Florida Center for Addictions and Dual Disorders

100 West College Drive
Avon Park, Florida 33825
Phone: 863.452.3858 Fax: 863.452.3863

The Florida Center for Addictions and Dual Disorders is a residential facility for Florida residents who suffer with co-occurring substance dependence and moderate psychiatric disorders. It is licensed by the Florida Department of Children and Families and monitored by the Commission on Accreditation of Rehabilitation Facilities [CARF]. The program is for adults only and incorporates a variety of therapeutic strategies including:

***Individual and Group Therapy *Psycho-Educational Modules *Psychiatric Evaluation**

***Recreational Therapy *HIV Screening and Counseling *Medication Management**

***AA/NA/Double Trouble Meetings *Transitional Living Monitoring *Drug Screens**

About the Florida Center

The primary focus of the program is to treat substance dependence and mental disorders simultaneously. Residents are educated about their co-occurring disorders and provided increased understanding of them. The treatment for substance dependence relies heavily on the Twelve Step Program and on the Disease Model of Addiction and Recovery. The residents are asked to follow the Four Phases listed below.

Phase I- Assessment: The Assessment Phase combines evaluative processes, psycho-educational groups, and an orientation schedule to provide a period of intensive engagement over the first three to four weeks of treatment.

Phase II – Treatment: Upon moving to this phase, residents are expected to fully engage in treatment and make forward progress on individual treatment goals developed with their counselor. There are greater expectations for participation in treatment and increased responsibilities for residents. Residents are also expected to also demonstrate empathy regarding fellow residents.

Phase III – Continuing Care: Residents in this phase maintain all the responsibilities along with the added component of developing a plan of transitioning into a transitional living placement such as a half-way house.

Phase IV – A Minimum of 90 Days in Transitional Housing: Individuals will transition from the 65-day residential program and maintain all the responsibilities of Phase I – III but will do so in community-based housing. This placement should have been identified prior to admission to the Florida Center. Residents are also required to attend 90 self-help meetings [AA/NA] in 90 days.

Upon completion of Phase IV, A "Certificate of Completion" is provided to the Resident.

Admission Criteria

- Applicant must be an adult (18 years of age or older) and a resident of the state of Florida
- Applicant must be diagnosed with a Substance Dependence Disorder and a Mental Health Disorder by a qualified professional
- Applicant must demonstrate the need for Residential Level II treatment.
- Applicant must be able to demonstrate emotional stability as evidenced by medication compliance and no homicidal or suicidal ideation present within the past 60 days
- Applicant must be free from medical/dental conditions which would require extensive nursing care or that would inhibit full participation in program components. In addition, the applicant must be ambulatory and capable of self-care.
- Applicant must agree to be Nicotine and Tobacco free. *(Medically approved nicotine patches permitted and may be provided.)*
- Applicant may be on probation, parole, community control, or house arrest, but must be free from obligations to court appearances which would inhibit full participation in the program.
- Applicant must be willing to participate in all four of the phases of treatment including the 90-day transitional housing component to receive a "Certificate of Completion."

The Florida Center for Addiction and Dual Disorders is in Highlands County located on the South Florida State College campus. The environmental surroundings of the Center and the College work jointly to ensure proper safety and housing of the residents. Applicants are individually reviewed by our admissions committee and each case is given personalized attention. Considerations, if possible, are made in each applicant's situation.

However, there are ***some*** reasons an applicant may be denied entry into the program including:

- Pattern or recent charges of violence
- Arson charges
- Sexual-related Charges and Crimes
- Child and Elderly Abuse Charges
- Severe, chronic, unmanaged mental illness
- Recent history of non-compliance with prescribed medications

APPLICATION CHECKLIST

____ **Applicant Statement (page 4)**

____ **Applicant and Referral Agreement (page 5)**
-Must be completed in full, signed, initialed where requested and witnessed

____ **Application for Treatment (pages 6 & 7)**

____ **Consent for Release of Information (pages 8 & 9)**
-Applicant needs to complete for anyone that they give permission to in order to get information regarding their application status. Such as the referral, attorney, family, treatment facility, probation, and third part insurance information.

-If additional releases are needed, the blank release of information may be copied.

____ **Psycho-Social Assessment** (must be updated within last 30 days) **(page 10)**
-Must be completed by a qualified professional. The following are considered qualified professionals: Licensed Psychiatrist, Psychologist, Master's Level Counselor (LCSW, LMHC, etc.), or Certified Addictions Professional
-List of contents of Summary are listed on page 10
-A Mental Status Examination
--Must have Substance Use and Mental Health Diagnosis

____ **Current Medical History Form (pages 11, 12, & 13)**
-Must be completed by a medical professional
-If available, most current lab results to CHEM / CBC / RPR
-Current list of medications prescribed
-PPD or Current Chest x-ray within the last three months
-Agency Medical History Reports containing same information may be acceptable

____ **Copy of Arrest/Legal History**

____ **Aftercare Support Contact and Plan (page 14)**

____ **Copy of Insurance Cards, and Valid Photo ID**

Please mail or fax the admission packet to:

The Florida Center for Addictions and Dual Disorders
Admissions Department
100 West College Drive
Avon Park, Florida 33825
Fax Number: (863) 452-3863

All forms in the admission packet must be completed fully, legibly, and accurately by the applicant and referral representative to begin the review process.

Florida Center for Addictions and Dual Disorders

Application for Treatment

Applicant's Statement

This statement should be in the applicant's own words and handwriting. The applicant should clearly state their reasons for seeking admission to the Florida Center. (Applicants who cannot write their own statements may dictate their response to the referral representative assisting with the application.)

I certify that all the information provided in this application is true, accurate and complete to the best of my knowledge. I understand that failure to supply all information requested, may result in my application to the Florida Center being denied. I hereby request admission to the Florida Center for treatment of my substance abuse disorder and mental illness.

_____ _____

Applicant's Signature Date

_____ _____

Referral Representative/Credentials Date

Florida Center for Addictions and Dual Disorders

APPLICANT AND REFERRAL UNDERSTANDING OF AGREEMENT

It is essential for both applicant and referral to recognize and agree to the following information. Please acknowledge by both initialing each statement and then signing in the designated signature block.

___/___ I/We understand the Florida Center is an open facility situated on a college campus.

___/___ I/We understand when applying for financial assistance through the Department of Children and Families, there is still a co-payment for services. I am responsible for the payment of all services incurred.

___/___ I/We understand that all scheduled court appearances must be delayed a minimum of 10 weeks from the date of admission. All requirements of probation, parole, community control, or house arrest must be waivered or adjusted so they will not interfere with the course of treatment.

___/___ I/We understand that I must **bring** or have the provisions to provide a 30-day supply of ALL PSYCHOTROPIC and a 65-day supply of ALL PRESCRIBED medications or the funds to purchase them.

___/___ I/We understand that transportation to and from the Florida Center must be arranged. I understand that the Florida Center is not responsible for arranging transportation. Admission hours are between 8 – 9 am.

___/___ I/We understand that I must have access to a valid Photo ID or Birth Certificate in order to be admitted into the Florida Center program.

___/___ I/We understand that I must be willing to participate **in all phases of the program.** This includes attending a halfway house after completing the 65 days of intensive residential treatment. I must also have some form of financial assistance/support for the transitional phase of treatment to offset the cost associated with the halfway house, medication, and transportation. (This information must be submitted with the application.)

___/___ I/We understand that controlled medications are not permitted at the Center. If upon arrival applicant has such medication on person, they will be asked to dispose of medication or give it to whoever brought them.

___/___ I/We understand that I must be free from medical/dental conditions that would require extensive care and that would inhibit full participation in the program's components.

___/___I/We understand that I must demonstrate emotional stability evidenced by compliance with medication management and have no suicidal or homicidal ideations present within the last sixty days.

___/___ I/We understand that I am expected to arrive at the Florida Center **sober and drug free.** If I arrive under the influence of alcohol or drugs, I may be sent to the emergency room or detox, and charged the appropriate fees as outlined in the Tri-County Human Services, Inc. guidelines.

___/___ I/We understand that an applicant statement should be written in the applicants' own words and handwriting. The statement should clearly state reasons for seeking admission into the Florida Center. **(Applicants who cannot write their own statements may dictate their responses to the referral representative assisting with the application.)**

Applicant's Signature **Date**

Referral/Credentialed Signature **Date**

Florida Center for Addictions and Dual Disorders - Application for Treatment

Demographics

Last Name:	First Name:	Middle Name:
SSN:	DOB:	Date:
Age: Gender: Race:	Marital Status:	Phone:
Address:		County:
Referral Name and Agency Affiliation		Referral Phone:

Substance Abuse History

○ **Denies any current use**					
Drug / Alcohol Use – Check all that apply	Age at Onset	Date of Last Use	Frequency / Patterns of Use	Usual Amount	Route of Admission
○ Alcohol:					
○ Crack/Cocaine:					
○ Hallucinogens:					
○ Inhalants:					
○ Marijuana:					
○ Nicotine:					
○ Opiates:					
○ Sedatives:					
○ Stimulants:					
○ Tranquilizers:					
○ Other:					
○ Other:					

Medication Information

Name of Medication	**Dose**	**Start Date**	**End Date**	**Who is Prescribing the Medication**	**Reason for taking the Medication**

Substance Abuse and Mental Health Treatment History

Level of Care	YES/NO	Name of Provider	Dates of Treatment	Reason	Outcome
Detoxification SA					
Inpatient MH					
Residential SA					
Residential MH					
Outpatient MH					
Outpatient SA					
Jail/Prison					
Baker Act					
Marchman Act					
Other SA/MH					

TRI-COUNTY HUMAN SERVICES, INC.
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____

[print or type]

My signature on this form authorize Tri-County Human Services, Inc., to exchange information as indicated below, regarding my contacts/treatments in accordance with Florida Statues and Federal Administrative Rules and Regulations.

To whom I authorize information to be received and/or disclosed:

1. **Individual(s):**
   a) _____
   b) _____
   c) _____
2. **Entity(entities) with a Treating Provider Relationship:**
   a) _____
   b) _____
   c) _____
3. **Third Party Payer(s):**
   a) _____
   b) _____
   c) _____
4. **Entity(entities) without a Treating Provider Relationship (list entity AND name(s) of individual participants; may also include general designation option as applicable:**
   a) _____
   b) _____
   c) _____

NOTICE for USE of GENERAL DESIGNATION: Participating providers must attest to having a treating provider relationship before accessing Person Served's Part 2 information. Person served has right to request List of Disclosures. Person Served request must be in writing and only has right to list of disclosures made in the past 2 years. The intermediary entity is responsible for providing the list of disclosures to the Person Served. Intermediary entity must respond to Person Served's request in 20 day or fewer. For each disclosure, list must contain: name of entity to which disclosure was made, date of disclosure, and brief description of patient indemnifying information disclosed

Information may be Released and/or Received as follows:

- ☐ Name and other personal identifying information
- ☐ Identity as an applicant for, or recipient of Substance Use Disorder and/or Mental Health Service
- ☐ Psychiatric Evaluation, including Substance Use Disorder Information
- ☐ Psychosocial Evaluation, including Substance Use Disorder Information
- ☐ Attendance, progress and compliance in Substance Abuse Disorder and/or Mental Health Services
- ☐ All drug screen/breathalyzer test results
- ☐ All medications, including Substance Use Disorder medication
- ☐ Discharge Summary/Status including Substance Use Disorder Information
- ☐ Other:_____

The purpose for disclosure, receipt, and use of information authorized by me in the document is to enable the parties to evaluate my need, coordinate, and provide service to me.

This authorization expires at the earlier of 12 months from date of client's signature OR the following date: _____

Print name of Person Served: _____

Signature of Person Served: _____

Print name of Witness: _____

Signature of Witness: _____

Date: ___/___/____ Person Served's Date of Birth ___/___/___ Person Served's SSN ____-___-____

For Personal Representative of the Client (If Applicable):

Print name of Representative: _____ Signature of Representative: _____

Describe Relationship: _____ (parent, guardian, etc.) Date: ___/___/_____

NOTICE of PROHIBITION ON RE-DISCLOSURE: This information has been disclosed to you from records by Federal Rules governing confidentiality rules (42 CFR Part 2) and Florida Statutes (394.459, 396.112, 397.053, 381.609, 455.2416, 90.503, 90.242 and CFR Part 160-164). As a lawful holder of Part 2 protected information, the Federal Rules and State Statutes prohibit you from making any further disclosure of the information with the specific written consent of the person to who it pertains.

Information used or disclosed pursuant to thus authorization may be subject to Redisclosure by the recipient and no longer be protected by the rules above. Tri-County Human Services, Inc. is released from all legal liability that may arise from the release of information requested. I understand I have the right to refuse this authorization or revoke it at a later date by submitting a written notice. I understand that I am not required to sign this authorization in order to receive treatment. When exchanging information where the patient/client is involved in treatment with other agencies/professionals to assist in coordinating treatment, this authorization may include verbal, written and/or electronic communication

Florida Center for Addictions and Dual Disorders
Application for Treatment
Psychosocial Assessment

The Florida Center for Addiction and Dual Disorders is a Level 2 Residential Treatment Center. This level is appropriate for persons characterized as having chaotic and often abusive interpersonal relationships, criminal justice histories, and/or prior substance use treatment episodes in less restrictive care. This group of people also tend to demonstrate inconsistent work histories, educational experiences, and anti-social behaviors due to substance dependence. To determine if the applicant meets criteria, a thorough psychosocial assessment is needed. The assessment needs to be completed by a qualified professional and include the following:

a. ***Emotional or mental health***. This includes but is not limited to a mental status exam (i.e. appearance, dress, attitude, behavior, content, and quality of speech with through process, intelligence, sensorium, insight and judgement, mood and affect).

b. ***Level of substance abuse impairment***. This should include the applicant's substance abuse history including onset, choice of drugs, pattern of use, consequences of use, type, and duration of, response to, and prior treatment episodes.

c. Family history including substance abuse by other family members.

d. ***Educational level, vocational status, employment history, and financial status***.

e. ***Social history and functioning***, including support network, family and peer relationships, and current living conditions.

f. ***Past or current sexual, psychological, or physical abuse or traumas***.

g. ***Legal history and status***.

h. A ***clinical summary***, including an analysis and interpretation of the results of the assessment plus recommendations.

i. <u>Diagnosis</u> by a qualified professional, licensed psychiatrist, psychologist, psychiatric nurse or a master's level therapist, (i.e. mental health counselor, clinical social worker, marriage family therapist or CAP.) Please print and sign the name of the licensed qualified professional completing the assessment.

TRI-COUNTY HUMAN SERVICES, INC.

FLORIDA CENTER FOR ADDICTIONS AND DUAL DISORDERS

NURSING ASSESSMENT AND MEDICAL HISTORY

CLIENT_____DATE OF BIRTH_____

AGE _____ SEX _____ DATE OF HISTORY/ASSESSMENT_____ LOCATION_____

HT _____WT_____BP _____T _____ P _____R _____ INTOXIMETER READING _____

TIME _____

CIRCLE APPROPRIATE ITEMS:

ALCOHOL/DRUG WITHDRAWAL HISTORY

SHAKES	STOMACH CRAMPS
SEIZURES	MUSCLE CRAMPS
HALLUCINATIONS	PARANOIA
DTS	LETHARGY
MOOD SWINGS	CHILLS/FEVER
NAUSEA	DIARRHEA
DEPRESSION	ANXIETY

PRESENTING WITHDRAWAL SYMPTOMS:
_____
_____
_____

MEDICAL HISTORY – SYSTEM REVIEW

(X) ALL THAT APPLY

NEUROLOGICAL	DATE/ONSET
CVA/TIA	_____
SEIZURE DISORDER	_____
HEADACHES	_____
ORIENTATION	_____
MOOD/AFFECT	_____
SUICIDAL IDEATION	_____
TINGLING/NUMBNESS	_____
POOR BALANCE	_____
WEAKNESS	_____

PSYCHIATRIC

ORIENTATION	_____
MOOD/AFFECT	_____
SUICIDAL IDEATION	_____

SUICIDE ATTEMPTS _____

HISTORY OF PSYCHOSIS _____

PRIOR TREATMENT _____

HEAD/EENT	DATE/ONSET
HEARING	_____
VISION	_____
FREQUENT COLDS	_____
PAIN	_____
DISCHARGE	_____
DENTAL	_____

HEAD LICE _____ PRESENT _____ NOT PRESENT
COMMENTS: _____
_____
_____

CARDIORESPIRATORY	DATE/ONSET
HTN	_____
CHEST PAIN	_____
PALPITATIONS	_____
ANGINA	_____
HEART ATTACK	_____
CLIENT _____	
COUGH/PRODUCTIVE	_____
DYSPNEA	_____
TB	_____
LAST TB TEST	_____
LAST CXR	_____
INH THERAPY	_____
NIGHT SWEATS	_____

FATIGUE _____

LAST DRUG/ALCOHOL USE:

WHAT _____ WHEN _____QTY _____

LENGTH OF USE:

ALCOHOL	DRUGS	IV USE
_____ YEARS	_____ YEARS	_____ YEARS
_____ DAYS	_____ DAYS	_____ DAYS

PRIOR DRUG/ALCOHOL TREATMENT

GASTROINTESTINAL DATE/ONSET

GALLBLADDER DISEASE _____

ULCERS _____

HIATAL HERNIA _____

INDIGESTION _____

DIARRHEA _____

STOOL CHANGES _____

CIRRHOSIS _____

HEPATITIS _____

WT LOSS _____

FOOD ALLERGIES _____

SPECIAL DIET _____

COMMENTS _____

GENITOURINARY DATE/ONSET

BURNING _____

URGENCY _____

INFECTION _____

HEMATURIA _____

STONES _____

NOCTURIA _____

HISTORY OF STD _____

DISCHARGE _____

ENDOCRINE DATE/ONSET

THYROID _____

DIABETES _____

REVIEW OF NURSING/ASSESMENT/MEDICAL HISTORY DENOTES

_____

FEMALE

PREGNANCIES _____MISCARRIAGES_____

LIVE BIRTHS _____ ELECTIVE ABORTIONS _____

LKMP _____ REGULAR ____ IRREGULAR _____

MENOPAUSE _____ LAST PAP TEST _____

IF LAST PAP WAS WITHIN (1) YEAR, ENTER

VERIFICATION IN PROGRESS NOTES.

IS PAP REFERRAL NEEDED _____ YES _____ NO

WAS PAP REFERRAL PROVIDED TO CLIENT?
_____ YES _____ NO _____ NA

PREGNANT MONTHS_____ DUE DATE _____

PREGNANCY TEST RECOMMENDED YES _____ NO _____

POST PARTUM WITHIN LAST TWO YEARS _____

DATE OF DELIVERY_____

SKIN

FEVER _____ CHILLS _____ SCARS_____

JAUNDICE _____ RASHES _____BRUISES_____

ABRASIONS _____ TATTOOS _____

MEDICATION
PAST _____

_____
PRESENT _____

_____
OVERDOSE _____

_____
ALLERGIES _____

_____
MISC/INJURIES/OPERATIONS _____

_____

PHYSICAL EXAMINATION

ONLY CURRENT MEDICAL CONDITIONS ARE TO BE DOCUMENTED. ANYTHING HISTORICAL MUST HAVE RESOLUTION INCLUDED.

CLIENT _____ DOB _____DATE OF EXAM _____

LAST FIRST MI

HEIGHT _____

WEIGHT _____

TEMP _____

P _____ R _____ BP_____

HEARING:

VISION:

DENTAL:

SKIN:

HEAD:

EYES:

NOSE:

MOUTH:

TONGUE:

NECK:

LYMPH:

RESPIRATORY:

LUNG SOUNDS:

HEART:

SOUNDS:

ABDOMEN:

LIVER:

SPLEEN:

VEINS:

DISTENDED:

HERNIA:

GENITALIA:

TESTES:

PELVIC:

KIDNEYS:

RECTAL:

EXTREMITIES:

PULSES:

EDEMA:

VARISCOSITIES:

MUSC/SKEL:

ROM:

NEUROLOGICAL:

PATH REFLEXES:

TREMOR:

SENSORY:

CEREBELLAR:

REFLEXES:

_____

PA SIGNATURE **DATE**

_____

PHYSICIAN'S SIGNATURE **DATE**

CLIENT _____

ADDRESS AND PHONE NUMBER _____

WHAT PROBLEMS (S) DOES CLIENT HAVE THAT WOULD PREVENT CLIENT FROM SELF-PRESERVATION IN THE EVENT OF EMERGENCY AT TRI-COUNTY?

_____

I CERTIFY THAT THE ABOVE MEDICAL HISTORY INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____

CLIENT'S SIGNATURE DATE NURSE'S SIGNATURE/CREDENTIALS DATE

_____

PHYSICIAN'S SIGNATURE DATE RN COUNTERSIGN DATE

Florida Center for Addictions and Dual Disorders
Application for Treatment

Instructions: This form should be completed by the applicant and referral representative. Please provide all information requested. Please type or print neatly. You may use multiple sheets for Support Information if needed.

Current Services

What services are you currently receiving in your community to assist support in your desire for sobriety right now?

Name of Service: _____

Location Address: _____

Contact Number: _____

Name of Service: _____

Location Address: _____

Contact Number: _____

Aftercare Plan

Housing Information: Please include name of halfway house, transitional living assistance facility, sober home, etc.) you plan to utilize for aftercare:

Name of Facility: _____

Location Address: _____

Facility Contact: _____

Emotional / Support System Information: (Please include name of family, friends, sponsor, agencies, programs, etc.) you plan to utilize while in aftercare:

Support Person/Source: _____

Address: _____

Contact Number: _____

Support Person/Source: _____

Address: _____

Contact Number: _____

Outpatient Treatment: (Please include names of counselors, psychiatrist, psychologist, programs, agencies etc.) you plan to utilize for aftercare:

Name of Agency & Contact: _____

Address: _____

Contact Number: _____