Welcome!

Thank you for your interest in Rainforest Recovery Center. Below is a list of the items needed to complete your application for treatment services. When you have completed the Client Intake Packet, you may submit it via fax, by mail, or in person at our front office. If you need a Behavioral Health Assessment, you may make an appointment by phone at 907-796-8654 or in person. If you have had an assessment within the last six months, please submit that with your Client Intake Packet. If you are applying for Residential Treatment Services, the medical section of the check list will also need to be completed and submitted with your application. All of your information will then be reviewed by our treatment team.

Once your application and assessment are complete and submitted for review, you will receive a phone call regarding the next steps. If we have any additional questions, we will ask you at that time. If you have any additional questions or need assistance with the application, please call our intake staff at 907-796-8722.

Thank you for choosing Rainforest Recovery Center.

Application Check List:

☐ Completed Client Intake Packet.

☐ Behavioral Health Assessment – If you have completed an assessment within the last 6 months, please let our intake staff know.

☐ Releases of Information (ROI) – Complete a separate ROI for each person you would like involved in your care (i.e. physician, attorney, outpatient counselors, or family).

☐ Insurance information (including Medicaid).

Medical: If you are applying for Residential Treatment Services you will also need:

☐ Complete Medical History and Physical – Completed within the last 30 days by your MD, DO, Nurse Practitioner, or Physician Assistant.

☐ TB Test – Completed within the last year.

☐ Current List of Medications.

As an Outpatient, if you do not show up for two weeks, and have not contacted your Counselor in regards to your attendance, you will be discharged from Outpatient services and will be required to re-apply.
Client Intake Packet

Identifying Data
Full Legal Name: ____________________________________________ SSN: ________________ DOB: ________________ Age: ________________
Preferred Name: ____________________________________________ Sex: ☐M ☐F Identify as: ☐M ☐F ☐Other
Maiden Name: ____________________________________________

Contact Information – Current
Please put * by best contact number below where a message can be left
Physical Address: ____________________________________________ Home Phone: ____________________________
Mailing Address: ____________________________________________ Cell Phone: ____________________________
City & State: ____________________________________________ Work Phone: ____________________________
Employer: ____________________________________________

If Applicable: ☐ Guardian ☐ Payee
Name: ____________________________________________ Home Phone: ____________________________
Physical Address: ____________________________________________ Cell Phone: ____________________________
Mailing Address: ____________________________________________
City & State: ____________________________________________ Work Phone: ____________________________
Employer: ____________________________________________

Emergency Contact Numbers:

<table>
<thead>
<tr>
<th>Name</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Relationship to Client</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why are you seeking services at this time? ________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

What type of services are you requesting?
☐ Assessment Only ☐ Outpatient ☐ Intensive Outpatient ☐ Residential

Are you currently? ☐ Pregnant Woman ☐ IV Drug User ☐ HIV/AIDS Positive ☐ Co-occurring disorder
- If pregnant what is the due date? ______/____/____ (i.e. In need of mental health/addiction treatment)

What is your drug of choice? ____________________________________________________________

What is your goal in treatment? My treatment goal will be: ______________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

What date are you available to enter treatment? ____________________________

What is the best way to contact you? ☐ Phone ____________________________ ☐ Email ____________________________

Time of day? ☐ AM ☐ PM May we leave a message identifying RRC on your phone or email? ☐ Yes ☐ No

Client Intake Packet.pdf

Signature: ____________________________________________ DATE: ________________
Admission Data

Client Information

Race:
☐ Aleut ☐ Haida ☐ Tsimshian
☐ American Indian ☐ Hispanic ☐ Yupik
☐ Asian ☐ Native Hawaiian ☐ Other Alaska Native___________
☐ Athabaskan ☐ Inupiat ☐ Other ______________
☐ Black/African American ☐ Pacific Islander
☐ Caucasian ☐ Tlingit

Ethnicity:
☐ Chicano/Other Hispanic ☐ Mexican American ☐ Not Spanish/Hispanic/Latino
☐ Cuban ☐ Puerto Rican
☐ Hispanic - origin not specified ☐ Spanish/Hispanic Latino

Gender Identity:
☐ Male ☐ Female Becoming Male ☐ Male Formerly Female
☐ Female ☐ Female Formerly Male ☐ Male Becoming Female

English Fluency:
☐ Excellent ☐ Moderate ☐ Good ☐ Poor ☐ Not at all

Education: (highest level completed)
☐ Kindergarten ☐ 9th Grade ☐ Post Secondary 1 Year
☐ 1st Grade ☐ 10th Grade ☐ Post Secondary 2 Yrs - Inc AA Degree
☐ 2nd Grade ☐ 11th Grade ☐ Post Secondary 3 Years
☐ 3rd Grade ☐ High School Diploma -Not GED ☐ Post Secondary 4+ Yrs -No Degree
☐ 4th Grade ☐ General Education Degree ☐ Special Education Ungraded Classes
☐ 5th Grade ☐ Graduate Work -No Degree ☐ Vocational Training Beyond High School
☐ 6th Grade ☐ Baccalaureate Degree-BA.BS ☐ Other
☐ 7th Grade ☐ Master's Degree ☐ No Schooling
☐ 8th Grade ☐ Doctorate/Professional Degree

Special Need:
☐ None ☐ Traumatic Brain Injury ☐ Moderate to severe medical problems
☐ Developmentally Disabled ☐ Visual Impairment /Blind ☐ Hearing Impairment /Deaf
☐ Learning Disorder: Type: _____ ☐ Major Difficulty in Ambulating or Intellectual Disability/Impaired
☐ Other: ___________________ ☐ non-ambulating.
☐ Cognitive Functioning

Veteran Status:
☐ Never in Military ☐ Retired from Military; No combat ☐ Afghan War Veteran; Combat
☐ Active Duty; No Combat ☐ Retired from Military; Combat ☐ In Reserves or National Guard; Combat
☐ Active Duty; Combat ☐ Vietnam Era Vet; Combat ☐ In Reserves or National Guard; No Combat
☐ Military Dependent ☐ Vietnam Era Vet; No Combat ☐ Iraq War Veteran; Combat
☐ Veteran; Other Eras ☐ Gulf War Veteran; Combat

Are you an injection drug user? ☐ Yes ☐ No

Have you ever experienced, or are you currently experiencing violence in an intimate relationship? ☐ Yes ☐ No
Prior Clinical Admissions and Hospitalizations

<table>
<thead>
<tr>
<th>Number of Prior Substance Abuse Treatment Admissions?</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Prior Substance Abuse related hospitalizations in the last 6 months?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Number of Prior Mental Health Treatment Admissions?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Number of Prior Mental Health Hospitalizations?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Employment Status:

- Employed Full-time
- Employed Part-time
- Disabled
- Homemaker
- Not in Labor force - Other
- Not in Labor for - Resident/Inmate
- Seasonal Employ; In Season
- Seasonal Employ; Out of Season
- Unemployed - Seeking Work
- Unemployed - Not Seeking Work
- Unemployed - Subsistence lifestyle
- Not Seeking Work
- Other
- Retired
- Student
- In Armed Forces

Annual Household Income in Thousands (How much money does your family make in a year?)

| $ 0 - $999 | $ 1,000 - $4,999 | $ 5,000 - $9,999 | $ 10,000 - $19,999 | $ 20,000 - $29,999 | $ 30,000 - $39,999 | $ 40,000 - $49,999 | $ 50,000 - over |

Expected Payment Source: (How will services be paid?)

- Aetna
- Blue Cross/Blue Shields
- Medicaid
- Other Private Insurance
- Other Government Grant
- Other Public Insurance
- Client Self-Pay
- CIGNA
- HMO

Marital Status:

- Single
- Separated
- Cohabitating
- Married
- Divorced
- Widowed

Living Arrangement:

- Foster Care
- Assisted Living Facility
- Correctional Halfway House
- Group Home
- Homeless
- Hospital for Psychiatric Purposes
- Hospital/Non-Psychiatric Purposes
- Jail /Correctional Facility
- Crisis Resident
- Nursing Home
- Private residence w/ support
- Private residence w/o support
- Residential treatment
- Shelter
- Other: __________________________
- Therapeutic Foster Care

Do you have a religious preference?  □ Yes □ No

Religious Preference: ____________________________

Legal Status:

- 30 Day Commitment
- 90 Day Commitment
- 180 Day Commitment
- Case pending
- Community sentencing
- Furlough/Rehabilitation
- Emergency Commitment
- Deferred Prosecution
- Deferred Sentence
- Incarcerated-Sentenced
- Incarcerated-Unsentenced
- Protective Custody
- Probation/Parole
- Court ordered, observation & evaluation
- Court ordered for alcohol treatment
- Court ordered for mental health treatment
- None / No Involvement
- Other: __________________________

Number of arrests in the past 30 days? ________
Household Composition: (who do you live with?)
- [ ] Client Lives Alone or Independently
- [ ] Client Lives with Significant Other
- [ ] Other: ______________________
- [ ] Client Lives with Children
- [ ] Client Lives with Relatives
- [ ] Client Lives with Significant Other & Children
- [ ] Client Lives with Non-relatives
- [ ] Client Lives with Adolescents

Number of Children in Household?
- [ ] 0
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] Other

How many people live at your residence? (Including yourself)
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] Other

Primary Income Source:
- [ ] Alaska Native Corporation Dividends
- [ ] Social Security
- [ ] Railroad Retirement
- [ ] Child Support
- [ ] Social Security Disability -SSDI
- [ ] Alaska PFD
- [ ] Employment
- [ ] Alimony
- [ ] Self-Employment
- [ ] Interest and Other
- [ ] SSI/SSDI Never
- [ ] Unemployment Compensation
- [ ] Spouse's or Significant Other's Income
- [ ] SSI/SSDI Previous
- [ ] Tribal Assistance Program
- [ ] Parent's Income
- [ ] Other:_______________________
- [ ] Public Assistance/Welfare Payments

What is your Occupation?
- [ ] Accommodation & Food Services
- [ ] Administrative & Support Services
- [ ] Agriculture, Forestry, Fishing & Hunting
- [ ] Art, Entertainment, & Recreation
- [ ] Construction
- [ ] Educational Services
- [ ] Finance & Insurance
- [ ] Government
- [ ] Health Care & Social Assistance
- [ ] Information
- [ ] Management of Companies & Enterprises
- [ ] Manufacturing
- [ ] Mining, Quarrying, Oil & Gas Extraction
- [ ] Other Services (Except Public Admin.)
- [ ] Professional, Scientific & Technical Servs.
- [ ] Real Estate, Rental, & Leasing
- [ ] Retail Trade
- [ ] Self-Employed
- [ ] Transportation & Warehousing
- [ ] Utilities
- [ ] Wholesale Trade
- [ ] None

Health Status:
- [ ] Excellent
- [ ] Very Good
- [ ] Good
- [ ] Fair
- [ ] Poor

Do you currently use Tobacco?
- [ ] Cigarettes  # of packs a day _______
- [ ] Smokeless tobacco
- [ ] Cigars or pipes
- [ ] Combination of more than one
- [ ] N/A – no Tobacco use

Signature: _____________________________________________ DATE: ________________
Referral Source:

- Alcohol Detox or Residential Program
- Alaska Native Hospital
- Assisted Living Facility
- Alcohol Program
- API
- ASAP
- Attorney
- Court-Civil Proceedings
- Other Social/Community Agencies
- Correctional Agency (Probation Parole)
- Crisis/Respite Care
- Court-Criminal Proceedings
- Department of Corrections/Jail
- Developmentally Disabled Program
- Developmental Disabilities Residential Program
- Division of Vocational Rehabilitation
- Drug Detox or Residential Program
- Federal Probation
- Halfway House
- Individual (including self-referral)
- Internal Referral
- Supervised Apartment
- Nursing Home/Immediate Care Facility
- Other CMHC Outpatient Caseload
- Office of Children Services
- Other MH, Not Psych; School, Church
- Other Residential/Institutional
- Partial Care or Day Care Program
- Private Psychiatric Hospital
- Psychiatrist/Psychiatric Outpatient Clinic
- Public Health (HS, PHS, Div Public Health)
- Community Health Center
- School
- SEARHC
- Self, Family or Friend
- Therapeutic Court
- Tribal Health Authority
- Tribal Health Facility
- Transitional Housing
- V.A. Hospital
- Village Health Aide
- Wellness Court
- Mental Health Court
- Physician
- Public Safety
- Drug Program
- Employer

Agency name and contact: You must furnish a release of information from this agency.

Name: ___________________________ Agency: ___________________________ Phone #: ___________________________
Billing Information / Authorization

**Expected Payment source** (check all that apply):

- ☐ Medicaid *(Includes Denali Kid Care)*  ☐ Other Insurance  ☐ Self-pay

Rainforest Recovery offers Charity Care Programs for qualifying applicants. If you are self-paying and do not have insurance, please apply for our Sliding Fee Scale application. You may ask our front office for more information or contact Patient Financial Services at 907-796-8328.

**Medicaid ID Number:**
Please provide a copy of proof of coverage from Medicaid.

**Insurance** (All asterisked information must be completed. Copy of both sides of insurance Card Enlarge so it is legible when faxed. ☐

<table>
<thead>
<tr>
<th>*Name of Primary Insurance Company</th>
<th>Subscriber’s Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Subscriber (Policy Holder) Name</td>
<td>Insurance Company Address</td>
</tr>
<tr>
<td>*Subscriber’s ID Number</td>
<td>Insurance Company Phone</td>
</tr>
<tr>
<td>*Subscriber’s Date of Birth</td>
<td>Group or Plan #</td>
</tr>
<tr>
<td>Relationship to Client</td>
<td>Subscriber’s Address (if different from above)</td>
</tr>
<tr>
<td></td>
<td>Subscriber’s Home Phone (if different)</td>
</tr>
</tbody>
</table>

Copy of both sides of insurance Card Enlarge so it is legible when faxed. ☐

<table>
<thead>
<tr>
<th>*Name of Secondary Insurance Company</th>
<th>Subscriber’s Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Subscriber (Policy Holder) Name</td>
<td>Insurance Company Address</td>
</tr>
<tr>
<td>*Subscriber’s ID Number</td>
<td>Insurance Company Phone</td>
</tr>
<tr>
<td>*Subscriber’s Date of Birth</td>
<td>Group or Plan #</td>
</tr>
<tr>
<td>Relationship to Client</td>
<td>Subscriber’s Address (if different from above)</td>
</tr>
<tr>
<td></td>
<td>Subscriber’s Home Phone (if different)</td>
</tr>
</tbody>
</table>

Your insurance will be billed separately for physician services. You may receive a bill from Southeast Physician Services for any balance not covered by insurance.

Thank you again for choosing Rainforest Recovery Center. Your first step to a life free from addiction.
Facility Rules and Information

- **We are a tobacco free facility.** Bartlett Regional Hospital (BRH) and Rainforest Recovery Center (RRC) are tobacco free facilities. In accordance with city ordinance, no one is allowed to smoke or use tobacco products while in the Rainforest Recovery Center program. This includes both on and off campus, including community outings and meetings. Nicotine Replacement Therapy is available to you. Smoking items such as cigarettes, chew, lighters and matches are considered contraband and will be placed in storage.

- **Random Drug/Alcohol Screening.** A breathalyzer (BrAC) test and an observed Urine Drug Screen (UDS) will be completed at the time of admission and randomly throughout your stay.

- **Room Searches.** As part of residential drug and alcohol treatment, RRC may, at any time, conduct a thorough search of individual patients’ belongings and living spaces.

- **No Electronics.** For patient safety and confidentiality, patients are not allowed cell phones or electronic devices in treatment. This includes cell phones, iPods, iPads, tablets, computers, mp3 players, cameras, and other electronic recording devices or equipment. Any electronic device arriving with a new patient, without three prongs, will be held in storage until discharge.

- **Telephone use.** The phone will be available every day during certain scheduled times. Telephone calls are NOT allowed during any scheduled activity, including the Saturday Family Program, recreational therapy, program videos, and twelve-step meetings. In emergencies, the counselor can approve phone calls made with supervision from their offices.

- **Medications.** Please bring a 30-day supply of all your current medications. Over-the-counter medications must be in factory sealed containers. Any prescribed medications, over the counter medications, or herbal-based supplements arriving with patients will be surrendered and will require approval by the RRC Medical Director prior to use in treatment. Your medications will be stored for you. We may dispose of any medications that are unidentifiable, not prescribed, or discontinued during your stay. You consent to this by entering the RRC program.

- **Living Area.** Please help to keep RRC and your room clean and neat. For housekeeping purposes your linens can be changed on Tuesdays. Laundry facilities and products are provided. Due to past problems with ants and other critters no food is allowed in the rooms.

- **Elopement Policy.** Under our care staff will perform 15 minute checks to ensure your safety. If you are absent from RRC, without informing staff, for 30 minutes then you will be considered to have left the residential program against medical advice and will be discharged.

- **Property Boundaries.** All patients are provided with a map detailing the property boundaries. While participating in off campus activities, you must stay within eye sight of staff at all times. You are not allowed in the following areas unless with staff:
  - Bartlett Regional Hospital building
  - The Rainforest Activity Center
  - Wildflower Court and Parking Lot
  - Vehicles in the parking lot
  - Surrounding wooded areas
  - The front reception area

- **Mail.** You can send and receive mail from RRC. Keep in mind this is a 28 day program; mail delivered after your discharge will be returned to sender. If you want to receive mail, give your sender the following address:

  (Your Name)
  c/o Rainforest Recovery Center
  3260 Hospital Drive
  Juneau, AK 99801
• **Visitors.** Visiting hours are posted at the care coordination center. Visitors must agree to abide by the federal laws of confidentiality. Visitation must occur in RRC common areas, not patient rooms. For patient safety, only staff shall grant admittance to the RRC facility. Visitors are expected to be sober and abide by the BRH no smoking rules. During the visit all visitor property will be turned into staff. All children must be supervised at all times.

**What To Bring**

• Enough clothing for seven days. Limit your clothing to one suitcase and a small personal bag such as a purse or backpack. Washer and Dryer are available.

• Bring a warm coat, gloves, winter hat and boots for outdoor activities. Waterproof material is preferable.

• Hand lotion, shampoo, conditioner, hairdressing gels, deodorant, etc. These items must not have propylene glycol, ethylene glycol, diethylene glycol, methanol, isopropanol (isopropyl alcohol), and ethanol (ethyl alcohol) listed within the first three ingredients. Other alcohol derivates such as cetyl, stearyl, cetearyl, lanolin, and denatured are ok to bring.

• Hairbrush and/or comb, toothbrush and toothpaste.

• A 30-day supply of all your current medications. Over-the-counter medications must be in factory sealed containers. Medications will be identified and must be approved by RRC Medical Director prior to you being allowed to take these medications. While in treatment, your medication will be stored for you and administered to you by nurses.

• You are expected to dress appropriately. Any clothing which is determined to distract or has the potential to distract will be locked away until discharge. Tight T-shirts, pants, shorts, low-cut tops, excessively loose or revealing clothing, are prohibited and you will be asked to change into more appropriate clothing. Clothing which advertises or glorifies alcohol or drug products is prohibited.

• Baggage is kept in a storage locker and accessed during arrival and departure. Contraband is locked away and may be returned upon discharge.

• No more than $100 will be allowed on your person at RRC and you are given the opportunity to secure it in storage. Any money over this amount will be stored in the safe at the hospital.

**What Not To Bring**

• Alcohol, marijuana, tobacco products, including e-cigarettes, chew, and vapors, and any unsealed over-the-counter, prescription, un-prescribed, or illegal drugs.

• Weapons of any sort.

• Pornography or any sexually explicit material.

• Toiletry articles containing propylene glycol, ethylene glycol, diethylene glycol, methanol, isopropanol (isopropyl alcohol), and ethanol (ethyl alcohol) within the first three ingredients, i.e. hair gels, shampoo, conditioner, aftershave, mouthwash, etc.

• Perfumes or other fragrances. BRH/RRC is a fragrance-free facility.

• IPod’s, IPad’s, tablets, MP3 players, personal televisions/DVD players, videos or hand-held games kept on your person. Any electronic devices unless given to you by staff.

• Any item which is determined to distract, or has the potential to distract from the treatment program will be locked away in RRC storage until discharge.

• Cell phones will be kept in storage and may not be utilized during your stay unless for specific approved treatment purposes.