

<u>Name:</u>	<u>Relation:</u>	<u>Telephone #</u>

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 |
| <hr/> | | |
| 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 |
| <hr/> | | |
| 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



Wellspring, Inc. Controlled Substances Guidelines

Wellspring is committed to providing a safe, supportive, and clinically appropriate environment for substance use and co-occurring mental health treatment. As part of this commitment, we maintain policies regarding prescribed controlled substances, including but not limited to:

- Benzodiazepines (e.g., Xanax, Klonopin, Ativan)
- Stimulants (e.g., Adderall, Ritalin)
- Opioid medications (e.g., oxycodone, hydrocodone)
- Sedative-hypnotics or barbiturates
- Other DEA Schedule II–V medications, or other prescribed medications

Please be advised as you apply for admission, these medications may or may not be continued while you are a resident at Wellspring. Due to the potential interference with therapeutic progress, and your recovery, Wellspring asks you to work with your prescriber to ensure a therapeutic dose that allows for active engagement in your treatment.

Wellspring is committed to working collaboratively with outside prescribing providers to support safe and clinically appropriate care, including advocating for medications for opioid use disorder. Our clinical staff will coordinate with your current prescribers to assess medication needs, explore alternative and supportive treatments when appropriate, and ensure continuity of care that aligns with the goals of recovery and program safety.

By signing below, I acknowledge that:

- I have been informed that Wellspring may not be able to continue or advocate for the use of controlled substances without further review.
- I understand that Wellspring will make reasonable efforts to communicate and coordinate care with my outside prescribing provider(s) to determine the best course of action for my treatment and safety.
- I agree to fully disclose all current medications and prescribing providers during the intake and assessment process.
- I authorize the release and exchange of medical and medication-related information between Wellspring and my outside providers for the purpose of care coordination.
- I understand that if my current medication regimen is determined to be clinically inappropriate or unsafe in a residential treatment setting, adjustments may be recommended, including tapering or transitioning to non-controlled alternatives.
- I understand that undisclosed medication use, misuse, or diversion may affect my eligibility for continued treatment in the program.

If I have questions about this policy or its implications for my treatment, I have been given the opportunity to discuss them with program staff.

Client Signature

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 1 st : Monthly SNAP allocation added to card:	\$65.00
April 16 th : Wellspring draws down monthly allocation:	<u>\$-65.00</u>
April 17 th : 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 1 st : Monthly SNAP allocation added to card:	<u>\$65.00</u>
April 10 th : 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 be billed 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 **DOES NOT** 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



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



- 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



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.



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



**Wellspring, Inc.
Pre-Admission
Insurance Verification Authorization**

Client Name: _____ Date of Birth: _____

Insurance Provider: _____

Member ID (if known): _____

I authorize Wellspring, Inc. to contact my insurance provider, including MaineCare if applicable, for the purpose of verifying my insurance eligibility and behavioral health/substance use treatment benefits prior to admission.

This may include verifying:

- Active insurance coverage
- Behavioral health / substance use treatment benefits
- Deductible, copay, or out-of-pocket costs
- Prior authorization requirements
- Network participation

I understand that information used for verification may include my name, date of birth, and insurance identification number. This authorization may include information protected under HIPAA and 42 CFR Part 2, if applicable.

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 here: _____

I understand that:

- Signing this form allows the organization to verify my insurance benefits prior to admission.
- Refusal to sign may limit the organization's ability to determine insurance coverage for services.

Client Signature: _____ Date: _____



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)