CLIENT INFORMATION AND INITIAL ASSESSMENT (All Information given is confidential)

Last Name:_____ First Name:_____ Middle Initial:_____ Intake Date:_____

SSN:_____ DOB:_____ Age:_____ Gender:_____

Reinstatement Date: _____

Residential Information: □ Own/Rent □Live w/ Friends/Family □ Homeless □ Transitional □In Shelter □Jail □w/ partner □Unknown

Address:_____ City:_____ State:_____ ZIP:_____

Telephone:_____ Cell Phone:_____ Crisis Client _____Yes _____ NO

Ethnicity: □ White (Non-Hispanic) □ Hispanic/Latino(a) □ African American □ American Indian/ Alaska Native □ Asian

□ Pacific Islander/ Native Hawaiian □ Other/ Unknown **MIS CLIENT ID: _____**

Target Population(All that apply): □Immigrant □Elderly □Physically Challenged □Gay/Lesbian □Bisexual □Transgender □ Other

Family Information: Marital Status: □ Married □ Single □ Divorced □ Live together □ Widowed

Name of significant other:_____ Yrs/Months together:_____ □ CYFD Involved

Children: Boys:_____ Ages:_____ Girls:_____ Ages:_____ Total Family Size: _____

Family Income: □ $0.00-19,623 □ $19,624-26,438 □ $26,439-33,253 □ $33,254-40,068 □ $40,069-46,883 □ $46,884-53698

□ $53,699-60,513 □ $60,514-67,328 □ $67,329-74,143 □ $74,144-80,958 □ $80,959-87,773 □ $87,774-94,558 □ $94,559-101,403 □ $101,404-108,218 □ $108,219-115,003

EMPLOYMENT/EDUCATION: □ Full Time □ Part Time □ Unemployed □ Actively Seeking Employment □ Retired □ Homemaker

Usual occupation:_____ Employer:_____ Telephone:_____

Education Completed: □ No diploma □ High School □ GED □ Higher Education Enrolled in Educational/Voc. school? □ Yes □ No
School Attending:_____

HEALTH/EMEREGENCY INFORMATION:
Health Insurance: □ None □ Medicaid □ Private Insurance Primary Care Doctor: _____
Health Issues:_____

PCP Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Receiving TANF Cash Assistance _____Yes _____No Medicaid Enrolled ____Yes ____No Medicaid#: _____

CRIMINAL HISTORY:

End of probation date:_____ Current charge:_____

Previous charges:_____

Pending Charges:_____
Probation officer / Tracker/CYFD Case Worker/ Reporting Entity:_____

Telephone:_____ Fax:_____ DV Offender? ____Yes ____NO

Secondary probation officer of Judge:_____

RECEIPT HIPAA PRIVACY NOTICE

I, the undersigned, have been informed of the "A New Awakening"

Notice of Privacy Practices on _____ _____, 20____.
Month Day Year

_____
Signature of Client

_____
Printed Name of Client

If Client **Refused** or is **Unable** to acknowledge please explain why:

_____

_____

_____

_____
A New Awakening Staff Signature

_____
Printed Name of Staff

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENTS RECORD

The confidentiality of alcohol and drug abuse client records maintained by this office is protected by Federal law and regulations. Generally, the office may not say to a person outside the program that a client attends the program, or disclose any information identifying a client as an alcohol or drug abuse client UNLESS:

(1) The client consents in writing;

(2) The disclosure is allowed by court order, or

(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.
(See 42 U.S.C. 290dd 3 and 42 U.S.C. 290ee 3 for Federal laws and 42 CFR Part 2 for Federal regulations.)

I acknowledge that I have been informed of these rights and I understand these rights.

_____	_____
Client Name (Printed)	Date
_____	_____
Client signature	Date
_____	_____
Staff Name (Printed)	Date
_____	_____
Staff Signature and Credentials	Date

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
ADVANCE MEDICAL DIRECTIVE

I, _____, willfully and voluntarily make known my desire and do hereby declare:

Section 1. Appointment of Agent to Make Health Care Decisions

- ❑ Check this box if you do not wish to elect an agent to make health care decisions.
- ❑ Check this box if you would like to designate an individual to make medical decisions regarding your medical care.
- ❑ I would like more information about Advance Medical Directives (Client given Advance Medical Directive packet)

I hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized in this document:
Primary Agent:
Telephone Number/ Fax Number:
Address/ E-mail Address:

If the above named primary agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following as successor agent to serve in that capacity:
Successor Agent:
Telephone Number/ Fax Number:
Address/ E-mail Address:

I hereby grant to my agent, named above, full power and authority to make health care decisions on my behalf as described below whenever I have been determined to be incapable of making an informed decision about providing, withholding or withdrawing medical treatment. The phrase "incapable of making an informed decision" means unable to understand the nature, extent and probable consequences of a proposed medical decision or unable to make a rational evaluation of the risks and benefits of a proposed medical decision as compared with the risks and benefits of alternatives to that decision, or unable to communicate such understanding in any way. My agent's authority hereunder is effective as long as I am incapable of making an informed decision.

The Purpose of and need for the disclosure is to inform interested parties that I have agreed to as reflected above access to certain documents contained in my confidential mental health record. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with treatment program and prognosis. If more detailed information is requested I will need to have an individual session to discuss my wishes for inclusion or exclusion of records. Requests for additional information not stated in this document will not be released until private consultation is completed.

I understand that this consent will remain in effect for one year or can be revoked by me at any time with written notice to this agency.

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records, and that recipients of this information may re-disclose it only in connection with their official duties.

_____	_____	_____	_____
Client Name (Printed)	Date	Client Signature	Date

_____
Signature of parent, guardian if client is under the age of consent or under age 14.

_____	_____	_____	_____
Counselor Name (Printed)	Date	Counselor Signature	Date

CONSENT FOR THE RELEASE OF CONFIDENTIAL

I,_____, hereby consent to communication between A New Awakening and _____.

The Purpose of and need for the disclosure is to inform interested parties that I have agreed to as reflected above access to certain documents contained in my confidential mental health record. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with treatment program and prognosis. If more detailed information is requested I will need to have an individual session to discuss my wishes for inclusion or exclusion of records. Requests for additional information not stated in this document will not be released until private consultation is completed.

I understand that this consent will remain in effect for one year or can be revoked by me at any time with written notice to this agency.

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records, and that recipients of this information may re-disclose it only in connection with their official duties.

_____ _____
Client Name (Printed) Date

_____ _____
Client Signature Date

_____
Signature of parent, guardian if client is under the age of consent or under age 14.

_____ _____
Counselor Name (Printed) Date

_____ _____
Counselor Signature and Credentials Date

INFORMED CONSENT TO TREATMENT

Welcome to A New Awakening treatment center. Participating in treatment can have some significant positive effects on you and your family's life. Treatment is different for everybody and the type and amount of time treatment can take is different from person to person. In general our program is designed to take from 6 to 12 months. This may seem like a long time but if you consider how long it took to get you to this point in your life that now you require help it will take time to help get things together for you.

Your treatment plan outlines what goals you would like for your life and tasks that are needed to be successful. You and your counselor will review these goals every month. At that time you can expect to receive an estimated time your treatment might be complete. This completion date is not dependant upon a date assigned by the courts, meaning even if the courts mandate 3 months you may be here longer depending upon your participation or severity of your needs to help you get better. The average client who successfully completes our program usually does so within 6 to 12 months.

Leaving treatment before you are ready has some risks and below is a list of some common things that may happen to you if you leave treatment before your discharge date:

1. Failure to successfully discharge will result in a letter to your tracker, probation/parole officer, the court system or other system that directed you here.
2. A risk of relapse of narcotics or alcohol and further exposure to the criminal justice system.
3. Loss of funding from the city or state government that pays for your treatment (AMCI).
4. If you miss more than two appointments without calling you will be discharged as non-compliant.

At New Awakening we encourage our clients to openly discuss discharge and plan well for discharge to prevent any harm to come to you. Prior to discharge it is our policy that you speak to your primary counselor under supervision of the clinical supervisor to ensure that you have received enough services to help make your life successful.

I acknowledge that I have read and understand the following regarding discharge dates and when I can expect to complete treatment.

_____ _____

Client Name (Printed) Date

_____ _____

Client signature Date

_____ _____

Staff Name (Printed) Date

_____ _____

Staff Signature and Credentials Date

PATIENT'S LEGAL AND HUMAN RIGHTS

1. You have the right to privacy in your treatment, in your care, and in the fulfillment of your personal needs.
2. You have the right to be fully informed of all services available to you, and of any changes in the services.
3. You have the right to be fully informed of your rights as a patient and of all rules and regulations governing your conduct as a patient in this facility.
4. You have the right to receive information necessary to give informed consent prior to start of any procedure and/or treatment.
5. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of this right.
6. You have the right to voice opinions, recommendations and grievances in relation to policies and services offered by the facility, without fear of restraint, interference, coercion, discrimination, or reprisal.
7. You have the right to be free from physical, chemical and mental abuse.
8. You have the right to confidential treatment of your personal and medical records. Information from these sources will not be released without your prior consent, except in your transfer to another health care facility, or required by law, or under third party payment contracts.
9. You have the right to refuse to perform any services for the facility, or for other patients, unless they are part of your therapeutic plan of treatment, which you have approved.
10. You have the right to be treated with dignity and respect; as an individual who has personal needs, feelings, preferences and requirements.

Policy
A New Awakening staff shall utilize their full professional expertise to ensure protection of the patients legal and human rights. It is the responsibility of all A New Awakening staff to make these rights to the patients and the public.

Purpose
A New Awakening staff shall establish and maintain an environment that enhances the positive self-image of the patient and preserves human integrity.

_____ _____
Client Name (Printed) Date

_____ _____
Client signature Date

_____ _____
Staff Name (Printed) Date

_____ _____
Staff Signature and Credentials Date

REASONS FOR NON-COMPLIANCE WITH TREATMENT

For clients involved with the criminal justice system we are required to report to your supervising agent. Here are the reasons you could be in non-compliance with treatment; A REPORT INDICATING NON-COMPLIANCE WILL BE SENT TO YOUR REPORTING ENTITY. This policy applies to Home-Visits as well.

1. If you miss more then two sessions in a row and don't call to explain why. Also, please note that if you are referred by the judicial system, a communication letter will be sent to your reporting entity at least monthly documenting your progress or lack thereof (with release of info.). If you miss any scheduled appointments, your reporting entity will be notified of such.
2. If you are more than 15 minutes late to any treatment session, it is considered a "No Show" (No Show policy applies and your reporting entity will be notified.)
3. If you miss 8 or more sessions in a 3 month period.
4. If you refuse to attend any service recommended by your primary counselor
5. If you refuse to participate in counseling
6. If you are disruptive to others in group classes
7. If any threats are made to A New Awakening staff or other clients in the agency.
8. If owed balance is over $50.00. If you have a balance over $50.00, you will not be seen for services until you pay on your balance.

If you are MONITORED BY ANY LEGAL ENTITY, Non-compliance with treatment occurs for the above and the following reasons and will result in an immediate notification of non-compliance behavior to your probation officer:

1) Any missed treatment sessions whatsoever
2) Being more than 15 minutes late to a treatment session
3) Failing a drug screen or BAC
4) Disruptive or non-participatory behavior in any treatment session
5) Any form of disrespectful behavior or triangulation behavior (lying or telling drug treatment staff conflicting information)

_____ _____

Client Name (Printed) Date

_____ _____

Client signature Date

A New Awakening
Group Counseling Rules and Expectations

BE ON TIME

1. Being on time for group helps group members get on track with their program and reduces interruptions and distractions. It is a matter of respect to others and your own program to be on time.
2. Please come early for your group times, as check in may take longer during busy peak hour in the agency.
3. You are expected to be on time to your group. We do allow a 15-minute window to be allowed to enter the group but this cannot be done on a constant basis. If you are late on a regular basis you will be asked to meet with the group counselor on an individual basis to discuss continuing in group therapy.

CHILDREN AND GUESTS

1. We understand that childcare is difficult and having a family and a job while in treatment is tough. We also want to protect your children and as such the topics covered are NOT appropriate for small ears. In addition we can assume no liability for your children within the agency, there is no childcare available.
2. Children are only allowed to attend the family group and the parenting groups on a regular basis. And these are the groups that your children can participate in and are an active part of.
3. Guests are not generally allowed in-group with the exception of parenting group, family group, and couples group. If you would like to bring a guest you must ask the group counselor BEFORE group so that we can ensure confidentiality of others.

CELL PHONES

1. CELL PHONES ARE NEVER ALLOWED IN GROUP!!!! Cells are to be turned off during group. No texting, no looking at vibrating cells, no nothing.
2. You will be asked to leave group if you use your cell in-group. This will be an unexcused absence.

DRESS CODE

1. Please dress like your coming to counseling, be mindful that this place of healing and safety. If you do not follow this guideline you will be counseled individually with the group counselor to discuss safety and healthy boundaries.

CONFIDENTIALITY

1. All information disclosed within your group sessions is strictly confidential and may not be revealed to anyone outside by the agency staff without written permission of the client or the client's family.
2. Do not discuss what occurs in group with anyone else at any time. If you are known to violate confidentiality you will be removed from the group and assigned to individual counseling sessions.

RESPECT

1. Do not cross talk or in any way be disrespectful to the group counselor or other group members. Your group counselor will attempt to let you know you are disrespectful and at that time you must put yourself in check.
2. Clients who are having trouble being respectful will be counseled individually to be coached on being respectful in group.

POLICY AND PROCEDURE ABOUT MISSING GROUPS – Effective 1-21-2010

Clients are prohibited from making up groups. Clients that miss a group or other session will be charged $25.00 and a non-compliance report sent to the probation officer or reporting entity. To switch groups, you must schedule an individual appointment with your counselor.

a. Conditions of treatment require abstinence from all drug and alcohol use for the entire treatment program. If I am unable to make this commitment, I will discuss other treatment options with the program staff.
b. I will discuss any drug or alcohol use with the staff and group while in treatment.
c. Treatment will be terminated if I attempt to sell drugs or encourage drug use by other patients.
d. I understand that graphic stories of drug or alcohol use will not be allowed.
e. I will not become involved romantically or sexually with other patients.
f. I understand that it is not advisable to be involved in any business transactions with other clients.

_____ _____

Client Name (Printed) Date

_____ _____

Client Signature Date

COST/ VALUE OF TREATMENT

Client name:_____ Date:_____

Self Pay Clients: Fees are due and payable at the time of service. Payment can be made by cash or credit/check card .

All Other Clients: If you are not a self-pay client, the fees below will be paid by your vouchering agency or referring agency (Example: AMCI, Premier Care, Medicaid, etc.)

Self Pay Services	Fees
Mental Health BioPsychoSocial Assessment	$60.00
Acupuncture or Massage	$60.00
Addiction Severity Index	$60.00
Domestic Violence Assessment	$60.00
Individual, Family, Couples, or Child session	$60.00
Reinstatement or ½ Case Management Session	$30.00
All groups (IOP, substance abuse, tai chi, relapse prevention, domestic violence, etc.)	$25.00
Urine Analysis (not covered by Medicaid)	$10.00
Breathalizer or other drug screen, not including UA	$3.00

*We do accept some insurances, esp. Presbyterian, Lovelace, and Blue Cross Blue Shield as OUT OF NETWORK PROVIDERS and vouchering services to help ease the burden of payment for counseling services. Please inquire about these options from any member of our staff. ALL COPAYS ARE DUE AT TIME OF SERVICE; NO BALANCE MAY BE CARRIED FOR COPAYS. PLEASE NOTE THAT IF FUNDING SOURCES OR PRIVATE INSURANCES REFUSES TO PAY, CLIENT WILL BE HELD LIABLE FOR FULL AMOUNT OF RENDERED SERVICES.

24 Hour "Notify or Pay" Policy

ALL CLIENTS, whether self pay or agency funded must give 24 HOURS ADVANCED NOTICE in person or by phone, if you are going to miss a scheduled individual counseling session. Acupuncture or massage appointment. If less than 24 hours advanced notice is given, you will be charged $25.00 for the missed individual appointment. A "Charge Dispute" form is available at the front office should you feel you have a significant reason for missing your appointment. The Finance Director will review your dispute and be the final and only judge of the amount due. Clients are only allowed one Charge Dispute.

I have read and understand the above policies and agree to the terms of services rendered.

_____ _____

Client Name (Printed) Date

_____ _____

Client Signature Date

ORIENTATION FORM Client Name: _____

Signing In – All Clients must sign in at the front desk for ANY AND ALL SERVICES completed at the agency. You must sign in one line per event attended. This is crucial to ensuring that you receive credit for attending services. You will be given a poker chip to give to your group or 1:1 counselor as indication that you have signed in.

Please refer to the Client Handbook for hours of all our locations (Downtown ABQ, Westside/RR, and Las Cruces)
Hours of Operation (ANA Downtown) = Monday – Thursday 9am-8pm, Fridays 9am-6pm, Saturdays 9am-3pm.
Drug Screening Hours = Monday – Thursday 9am-7:30pm, Fridays 9am-5:30pm, Sat. 9am-2:30pm
Note: Norchem testing hours are different than 5 Panel Drug Screening hours
Norchem Hours: M-Fri. is 9am-5:45pm
BAC hours are also different – M-Fri. 4:30pm-6pm, Sat. 11am-1pm.

Bathroom Location = 2nd Floor, near the elevators/ center of the building – you must get a key from the upstairs front desk
Group Rooms = rooms are listed on the "Group Schedule" – look for the room # painted on the wall next to the room
Session Durations – It is very important that you are on time for all group and individual sessions. If you are more than 15 minutes late to any session, you will be in non-compliance. Please refer to the "Reasons for Non-Compliance" sheet of your Intake paperwork.

- All Individual Sessions last for **50 MINUTES**, NOT A FULL HOUR. Counselors need time to do their notes after the session
- All Case Management Sessions last **25 MINUTES,** NOT 30 MINUTES. Counselors need time to do their notes after the session
- All Domestic Violence Groups must last **90 minutes** to meet state legal compliance.

Grievance Procedure = A New Awakening, Inc has a policy for clients with legitimate complaints against the agency, an employee, or a volunteer serving on behalf of the Agency.

1. The client is requested to first discuss the matter with the employee(s) or volunteer(s) involved. If the matter is not resolved the client is requested to talk directly to the employee(s) immediate supervisor(s). If the complaint is not resolved at this administrative level then the client will proceed to documentation.
2. The client will write the complaint on the approved form. Copies of the form may be obtained at the Front Desk.
3. The client will provide a copy of the complaint to: The employee(s) or volunteer(s) involved, the immediate supervisor, and the Executive Director within three working days of the meeting with the supervisor
4. The complaint will be investigated by the Executive Director, his/her designee. If a resolution is not reached at that level, the complaint will be referred to the Board of Directors.

Policy and Procedure about reporting elderly abuse, child abuse, neglect or exploitation to the state = Clients shall be informed of the agency's standards regarding the protection of clients, in-house client grievance policies and procedures reporting client abuse, neglect, or exploitation to the State of New Mexico, including the telephone number to report abuse to the State Licensing Board. The provisions regarding the grievance procedures and reporting to the state do not apply to persons incarcerated in local correctional facilities. A New Awakening, Inc. shall not discourage or prevent a client from contacting the State. Additionally, during the Initial Intake process, all clients are informed of their legal obligation to adhere to the New Mexico statutory requirements concerning the mandatory reporting of suspected child abuse and neglect.
Confidentiality is waived in cases of suspicion of child abuse, neglect, or exploitation, or of elderly abuse as all clinical staff are mandated reporters of any suspicion of abuse or neglect. All clients are notified of this policy during the Intake process and this policy is also posted in the front desk area in plain view.

ORIENTATION FORM (cont.)

- In cases of suspicion of child or elderly abuse, clinical staff will make a report to the state at the following number: **(1-800-797-3260)** .
- The Clinical Supervisor will be notified as well as an Incident Initial and Follow-up Assessment Sheet completed. During clinical operations, if a client wishes to make a report to the state regarding child abuse, neglect, exploitation, and/or elderly abuse, clinical staff will assist the client.
- No Client shall be discouraged or prevented from contacting the State regarding clinical matters of neglect and/or misconduct. The number for the State Licensing Board is
- In cases of threat of suicide/harm to self and/or others (homicidal intentions), confidentiality will be waived and legal authorities notified, as well as the Clinical Supervisor. An Incident Initial/Follow-up Assessment Sheet will be completed.

Parking = Metered Parking is available on 1st Street and Roma and the surrounding streets. There is also a dirt lot with parking available for $2.25. Do not park in any undesignated areas. Do Not attempt to park at meters without paying (Your car will be ticket and/or towed). After 6pm and on the weekends, all parking is free.

Intoxication = It is the policy of A New Awakening, Inc. that clients attending services at the agency who show up intoxicated be ASKED TO REMAIN IN THE FACILITY for safety purposes.

If there are any suspicions of intoxication of any client on any substance, Clients are asked to remain in the facility until such time as they can be medically assessed and safely transported either home or to an appropriate medical treatment facility. An Incident Report will be made and filed in the Incident Reporting Manual. All proper Incident Reporting procedures will be followed.

Weapons and Illicit substances – It is the policy of A New Awakening, Inc. that it is prohibited to bring any weapons or illicit substances into the facility at any time. If such actions are suspected, individual may be refused services and/or asked to leave the facility. An incident report will be completed and law enforcement may be notified.

Treatment Team Approach = For the purposes of providing excellent clinical care, A New Awakening, Inc. functions as a treatment team, meaning that all clinical staff work together to ensure that clients are giving the best clinical care and have access and proper referrals to community resources.

Infectious Diseases and Contagions Policy and Procedure = A New Awakening, Inc. shall maintain standards that describe the methods for assessing clients involved in high-risk behavior for communicable disease, including the human immunodeficiency virus (HIV) and hepatitis B and C virus (HB/CV). The program shall encourage persons found to be at risk of HIV and or TB exposure to submit to voluntary testing upon referral. General physical health questions are discussed during the assessment process that occurs at A New Awakening, Inc., AMCI, Pathways, or other referring agencies, especially those assessment questions about high-risk behaviors. If upon assessment the client is at high-risk of possibly being infected with HIV, HB, CV, or other infectious disease, the client will be referred to the most appropriate medical facility for voluntary testing. Any client presenting with symptoms suspicious of being an infectious disease such as measles, mumps, etc., a report will be made by the first observing staff member to the county health department. Clients with infectious diseases will be referred to the closest medical facility. All information regarding this matter will be noted in the client record.

_____ _____

Client Name (Printed) Date

_____ _____

Client signature Date

RANDOM URINE/ DRUG SCREEN AGREEMENT

Client name:_____ Date:_____

As part of your program plan you are required to participate in a system of random urine drug screening as well as BAC (Breath Alcohol Content) until such time as your counselor, tracker, probation or pretrial officer, the courts, or the ANA office staff informs you it is no longer needed. If you are referred by drug court, your participation in drug screening/BAC screening is mandatory.

IF YOU ARE TESTED FOR A BAC AND REGISTER A POSTIVE RESULT OF ANY KIND YOU WILL BE ALLOWED TO TEST ONLY ONCE MORE WITHIN A 15 MINUTE WINDOW. SHOULD YOU CONTIUE TO DISPLAY ANY POSITIVE RESULTS THE FOLLOWING ACTIONS WILL TAKE PLACE:

1. **YOU WILL NOT BE PERMITTED TO ATTEND PROGRAMMING WHILE REGISTERING A POSITIVE BAC.**
2. **YOU WILL NOT BE PERMITTED TO LEAVE THIS FACILITY TO OPERATE A VEHICLE , A SOBER DRIVER MUST COME TO THE OFFICE TO VERIFY A RIDE AND ALLOW YOU TO LEAVE THE FACILITY.**
3. **SHOULD YOU CHOOSE TO LEAVE THE FACILITY WITHOUT A DESIGNATED DRIVER THE ALBUQUERQUE POLICE DEPARTMENT WILL BE CALLED AND A POLICE REPORT WILL BE FILED AGAINST YOU.**
4. **YOU MAY REMAIN IN OUR FACILITY (AS LONG IT IS WITHIN NORMAL BUISNESS HOURS AND IF BEHAVIOR IS APPROPRIATE TO THE FACILITY) UNTIL A NEGATIVE BAC IS ACHIEVED TO OPERATE YOUR VEHICLE.**
5. **IF YOU BLOW A BAC ABOVE .19 THIS AGENCY VIEWS THIS AS A MEDICAL EMERGENCY AND ANA STAFF WILL DISPATCH EMERGENCY MEDICAL SERVICES.**

ALL CLIENTS ATTENDING UNDER SUPERVISION OF THE COURTS WILL BE REPORTED TO THEIR REPORTING OFFICIAL FOR ANY POSITIVE BAC.*

I have read and agree to participate in the random Urine Drug Screen Program as specified in this agreement.

_____ _____

Client Signature Date

RANDOM URINE/ DRUG SCREEN AGREEMENT

The results of any drug screening done by A New Awakening, Inc. will be used for the purposes of:

- Communication about client's compliance with abstaining from substance use between A New Awakening, Inc. and the client's probation officer, tracker, the courts, or any other supervising entity. Clients must sign a release of information to the appropriate entity in order for such communications to be made.
- Clinical Operations and Treatment recommendations
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
- All Clients referred for Domestic Violence counseling must submit to BAC before all groups. This is for the protection of all group members.

The ANA office is open for collection of Urine Drug Screens and BAC screens during the following hours. UDS specimens will not be collected at any other time.

Monday – Thursday	**9:00am to 7:30pm**
Friday	**9:00am to 5:30pm**
Saturday	**8:30am to 2:30pm**

DRUG COURT AND DOMESTIC VIOLENCE CLIENTS ARE REQUIRED TO BAC FOR EACH SESSION OR AT DESIGNATED TIMES AS ASSIGNED BY THE DISTRICT COURT. BAC COMPLIANCE TIMES ARE:

Monday – Friday	**4:30 pm – 6:00 p.m.**
Saturday	**11:00 am – 1:00 pm**

I have read and agree to participate in the random Urine Drug Screen Program as specified in this agreement.

_____ _____

Client Signature Date

Intake Mental Health Screening Tool

(Please fill out the following information)

Client Name (Printed): _____ Client's Signature_____

Past Psychiatric History:

Prior Treatment? □ Yes □ No If Yes, was treatment successful? □ Yes □ No

When?	Where?	Comments about prior treatment:

Medical History:

Name of Primary Care Physician: _____ Phone: _____

Document Obtained: □ Release of Information

Do you have any Medical Conditions (If yes, please list):

_____

Do you have any Allergies (If yes, please list):

_____

Are you on any Psychotropic Medications (If yes, please list):

_____

Are you on any Other Medications (If yes, please list):

_____

Have you ever been hospitalized for a Medical reason (If yes, please list):

_____

Comments: _____

Please answer the following questions with a "yes" or "no" response.

YES	NO	Counselor will evaluate:
		Anxiety – In the last 12 months, have you had significant worry, fear, over concern for your present or future including concern about your physical well being: Comments:
		Dangerousness – Have you ever been suicidal or homicidal? Have you ever had a plan to commit suicide or homicide? Comments:
		Head Trauma – Do you have a history of head trauma, seizure or loss of consciousness Comments:
		Mood Disorder – Have you ever been told you have depression, severe anxiety, bipolar, manic-depression, or other mood disorder? Comments:
		Psychosis: Have you ever seen something or someone that wasn't really there or heard something or someone that wasn't really there? Comments:
		Past History of Abuse – Do you have a past history of severe physical, emotional, or sexual abuse, especially in early childhood? Comments:
		Have you ever felt afraid of being hurt by your partner?
		Have you ever been hurt by your partner?
		Have you ever hurt your partner?
		Have you ever been afraid or concerned that you might hurt your partner?

Recommendations:
□ Substance Abuse Track □ Client referred for BioPsychSocial Assessment or □ DV Assessment

Client Name (Printed): _____

Client's Signature_____

□ AMCI □Self Pay Sliding Scale □ ATR □ Self Pay □ Medicaid □ Drug Court □ Prob./Par. MH Purple □ Pink DV Contract –CYFD □ Other: _____

Michigan Alcohol Screening Test

Client Name: _____ Date: _____

Please check the answers to the following YES or NO **questions regarding the last 12 months of your history**:

Questions:	YES	NO
1. Do you feel you are a normal drinker? ("normal" – drink as much or less than most other people)		
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?		
3. Does any near relative or close friend ever worry or complain about your drinking?		
4. Can you stop drinking without difficulty after one or two drinks?		
5. Do you ever feel guilty about your drinking?		
6. Have you ever attended a meeting of Alcoholics Anonymous (AA) for your own drinking issues?		
7. Have you ever gotten into physical fights when drinking?		
8. Have drinking ever created problems between you and a near relative, close friend, or partner?		
9. Have any family member, close friend, or partner gone to anyone for help about your drinking?		
10. Have you ever lost friends or a partner because of your drinking?		
11. Have you ever gotten into trouble at work because of drinking?		
12. Have you ever lost a job because of drinking?		
13. Have you ever neglected your obligations, your family, or your work for 2 or more days in a row because you were drinking?		
14. Do you drink before noon fairly often?		
15. Have you ever been told you have liver trouble such as cirrhosis?		
16. After heavy drinking, have you ever had delirium tremors (DTs), severe shaking, visual or auditory (hearing) hallucinations?		
17. Have you ever gone to anyone for help about your drinking?		
18. Have you ever been hospitalized because of drinking?		
19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?		
20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was a part of the problem?		
21. Have you been arrested more than once for driving under the influence of alcohol?		
22. Have you ever been arrested, even for few hours because of other behavior while drinking? (if yes, how many times?)		
Please score one point if you answered the following: 1. NO; 2. YES; 3. YES; 4. NO; 5. YES; 6. YES; 7.-22. YES **0-2 = No Apparent Problem 3-5 = Early or Middle Problem Drinker** **6+ = Problem Drinker**	**Score:**	

□ Due to no presented Alcohol problem, client was not referred for substance abuse treatment

□ Due to a suspected alcohol problem, client was offered outpatient substance abuse treatment with funding suggestions and information about A New Awakening, Inc. outpatient substance abuse treatment services

□ Client declined services or referral □ Client agreed to participate in outpatient substance abuse treatment

□ AMCI □Self Pay Sliding Scale □ ATR □ Self Pay □ Medicaid □ Drug Court □ Prob./Par. MH Purple □ Pink DV Contract –CYFD □ Other: _____

Drug Abuse Screening Test

Client Name: _____ Date: _____

Please check the answers to the following YES or NO questions **regarding the last 12 months of your history**:

Questions:	YES	NO
1. Have you ever used drugs other than those required for medical reasons?		
2. Have you abused prescription drugs?		
3. Do you abuse more than one drug at a time?		
4. Can you get through the week without using drugs (other than those required for medical reasons)?		
5. Are you always able to stop using drug when you want to?		
6. Do you abuse drugs on a continuous basis?		
7. Do you try to limit your drug use to certain situations?		
8. Have you had "blackouts" or "flashbacks" as a result of drug use?		
9. Do you ever feel bad about your drug abuse?		
10. Does your partner or parents ever complain about your involvement with drugs?		
11. Do your friends or relatives know of suspect you abuse drugs?		
12. Has drug abuse ever created problems between you and your partner?		
13. Has any family member ever sought help for problems related to your drug use?		
14. Have you ever lost friends because of your use of drugs?		
15. Have you ever neglected your family or missed work because of your drug use?		
16. Have you ever been in trouble at work because of drug abuse?		
17. Have you ever lost a job because of drug abuse?		
18. Have you gotten into fights when under the influence of drugs?		
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?		
20. Have you ever been arrested for driving under the influence of drugs?		
21. Have you engaged in illegal activities to obtain drugs?		
22. Have you ever been arrested for possession of illegal drugs?		
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?		
24. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, or bleeding)?		
25. Have you ever gone to anyone for help for a drug problem?		
26. Have you ever been hospitalized for medical problems related to your drug use?		
27. Have you ever been involved in a treatment program specifically related to drug use?		
28. Have you been treated as an outpatient for problems related to drug abuse?		
Please score one point if you answered the following: 1.-3. YES; 4. and 5. NO 6.-28. YES **0-2 = No Apparent Problem 3-5 = Mild to Moderate Drug Problem** **6+ = Drug Abuse or Dependence Problem**	**Score:**	

□ Due to no presented Drug problem, client was not referred for substance abuse treatment

□ Due to a suspected Drug problem, client was offered outpatient substance abuse treatment with funding suggestions and information about A New Awakening, Inc. outpatient substance abuse treatment services

□ Client declined services or referral

□ Client agreed to participate in outpatient substance abuse treatment