Anishinaabe Endaad Program Application

DEMOGRAPHICS

First name:		Last name	
Previous name:		Indian/Alias name:	
Address:			
City:	State:	Zip:	
Phone:	Email:		
DOB:	SSN:	MA#:	OID#:
Gender: ☐ Male ☐ Female ☐ Transgender M/F ☐ Transgender F/M ☐ Other			
Race (select all that apply): ☐ White ☐ Black or African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic, Latino, or Spanish origin ☐ Middle Eastern or North African ☐ Some other race, ethnicity, or origin			
Are you enrolled: ☐ Yes ☐ No Tribe:			
Are you a descendant: ☐ Yes ☐ No Tribe(s):			
Veteran: ☐ Yes ☐ No			
Have you ever been incarcerated: ☐ Yes ☐ No if applicable, release date: / /			
Are you currently incarcerated: ☐ Yes ☐ No if applicable, release date: / /			

INCOME

Do you receive or expect to receive income from the following sources?

☐ Employment - wages, tips, other	☐ Unemployment	☐ Death benefits
☐ Supplemental social security (SSI)	☐ Severance pay	☐ Rental property
☐ Long / short-term disability	☐ Self-employment	☐ Annuity(ies)
☐ Social security - Federal (SS)	☐ Social security - State	☐ Armed force pay
☐ Cash received for labor	☐ Student financial aid	☐ Public assistance
☐ Gifts (cash or non-cash)	☐ Whole life insurance	☐ Alimony
☐ Tribal per-cap payments	☐ Retirement benefits	☐ Child support
☐ Adoption assistance	☐ Inheritance	☐ Pension
☐ Foster care payments		

Estimated annual household income: $_____

ASSETS

Do you have money held in any of the following:

☐ Investment items (coins, stamps etc)	☐ 401k	☐ Checking account
☐ Lump sum money received	☐ IRA	☐ Savings account
☐ Certificate of deposit (CD)	☐ Retirement accounts	☐ Cash card/EBT
☐ Capital investments/securities	☐ Stocks and/or bonds	☐ Money market
☐ Insurance settlements	☐ Treasury bills	☐ Real estate
☐ Whole life insurance	☐ Annuity accounts	☐ Contract for deed
☐ Jointly held accounts	☐ Mutual funds	☐ Safety deposit box
☐ Funeral accounts	☐ Inheritance	☐ Real estate
☐ Lottery winnings	☐ Trusts	

Current value of all combined assets: $_____

EDUCATION, WORK EXPERIENCE AND SKILLS

Program participants are expected to attend 20+ hours of structured activity. Please tell us about your education, skills, and work experience.

I have my GED or high school diploma? ☐ Yes ☐ No

Adult Education (select any that apply)

☐ No college ☐ Some College ☐ Associate's ☐ Bachelor's ☐ Master's

I'm interested in the following structured commitments. (choose any that apply)

☐ Job training program ☐ Volunteer ☐ Work
☐ Technical college/ university ☐ GED classes ☐ Other

Previous employers

Company	Position	Start date	End date

Please tell us about your skills and abilities. What are you good at?

_____

_____

_____

Please tell us about your hobbies. What do you enjoy doing?

_____

_____

_____

INDEPENDENT LIVING

	Yes	No		Yes	No
I can prepare my own meals	☐	☐	I have a driver's license	☐	☐
I'm willing to complete a daily chore	☐	☐	I can do my own laundry	☐	☐
I require special accommodations	☐	☐	I have my own car	☐	☐

If you require special accommodations, please describe:

_____

_____

CULTURAL KNOWLEDGE AND HISTORY

Have you participated in the following cultural activities?

☐ Smudging	☐ Sweat lodge	☐ Sugar bush	☐ Sun dance
☐ Berry picking	☐ Beading	☐ drawing /painting	☐ Powwow
☐ Hunting and fishing	☐ Lacrosse	☐ Other	

HISTORY OF HOMELESSNESS

The following questions will help us determine if you meet the definition for long-term homelessness.

Are you currently homeless? ☐ Yes ☐ No ☐ currently incarcerated or in a facility

If you're homeless, where did you sleep last night? _____

How many times have you slept outside during the previous 36 months, exclude time spent living in an institution or in jail/prison?_____

How many times have you unexpectedly crashed with friends or family during the previous 36 months, exclude time spent living in an institution or in jail/prison?_____

How many times have you road public transit because you didn't have a place to sleep during the previous 36 months, exclude time spent living in an institution or in jail/ prison?_____

How many times have you stayed in shelter during the previous 36 months, exclude time spent living in an institution or in jail/prison?_____

INCARCERATION AND INSTITUTIONAL HISTORY

Please tell us about your experience living in institutions or incarcerated?

1) Do you currently reside in an institution? ☐ Yes ☐ No (if no, skip to question 2)

If yes, what type of institution?

☐ County jail or workhouse ☐ Drug treatment program ☐ Group home
☐ State or federal prison ☐ Mental health facility ☐ Halfway house
☐ Other: _____

If yes, were you homeless the night before you were institutionalized or incarcerated? ☐ Yes ☐ No

2) How many times have you been incarcerated in a jail or workhouse?_____

3) How many times have you been incarcerated in prison?_____

4) How many felonies do you have?_____

5) Do you have any sex offenses? ☐ Yes ☐ No

If yes, what level (1-3)?_____

6) History of violent offenses? ☐ Yes ☐ No

If yes, describe the circumstances for each violent offense:

_____

_____

7) Do you have any restrictions where you can live? ☐ Yes ☐ No

If yes, describe the restrictions:

_____

_____

Drug and Alcohol Use / Treatment History

Are you currently in drug or alcohol treatment? ☐ Yes ☐ No

Date of last use: _____

Drugs used in your lifetime?

☐ Marijuana/weed	☐ Alcohol	☐ Inhalants	☐ Nicotine
☐ Barbiturates/sedatives/hypnotics	☐ Crack	☐ Ibogaine	☐ Gabapentin
☐ Meth/amphetamines	☐ Heroin	☐ Mushrooms	☐ Cocaine/Coke
☐ Benzodiazepines	☐ LSD	☐ Ecstasy	☐ Other opiates/opioids

Drugs used in the past 12 months?

☐ Marijuana/weed	☐ Alcohol	☐ Inhalants	☐ Nicotine
☐ Barbiturates/sedatives/hypnotics	☐ Crack	☐ Ibogaine	☐ Gabapentin
☐ Meth/amphetamines	☐ Heroin	☐ Mushrooms	☐ Cocaine/Coke
☐ Benzodiazepines	☐ LSD	☐ Ecstasy	☐ Other opiates/opioids

Have you ever injected drugs? ☐ Yes ☐ No

What is the longest period of sobriety you've had outside of an institution?_____

How many times have you been in outpatient treatment?_____

How many times have you been in inpatient treatment?_____

How many times have you overdosed on pills or heroin?_____

Has anyone revived you with Narcan? ☐ Yes ☐ No

Are you currently being treated with the following medications?
☐ Suboxone or Buprenorphine ☐ Methadone ☐ Vivitrol

Have you ever been prescribed the following medications?
☐ Suboxone or Buprenorphine ☐ Methadone ☐ Vivitrol

Are you interested in the following anti-relapse medication for preventing heroin or opioid cravings?
☐ Suboxone or Buprenorphine ☐ Methadone ☐ Vivitrol

Mental Health Questionnaire

When was the last time you had significant problems with:

	Past month	2-12 months	1+ year ago	Never
feeling trapped, lonely, sad, depressed or hopeless about the future?	☐	☐	☐	☐
trouble sleeping, such as bad dreams, sleeping restfully, or falling asleep during the day?	☐	☐	☐	☐
feeling very anxious, nervous, tense, scared, panicked, or like something bad is going to happen?	☐	☐	☐	☐
becoming very distressed and upset when something reminded you of the past?	☐	☐	☐	☐
thinking about ending your life or committing suicide?	☐	☐	☐	☐

Have you ever been diagnosed with the following mental health disorders?

☐ Schizophrenia or schizoaffective	☐ Major depression	☐ Unsure
☐ Borderline personality disorder	☐ Bipolar	☐ Other

If yes, when were you diagnosed?_____

Do you have a traumatic brain injury (TBI)? ☐ Yes ☐ No

Do you have a case manager or ARMHS Worker? ☐ Yes ☐ No

Are you seeing a therapist? ☐ Yes ☐ No

Are you being treated by a Psychiatrist? ☐ Yes ☐ No

List of current medications:_____

RECOVERY QUESTIONNAIRE

Do you have a sponsor, spiritual advisor or mentor? ☐ Yes ☐ No

Do you or will you use the following recovery approaches?

	Yes	No	Maybe
Alcoholics Anonymous (AA)	☐	☐	☐
Narcotics Anonymous (NA)	☐	☐	☐
Wellbriety or White Bison	☐	☐	☐
Talking circle	☐	☐	☐
Ceremony	☐	☐	☐
Smart Recovery	☐	☐	☐
Cultural or sober activities	☐	☐	☐
Activism	☐	☐	☐
Exercise and wellness	☐	☐	☐

On a scale from 1-5, how would you rate your knowledge of Native American culture and practices? _____

Tell us about your recovery?

_____

_____

Tell us about your spirituality?

_____

_____

How do you handle conflict?

_____

_____

What are you working on personally?

_____

_____

What are your goals and aspirations in life?

_____

_____

What do you need to be successful?

_____

_____

MOVE IN LOGISTICS

Requested move in date: _____

Requested bedroom size

☐ Single or double room (shortest waitlist) ☐ Single room only (longer waitlist ☐ Double room only

Bedroom furnishing

☐ Yes, please furnish my bedroom ☐ No thank you, I'll furnish my own room

PROFESSIONAL AND PERSONAL REFERENCES

Please provide contact information for one personal reference and up to two professionals in your life who can help us get to know you better. You will need to sign a release of information so we can contact each of them. Professional example: Release Planner, Case Manager, Counselor, Therapist, Parole/Probation Officer, Outreach Worker, Spiritual Advisor. Personal example: grandparents, siblings, cousins, or a close friend.

Application completed by?

☐ Self ☐ Case Worker or Professional ☐ Family member ☐ Other:_____

Professional Reference

First name:	Last name	
Address:		
City:	State:	Zip:
Phone:	Email:	
Relationship:		

Professional Reference

First name:	Last name	
Address:		
City:	State:	Zip:
Phone:	Email:	
Relationship:		

Personal Reference

First name:	Last name	
Address:		
City:	State:	Zip:
Phone:	Email:	
Relationship:		

Applicant Signature: _____ Date: _____

Rev. 1.0
10/14/2019

ANISHINAABE ENDAAD (AE)

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY/PERSON	NAME OF PERSON/ORGANIZATION/FACILITY Adam Fairbanks / Anishinaabe Endaad
ADDRESS	ADDRESS 4309 Queen Ave North
CITY/STATE	CITY/STATE Minneapolis, MN 55412

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____

☐ Personal Use ☐ Insurance ☐ Disability ☒ Health Information Exchange (/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☒ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☒ Mental Health *(Other than Psychotherapy Notes)*

☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

NAME *(Last, First, MI)*

ADDRESS

CITY/STATE	DATE OF BIRTH

Rev. 1.0
10/14/2019

ANISHINAABE ENDAAD (AE)

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY/PERSON	NAME OF PERSON/ORGANIZATION/FACILITY Adam Fairbanks / Anishinaabe Endaad
ADDRESS	ADDRESS 4309 Queen Ave North
CITY/STATE	CITY/STATE Minneapolis, MN 55412

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____

☐ Personal Use ☐ Insurance ☐ Disability ☒ Health Information Exchange (/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☒ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☒ Mental Health *(Other than Psychotherapy Notes)*

☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

NAME *(Last, First, MI)*

ADDRESS

CITY/STATE	DATE OF BIRTH

Rev. 1.0
10/14/2019

ANISHINAABE ENDAAD (AE)

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY/PERSON	NAME OF PERSON/ORGANIZATION/FACILITY Adam Fairbanks / Anishinaabe Endaad
ADDRESS	ADDRESS 4309 Queen Ave North
CITY/STATE	CITY/STATE Minneapolis, MN 55412

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____

☐ Personal Use ☐ Insurance ☐ Disability ☒ Health Information Exchange (/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☒ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☒ Mental Health *(Other than Psychotherapy Notes)*

☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

NAME *(Last, First, MI)*

ADDRESS

CITY/STATE	DATE OF BIRTH

AVIVO

Chemical and Mental Health, 1900 Chicago Avenue, Minneapolis, MN 55404
MAIN 612.752.8000 | FAX 612.752.8001 | avivomn.org
A proud partner of the American Job Center network

Avivo (formerly RESOURCE) Authorization to Obtain/Release Confidential Information

I, _____, _____, authorizes **David Jeffried / Red Lake Program** to
(First & Last Name) (DOB) (Avivo staff member)

☒ Obtain records/ information from ☒ Release Records/ information to:

Contact/Healthcare Professional Name:	
Agency/Entity:	
Phone:	Fax:

Reasons for Releasing Information:

☒ Coordination of ongoing treatment ☐ Transfer of Care ☐ Evaluation/Treatment ☐ Legal

☐ Social Security Disability determination ☐ Other: _____

Information to be released

IMPORTANT: Indicate only the information that you are authorizing to be released.

☐ Specific dates/years of treatment _____

☒ All health *information (If you select this, it will include any information about you related to mental health evaluation,, concerns about drug and/or alcohol use, and any reported health information/diagnosis/testing results.)*

OR to only release specific portions of your health information, indicate the categories to be released:

☐ Rule 25 Assessment (please check chemical dependency box below)
☐ Diagnostic Assessment ☐ Case Management Notes ☐ Discharge summary
☐ Progress notes ☐ Billing records
☐ Housing Information ☐ Other information or instructions _____

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

☐ Chemical dependency program *(This information comes from a program/provider that specficially assesses and treats alcohol or drug addictions and receives federal funding. This type of health information is different from notes about a conversation with your physician or therapist about alcohol or drug use. To have this this type of health information sent, check this box).*

☐ Psychotherapy *notes (Consent cannot be combined with any other. Only this box should be checked if requesting psychotherapy notes). Name of professional providing psychotherapy notes:* _____

This information includes written and oral information.

I understand that by signing this form, I am requesting that the health information specified in the check boxes above be sent to the third party named above.

I may stop this consent at any time by writing to the organization(s) facility(ies), and/or professional(s) named above.

If the organization, facility, or professional named above has already released health information based on my consent, my request to stop will not work for that health information.

I understand that when the health information specified in the check boxes is sent to the third party above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the organization to which information is sent is a health care provider, they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

If I choose not to sign this form and the organization to which information is sent to is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care.

This release of information is effective for one year of the signature date, unless an alternate date is specified here _____.

Client's signature _____ Date ____/____/____
MM DD YYYY

OR legally authorized representative's signature _____ Date ____/____/____
MM DD YYYY

Representative's relationship to patient (parent, guardian, etc.) _____

Avivo Staff Signature _____ Date ____/____/____

ANISHINAABE ENDAAD (AE)

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY OF YOUR PRIVACY RIGHTS

- Understanding your privacy rights. The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical/mental health records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. HIPAA gives you rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.
- Understanding what is in your medical record and how the information is used helps you to:
  - Ensure its accuracy
  - Better understand why others may review your health information
  - Make informed decisions when authorizing disclosures
- You are never required to sign a release of information (ROI). However, we may not be able to determine your eligibility if we are unable to gather the information required to process your application.
- You have a right to restrict and limit who we talk to and what we can disclose about you.
- You have the right to request, inspect and receive a copy of your protected health information.

NOTICE OF PRIVACY PRACTICES

- The information you provide to AE is confidential and used to determine your eligibility for sober housing. The property owner will use the collected information to gather/determine your:
  - criminal background
  - financial eligibility for sober house funding
  - recovery goals and objectives
  - interest and knowledge of cultural practices
  - eligibility for case management
  - Insurance status
- Secure Storage: Your personal information is stored in a HIPAA compliant cloud storage environment. Additional information regarding HIPAA compliant GSuite cloud storage can be found at: https://static.googleusercontent.com/media/gsuite.google.com/en//terms/2015/1/hipaa_implementation_guide.pdf
- Collateral Contacts: We will contact your professional and personal references so we can learn more about you. The information discussed will be limited to what you authorize through an ROI.
- We may disclose how many Tribal affiliated individuals live at AE but we will not disclose your name or enrollment information without your written consent.
- Disclosures to house members: The information disclosed to house members is limited to your responses in the Recovery Questionnaire of the application.
- We may use and disclose your confidential information for obtaining program fees/reimbursement. An example would be sending an invoice to a funder to pay your rent.
- We may disclose your information in the event of a medical emergency.
- Redisclosures. We may redisclose your protected health information, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, if we receive a request signed by you.

SUMMARY OF OUR REQUIREMENTS

- We are required by law:
  - To maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy with respect to your protected health information.
  - To abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice of provisions effective for all protected health information that we maintain. We will post and you may request a copy of a revised Notice of Privacy Practices at any time.
- You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

_____

Printed Name

_____

Signature

_____

Date

Revision date: 10/18/2019