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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- Jules Ream at 207-941-1600 ext. 401 jream@wellspringsa.org
- Women's House- Mindy Martin at 207-941-1639 ext. 301 mmartin@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, 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

MH	SA	T

Counselor Reviewed - Signature

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 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 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

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.



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 for Use and Disclosure of Protected Health Information for Treatment, Payment, and Health Care Operations (TPO)

Client Name: _____

Date of Birth: _____

Purpose
This form explains how Wellspring Inc. may use and disclose protected health information (PHI) for purposes of treatment, payment, and health care operations (TPO) as permitted under the Health Insurance Portability and Accountability Act (HIPAA) and applicable state and federal laws.

Treatment
I understand that my information may be shared among health care providers involved in my care at Wellspring for purposes such as coordinating services, referrals and consultations, prescribing and managing medications, clinical supervision and care planning, emergency care, etc.

Payment
I understand my information may be used or disclosed for activities related to payment, including billing and claims submission, eligibility determinations, utilization review, prior authorizations, collection activities, and insurance communications.

Health Care Operations
I understand my information may be used for health care operations such as quality improvement activities, program evaluation, staff training and supervision, licensing, accreditation, and audits, compliance activities, business operations and legal and regulatory requirements.

Special Protections for Substance Use Disorder Records
If applicable, I understand that records related to substance use disorder treatment may be protected by 42 CFR Part 2 and may not be redisclosed without my specific written authorization unless otherwise permitted by law.

Client Rights
I understand that:
- This authorization is not required for me to receive treatment.
- I may request restrictions on certain uses or disclosures, though the organization is not required to agree except as required by law. These restrictions are: _____
- I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it.
- I have the right to receive a copy of this form.

Acknowledgment and Authorization
By signing below, I acknowledge that I have received and understand how my health information may be used and disclosed for treatment, payment, and health care operations as described above.

Client Signature: _____ Date: _____

Legal Representative (if applicable): _____
Relationship: _____

Witness/Staff Signature: _____ Date: _____