Distance Learning Paperwork Instructions

<u>These instructions MUST BE FOLLOWED EXACTLY or your ability to be in a virtual group will be in jeopardy.</u>

To be able to participate in this program you must have a laptop or desktop with a webcam that is in working condition throughout the program. You must have the ability to scan information in and be able to email it to the instructor. To participate in group you must be in a confidential setting. You must be the only person in that setting. Your instructor must be able to see you throughout the entire group. During the time you are in group you must be in an area where there are no interruptions and you will be able to focus on the group information. No cell phones are allowed. You must have paper and pen ready. Failure to comply with any of these requirements will result in termination.

Group information is CONFIDENTIAL and may not be recorded or filmed.

You will be required to take random drug screens. You must have your lab chosen and have contacted them regarding this program and its rules BEFORE the assessment.

Also, before completing the assessment you must scan in a picture ID BEFORE the scheduled appointment and send it to aellis@exoffender.org with this form signed and dated at the bottom.

After setting up a time to meet online with Ms. Ellis, you will read and complete the forms described below. Follow the instructions exactly to ensure your success and continuation in the program.

- **<u>Enrollment Form</u>** – Fill out **TOP-PORTION** of this form ONLY
- **<u>PERC Virtual Group Participant Fee Agreement</u>** – Please read. You will print and sign your name at the bottom of the form, and add the date when you have your assessment virtually. **Do not sign or date until that time.**
- **<u>Physical Health Questionnaire -</u>** Please read carefully. We will review this form together. You will print and sign your name at the bottom of the form, and add the date when you have your assessment virtually. If you are on any medications they need to be documented with a pharmacy list. **Do not sign or date until that time**
- **<u>Finding Your ACE Score</u>** – Write your name on the top of this page and add the date. Answer all questions. If you answer yes to any question, add the number 1 on the right hand side of the page. When finished total your score and enter it on the line that says "YES answers" at the bottom of this form.
- **<u>PERC Outpatient Substance Abuse Treatment Confidentiality</u>** – Read this form very carefully. You will print and sign your name at the bottom of the form and add the date when you have your assessment virtually. **Do not sign or date until that time.**

  <u>Release of Information Consent Form</u> – PLEASE COMPLETE ALL FORMS
- Fill in the following areas: Client Name/DOB/Print Client Name/Client's Address. Then fill in the information for the agency or person who has referred you to this course. We cannot release any information such as your attendance or progress if you do not give us the referral source name and email address. You will print and sign your name at the bottom, and add the date when you have your assessment virtually. **Do not sign or date until that time.**

  The next form has The Department of Children and Families entered. DCF licenses our program. To maintain our license they monitor our files yearly and may randomly choose your file. This has nothing to do with any

dependency issues. It is strictly related to ensuring that PERC maintains a licensed program and meets all the requirement of DCF.

The third blank release MUST be taken to any lab that you choose to use. We MUST be able to verify that you actually went to that specific lab. You must take this release to the lab you choose and have their agreement that they will email the results to aellis@exoffender.org. You may need to sign their release also. **WITHOUT THIS INFORMATION WE WILL CONSIDER YOUR UA REULTS POSITVE.** Throughout the program you will be required to take a UA within 24 hours of being contacted. This is done on a random basis. You may choose to do your UA's at PERC to avoid this. The UA fee at PERC is $20.

- **PERC Outpatient Substance Abuse Treatment Grievance Procedure** – Read this form very carefully. You will print and sign your name at the bottom, and add the date when you have your assessment virtually. **Do not sign or date until that time.**
- **PERC Outpatient Substance Abuse Treatment Your Rights as a Participant** – Read this form very carefully. You will print and sign your name at the bottom of the form, and add the date when you have your assessment virtually. **Do not sign or date until that time.**
- **Description of/and Consent for Services to be Provided** – Read this form very carefully. You will print and sign your name at the bottom of the form, and add the date when you have your assessment virtually. **Do not sign or date until that time.**
  Communicable Disease/Risk – Fill in your name at the top of the page. Check any box that applies to you. You will print and sign your name at the bottom, and add the date when you have your assessment virtually. **Do not sign or date until that time.**
- **Program Infection Control Policies and Procedures** – Read this form very carefully. You will Print and Sign your name at the bottom, and add the date when you have your assessment virtually. **Do not sign or date until that time.**
- **Diagnostic/Ancillary Service Log** – Write your name and date of birth at the top of this form ONLY
- **Signature Page** – You will sign your name on each line, and add the date when you have your assessment virtually. **Do not sign or date until that time.**
- **Orientation Packet –** This information is for you to read **BEFORE** your virtual assessment. It will be discussed with you after your assessment. That is the time to ask questions if you have any.

I have read and understand these instructions and agree to all of them. I understand failure to follow instructions may result in termination from the program.

Client Signature **Date**

Before emailing this information back please make sure you have:

- **a working webcam, laptop or desktop and the ability to scan information**
- **permission from a lab to email results to Ms. Ellis,**
- **your scanned picture ID**
- **a pay pal account or major credit card**

If you have any questions you may email me at Aellis@exoffender.org

Pinellas County Re-Entry Enhancement Center

6160 Ulmerton Road, Suite 10
Clearwater, Florida 33760

Enrollment Form

Phone: (855) 505-7372
Fax: (727) 600-8096

Date: _____

Last Name: _____ First Name: _____

DOB: _____ SSN: _____

Race: _____ Sex: _____

Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Alt. Phone: _____

Do not write below this line.
OFFICE USE ONLY

Referral Type:

- ☐ Court Order
- ☐ Probation Order – State (Felony)
- ☐ Probation Order – County (Misdemeanor)
- ☐ Department of Children and Families
- ☐ Other Person or Agency

(List): _____

- ☐ Injunction for Protection Order by Judge
- ☐ Pre-Trial Services
- ☐ Deferred Prosecution Agreement with State Attorney
- ☐ Volunteer

Probation Officer Name: _____ Probation Officer Phone: _____

BIP Clients Only

Victim's Name: _____

Victim's Address: (If Known) _____

_____

Comments: _____

_____

_____

_____

Enrollment Type:		Payment Plan	# Required	Start Date
Assessment/Evaluation ☐	_____	$ _____	_____	_____
Orientation ☐	_____	$ _____	_____	_____
Group ☐	_____	$ _____	_____	_____
Telephonic Check-In ☐	_____	$ _____	_____	_____
Urinalysis ☐	_____	$ _____	_____	_____
Other ☐	_____	$ _____	_____	_____

PINELLAS EX-OFFENDER RE-ENTRY COALITION OUTPATIENT SUBSTANCE ABUSE TREATMENT

Distance Learning Participant Fee Agreement

The fee for the Substance Abuse Assessment is $75.00 and is to be paid prior to the evaluation in Pay Pal. There must be proof of payment BEFORE the assessment can begin.

The fee for Substance Abuse group is $25.00 to be paid weekly in Pay Pal before entering group.

The fee for urinalysis testing is $20.00 per test to be paid before testing at PERC. You may pay at PERC before the test if you choose to be tested there. If you choose to use another lab you are required to pay their fees.

If payment is not made you will not be in compliance with the PERC Substance Abuse program and this information will be sent to your Probation Officer, DCF Worker or Referral Source.

We expect and appreciate your cooperation.

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

PINELLAS EX-OFFENDER RE-ENTRY COALITION PHYSICAL HEALTH ASSESSMENT QUESTIONNAIRE

A. Name: _____

B. Date Last Visit to Physician:_____ C. Current Primary Physician: _____

*Place an "X" in the appropriate column for Current (**Cur**) or Historical (**Hist**) health problems or complaints. If you are being treated for this problem now, place an "X" in the column labeled **Cur Rx** and write the name of your physician in the column labeled **Provider**.*

E. Health Concerns /Problems	Cur	Hist	Provider	Cur Rx	E. Health Concerns/ Problems	Cur	Hist	Provider	Cur Rx
1. Heart attack					21. Cancer				
2. High blood pressure					22. Dental				
3. Bronchitis					23. Eyes/Vision				
4. Emphysema					24. Blood transfusions				
5. Asthma					25. Seizures, epilepsy				
6. Ulcers					26. Head injury/trauma concussion/unconscious				
7. Hernia					27. Wounds/trauma				
8. Gallbladder					28. HIV				
9. Bowel disorder					29. AIDS				
10. Cirrhosis – Liver					30. Hepatitis A				
11. Thyroid					31. Hepatitis C				
12. Diabetes					32. Untreated STDs				
13. Bone/muscle					33. Tuberculosis				
14. Back/neck					34. Other Infectious Dis				
15. Arthritis					35. Allergies				
16. Other bone, joints					36. Hospitalizations - medical				
17. Reproductive					37.				
18. Kidney/bladder					38.				
19. Blood disorders					39.				
20. Pregnant ☐ No ☐ Yes ☐ Unsure Trimester ____ prenatal care ☐ No ☐ Yes Provider _____									

F. List all yes answers and provide details re: specific problem, including the number:

_____

_____

*Indicate yes or no (**Y** or **N**) in the first column for each symptom. If you are currently receiving treatment for this symptom, identify physician or clinic under **Provider** column. If you have a prescription for this symptom, place an "x" in the column labeled **Cur RX**.*

G. Current Acute Symptoms	Y/N	Provider	Cur RX Y/N	G. Current Acute Symptoms	Y/N	Provider	Cur RX Y/N
1. Fever/chills				6. Infection			
2. Weight loss				7. Lumps			
3. Night sweats				8. Lesions			
4. Discharge				9. Bleeding			
5. Productive cough				10. Rash			

H. List all yes answers with the number and identify the specific problem.

_____

_____

_____

Name: _____

PINELLAS EX-OFFENDER RE-ENTRY COALITION PHYSICAL HEALTH ASSESSMENT QUESTIONNAIRE

List any current medications you are taking, both prescription and over-the-counter medications you take regularly. Place an "X" in the appropriate column to indicate whether the medication is for a physical or mental health diagnosis. Fill in the remaining columns as labeled.

I. Medications (OTC, herbs, alternative meds, vitamins, home remedies and scripts)	Taken for what purpose	Side Effects Y/N	Dosage	How often	Last dose	Taken as prescribed Y/N	Does it help Y/N
1.							
2.							
3.							
4.							
5.							
6.							
7.							

J. Do you use tobacco? ☐ No ☐ Yes In what form? _____ How much daily? _____ How long? (years) _____

K. Nutrition Screen Weight _____ Height _____

Drink caffeine? ☐ No ☐ Yes how much daily? _____ what other fluids do you consume daily? _____

Recent weight gain/loss of more than 10 pounds ☐ No ☐ Yes (circle gain or loss) Food Allergies? ☐ No ☐ Yes

Special Diet? ☐ No ☐ Yes If Yes, what diet? _____ Following your diet? ☐ No ☐ Yes

History of eating disorders? ☐ No ☐ Yes What? _____

Current problem: ☐ No ☐ Yes Describe: _____

Ever seen a nutritionist, registered dietitian for these? ☐ No ☐ Yes

L. Pain Screen

Are you currently in pain? ☐ No ☐ Yes If Yes, level of pain (scale 1-10, 10 most severe) _____

Is the pain new or a reoccurring pain (circle correct response) Location of pain _____

Do you currently have any pain in your teeth? ☐ No ☐ Yes If yes, describe: _____

What helps your pain? _____? What makes it worse? _____

Currently receiving treatment for your pain? ☐ No ☐ Yes Helping? ☐ No ☐ Yes Provider: _____

M. Do any of the above concerns create problems in how you deal with life? ☐ No ☐ Yes IF YES, Please describe:

_____

_____

N. List any other immediate problems not listed above: _____

_____

For official use only:

Refer for health issues? ☐ No ☐ Yes Refer for nutrition assessment? ☐ No ☐ Yes Refer for mental health? ☐ No ☐ Yes

Refer for further pain assessment? ☐ No ☐ Yes Refer for physical examination? ☐ No ☐ Yes

**** For any "yes" answers – make sure that it is referenced on the treatment plan and in your progress notes***

O. Who completed Physical Health Screen Form?

☐ Client alone ☐ Client and staff ☐ Client and Other_____ ☐ Other _____

Client Signature: _____ Date:_____

Counselor Signature/Credential: _____ Date:_____

Finding Your ACE Score

Name: _____ Date: _____

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often…**
   ➢Swear at you, insult you, put you down, or humiliate you?
   OR
   ➢Act in a way that made you afraid that you might be physically hurt?
   ☐Yes ☐No If **Yes**, enter 1 _____

2. Did a parent or other adult in the household **often or very often…**
   ➢Push, grab, or slap, or throw something at you?
   OR
   ➢**EVER** hit you so hard that you had marks or were injured?
   ☐Yes ☐No If **Yes**, enter 1 _____

3. Did an adult or person at least 5 years older than you **ever…**
   ➢Touch or fondle you or have you touch their body in sexual way?
   OR
   ➢Attempt or actually have oral, anal, or vaginal intercourse with you?
   ☐Yes ☐No If **Yes**, enter 1 _____

4. Did you **often or very often** feel that…
   ➢No one in your family loved you or thought you were important or special?
   OR
   ➢Your family didn't look out for each other, feel close to each other, or support each other?
   ☐Yes ☐No If **Yes**, enter 1 _____

5. Did you **often or very often** feel that…
   ➢You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   OR
   ➢Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ☐Yes ☐No If **Yes**, enter 1 _____

6. Were your parents **ever** separated or divorced?
   ☐Yes ☐No If **Yes**, enter 1 _____

7. Was your mother or stepmother:
   ➢**Often or very often** pushed, grabbed, slapped, or had something thrown at her?
   OR
   ➢**Sometimes, often, or very often** kicked, bitten, hit with a fist or hit with something hard?
   OR
   ➢**Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?
   ☐Yes ☐No If **Yes**, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   ☐Yes ☐No If **Yes**, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   ☐Yes ☐No If **Yes**, enter 1 _____

10. Did a household member to prison?
    ☐Yes ☐No If **Yes**, enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

CLIENT QUESTIONNAIRE

Name: _____ Date: _____

These questions refer to the past 12 months:

☐Yes ☐No Have you used drugs other than those needed for medical reasons?

☐Yes ☐No Do you misuse more than one drug at a time?

☐Yes ☐No Are you always able to stop using drugs?

☐Yes ☐No Have you ever had blackouts or flashbacks as a result of drug use?

☐Yes ☐No Do you ever feel bad or guilty about your drug use?

☐Yes ☐No Does your spouse (or your parents) ever complain about your involvement with drugs?

☐Yes ☐No Have you neglected your family because of your use of drugs?

☐Yes ☐No Have you engaged in illegal activities in order to obtain drugs?

☐Yes ☐No Have you ever experienced withdrawal symptoms when you stopped taking drugs?

☐Yes ☐No Have you had medical problems as a result of your drug use (such as memory loss, hepatitis, convulsions, bleeding)?

Pinellas Ex-Offender Re-Entry Coalition
Outpatient Substance Abuse Treatment

Confidentiality

Your rights to Confidentiality are protected within all legal limits. The following laws and statutes guide decisions regarding confidentiality:

A. Federal Confidentiality law Title 42, Code of Federal Regulations, Part 2
B. Chapter 397 Florida Statutes

Your treatment file will contain an individualized treatment plan and counselor notes regarding your progress and issues. Federal and State laws protect this information. Clinical staff may only release pertinent information under the following circumstances:

1. You consent in writing to the release.
2. The disclosure is court ordered.
3. The disclosure is made to medical personnel to deal with a medical emergency.
4. The disclosure is part of a verified research program, audit, or program evaluation.
5. Information relating to a report of child abuse and/or neglect. Staff are required by law to report to the proper authorities any current incident of child abuse or neglect that may be disclosed to them.
6. Information relating to a crime committed by a participant while in the program, directed at either a staff member or other participant. This includes a threat to commit such a crime.

When you enter this program you will be required to sign a Release of Confidential Information Form, which is in compliance with 42 CFR Part 2. This release will authorize communication between the Program and the referral source, and The Department of Children and Families for monitoring purposes..

At any time while you are in treatment you may request and sign another Release of Confidential Information Form giving the Program permission to release limited information to a party of your choice. At certain points within your treatment experience it may be advisable for you to allow information to be released to other service agencies in furtherance of your treatment goals.

You may not share information involving other group members with anyone. You may not video or record any sessions or part of any session

PLEASE BE ADVISED THAT UNLESS YOU SIGN A RELEASE GRANTING THIS PROGRAM PERMISSION TO SHARE INFORMATION WITH EMPLOYERS, FRIENDS, OR FAMILY, THIS PROGRAM WILL NOT DISCUSS YOUR ACTIVITIES IN THIS PROGRAM WITH THESE INDIVIDUALS.

_____

(Print Client Name) (Client Signature) (Date)

_____ _____

(Counselor Signature) (Date)

RELEASE OF INFORMATION CONSENT FORM
Pinellas Ex-Offender Re-Entry Coalition

Client Name: _____ **DOB:** _____

I understand that by signing this form, I allow the agencies identified below to use and exchange information about me.

I, _____ of _____
(Name of client- please print) (Client's Address)

authorize The Pinellas Ex-Offender Re-Entry Coalition (PERC) to disclose and receive information to and from the following agencies/ individuals:

_____

_____

The following types of records/information may be released/exchanged:

- My identity, date of assessment, date of entrance/exit of program
- Assessment Information
- Court Documentation
- Criminal Justice Records
- Polygraph Examination
- Benefits/Services Needed, Planned, and/or Received
- Attendance Records
- Status of my program progress/compliance
- Progress/Case Management Notes
- Urinalysis Testing

By signing this document I am acknowledging that the information to be released was fully explained to me and that this consent is given of my own free will. I understand this information will remain confidential and will be released only between the agencies/groups designated above.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

Pinellas Ex-Offender Re-Entry Coalition
Outpatient Substance Abuse Treatment

Grievance Procedure

You have the right to file a grievance following PERC's established procedures. Initially meet with your counselor to address any grievances. If the issues involve your counselor meet with his/her immediate supervisor or the Clinical Director of Outpatient services. This meeting will be documented an you will be given a copy of the results of the meeting. We believe most issues will be able to be resolved at this level. However if your issue is not resolved you may meet with The Executive Director. This meeting will be documented and you will be given the results. That meeting will be documented and you will be given a copy of the results. That decision is final per PERC However you also have the right to report allegations to State Authorities, regarding the program. Contact information is as follows:

Abuse Hotline 1-880-96-ABUSE
Local Florida Advocacy Council 1-800-342-0825
DCF Substance Abuse and Mental Health Program Office 813-558-5700
Sun Coast Region SAMH Program Office
Tampa 813- 558-5700
These numbers are also posted in all group areas.

Program Rules

I know that participants **MAY** be terminated from the program under the following circumstances:

- Any violent behavior directed toward self or others while in the Substance Abuse program.
- Refusal to satisfactorily complete group assignments, or participate in assigned treatment activities or to take a UA on the designated day.
- Unexcused absence or refusal to attend group meetings. An excused absence is approved by the counselor prior to the group. Excessive absences, even if excused, may result in my discharge from the program. Missing three classes in a row will result in termination.
- Any other inappropriate, disruptive or noncompliant behavior as determined by treatment and/or security staff
- Any violation of the rules

Voluntary Consent for Treatment and Acknowledgement of Orientation

I understand that I have the option of participating, or declining to participate, in the PERC Outpatient Substance Abuse Treatment Program and understand what is expected of me to participate. I understand that if I choose to decline participation in the program that I may be required to address my specific Criminal Justice case issues with the Court or referring agency.
By signing below I agree to receive treatment services as described, I have received an Orientation describing the program and I agree to comply with Program Rules and Client Responsibilities.

(Print Client Name) **(Client Signature)** **(Date)**

Denise Hughes Conlon LMHC CAP

(Print Counselor Name) **(Counselor Signature)** **(Date)**

Pinellas Ex-Offender Re-Entry Coalition Outpatient Substance Abuse Treatment

Your Rights as a Participant

You have the right:

a. To participate in all counseling modes offered in the PERC Program.
b. To have a primary counselor appointed.
c. To **request** a change in your primary counselor.
d. To terminate your treatment, and work with the criminal courts regarding your sentencing.
e. Confidentiality as the law provides.
f. To be free from neglect, verbal or physical abuse, exploitation, or any form of corporal punishment, as well as access to information which provides referrals regarding available abuse services and facilities.
g. To file a grievance without recrimination, in a manner consistent with the PERC's Grievance Policy as given to and signed by you.
h. To report allegations of abuse to State Authorities.
i. To **request** access to my clinical records.
j. To be informed if you are involved in a research project or receive services from a student intern.
k. To actively participate in treatment, and to be included in any planning relating to discharge from the Program.
l. To receive treatment in a safe and humane environment.
m. To be informed that this Program does not utilize any special surveillance equipment in the conducting of its operations.
n. To be considered appropriate for admission or services regardless of race, gender, creed, marital status, national origin, handicap, or age.

Your individual dignity shall be respected. You will not be deprived of any civil, political, or property rights without due process of law. It is the policy of the Program to avoid hazardous situations of treatment for its clients.

Upon entering treatment and at appropriate times within treatment you will be presented with treatment options. Decisions about entering and continuing treatment will be made with your active participation.

Your consent for treatment will be documented in your chart.

IF YOU HAVE A LEGAL GUARDIAN THAT HAS BEEN APPOINTED TO YOU, FOR ANY REASON, YOU MUST ADVISE YOUR COUNSELOR IN ORDER FOR APPROPRIATE ARRANGEMENTS TO BE MADE REGARDING YOUR CONSENT.

_____

(Print Client Name) (Client Signature) (Date)

_____ _____

(Counselor Signature) (Date)

Pinellas Ex-Offender Re-Entry Coalition
Outpatient Substance Abuse Treatment

Description of and Consent for Services To Be Provided

You will receive the following services: Group Counseling which will include Substance Abuse Education, Life Skills and Individual Counseling, Family Counseling, Urinalysis Testing, or other types of educational classes if deemed necessary. The minimum length of stay in the program is 12-weeks.

The PERC Substance Abuse Treatment Program charges a fee of $25. per class and $75.for an assessment. Fees are expected to paid on the day of service. Any exceptions will need to be approved by the Outpatient Clinical Director.

The PERC Program combines drug education, ITM therapy, Motivational Enhancement, Seeking Safety and relapse prevention training. The program is also capable of providing services to individuals with co-occurring mental health and substance abuse disorders.

Your successful completion of treatment will be based upon your individual progress and compliance with treatment. Your progress will be determined by how well you comply and cooperate in the pursuit of the following program goals:

1. Learning to be drug and alcohol free, and adjusting to a drug-free lifestyle.
2. Building motivation to change substance-using behaviors.
3. Learning the warning signs of relapse and developing a relapse prevention plan.
4. Developing healthy ways of coping with life and stressors.
5. Establishing a non-criminal pattern of living.
6. Developing alternative thinking patterns through various cognitive therapeutic approaches.
7. Increasing Social Skills.
8. Maintaining compliance with Court sanctions including passing all UA's. If any UA's are positive or diluted you may be put on contract or terminated from the program.
9. Developing appropriate support systems in preparation of returning to the community. This will involve learning to utilize 12-step support recovery tools.

As a participant in the PERC Outpatient Substance Abuse Treatment Program you will receive:

1. A comprehensive bio-psychosocial assessment- which includes a history of substance use, current and past mental health issues, criminal history, and other information that is required to determine your treatment needs and to develop treatment recommendations.
2. An individualized treatment plan based on individualized needs. You and your counselor will collaboratively develop your treatment goals. You will identify specific interventions that you will use to achieve your treatment goals.
3. Group counseling sessions designed to address and focus upon areas of substance abuse and co-occurring mental health issues, to obtain and maintain abstinence.
4. Individualized aftercare plan and referral to agencies within the community if deemed necessary.
5. Ancillary services. These are linkages to services such as legal, vocational, employment, mental health, prenatal care, diagnostic testing, public assistance, child care, and transportation. These linkages may or may not occur while you are still in the program. This will be determined by your counselor.

BY SIGNING THIS I AGREE THAT I UNDERSTAND THE ABOVE INFORMATION AND AGREE TO PARTICICPATE.

_____ _____ _____
(Print Client Name) (Client Signature) (Date)

_____ _____ _____
(Print Counselor Name) (Counselor Signature) (Date)

PINELLAS EX-OFFENDER RE-ENTRY COALITION
Outpatient Substance Abuse Treatment
Communicable Disease/Risk Assessment

Name: _____ DOB: _____

TUBERCULOSIS SCREENING

CLIENT HAS:

- ☐ TB (Tuberculosis) at this time / ever had TB
- ☐ (Is) on TB medication or under medical care/ever been treated for TB
- ☐ Been around anyone diagnosed with TB
  If yes, how long ago was the exposure? _____
- ☐ Had an organ transplant
- ☐ Recently immigrated
- ☐ Injected drugs
- ☐ Had stomach surgery
- ☐ Been in jail, prison, nursing home
- ☐ Been homeless
- ☐ Diabetes
- ☐ Chronic kidney failure with dialysis
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Cancer of the head, neck, or lung

CLIENT HAD THE FOLLOWING SYMPTOMS RECENTLY:

- ☐ Cough and/or hoarseness lasting more than 3 weeks
- ☐ Recent unexplained weight loss
- ☐ Fever or night sweats for more than a week
- ☐ A productive cough or coughed up blood

HIV SCREENING

IN THE PAST TEN (10) YEARS, CLIENT HAS HAD:

- ☐ Unprotected sexual activity
- ☐ Tattoos
- ☐ Unprotected sexual activity with bisexual or homosexual persons
- ☐ IV drug use
- ☐ Sexual activity with persons who use IV drugs
- ☐ Sex in exchange for money, drugs, or favors
- ☐ Other sexually transmitted diseases
- ☐ Exposure as a health care provider
- ☐ A victim of sexual assault
- ☐ Multiple sexual partners
- ☐ Sexual activity while intoxicated, including alcohol
- ☐ Transfusions of blood/blood products before 1985

☐ You are not encouraged to contact a Dr. or the health Department regarding your health

☐ You are encouraged to follow through with services in the community if needed. Please contact the Pinellas County Health Department for further intervention: (727) 824-6932.

PERC EMPLOYEES ARE REQUIRED BY LAW TO REPORT ALL CASES OF COMMUNICABLE DISEASES TO THE PINELLAS COUNTY HEALTH DEPARTMENT.

_____ _____
Client Signature Date

_____ _____
Counselor Signature Date

Pinellas Ex-Offender Re-Entry Coalition Outpatient Substance Abuse Treatment

Program Infection Control Policies and Procedures

You were screened and provided with a risk assessment for both high-risk behavior and symptoms of communicable diseases. If you desire further screening or have questions regarding prior screening procedures you may contact the Pinellas County Health Department at 727-824-6932

If you are infected, you may be required to submit to appropriate treatment and counseling. Additionally, please be aware that you will participate in at least 1.5 hours of HIV and AIDS awareness education, during which you may request to be tested. Completion of this HIV and AIDS awareness education is mandatory for completion of PERC's Outpatient Substance Abuse Treatment, however, testing for the disease is **NOT** mandatory for completion.

I understand my responsibility and options should I learn that I have a communicable disease or should I suspect that I have a communicable disease.

_____ _____

Client's Signature Date

_____ _____

Counselor Signature Date

Pinellas Ex-Offender Re-Entry Coalition
Outpatient Substance Abuse Treatment

Name: ______________________ DOB ______________

Diagnostic Services Provided

Date	Description
Date	Description
Date	Description
Date	Description
Date	Description
Date	Description
Date	Description
Date	Description
Date	Description
Date	Description

Ancillary Services Provided

Date	Description
Date	Description
Date	Description
Date	Description
Date	Description
Date	Description
Date	Description
Date	Description
Date	Description
Date	Description

Pinellas Ex-Offender Re-entry Coalition
Outpatient Substance Abuse Treatment

By signing in the designated areas below I acknowledge that I have undergone the Orientation process for the PERC Outpatient Substance Abuse Treatment Program, and have received copies of the documents indicated. I acknowledge that these documents have been read to me and explained to me, and that this original signature page will become a permanent part of my treatment record with PERC.

Form	Signature	Date Received
Confidentiality Guidelines		
Release of Confidential Info.		
Participant Rights		
Description of Consent for Services Provided		
Grievance Procedures		
Infection Control Policies Procedures		
Orientation Packet Received /Reviewed		

Pinellas Ex-Offender Re-Entry Coalition
Outpatient Substance Abuse Treatment

Initial Treatment Plan

Date: ____

First Name: _____ Last Name: _____

PRESENTING PROBLEM # ____: *(Description of Behaviors/Symptoms)*
PROBLEMS: .

CLIENT'S PERCEPTION OF STRENGTHS & ABILITIES RELATED TO THE POTENTIAL FOR RECOVERY:
GOAL: Remain Alcohol and Drug Free

OBJECTIVES:

EXPECTED ACHIEVEMENT DATE:

1. _____
2. _____
3. _____
4. _____

Primary Counselor: _____

ObJ #	Methods (Services)	Amount	Frequency	Duration	Person Responsible
1	Utilize group material to successfully achieve individual goals	1 ½ hours	1 x weekly	12 weeks	client
2	Utilize group material to successfully achieve individual goals	1 ½ hours	1 x weekly	12 weeks	client
3	Utilize group material to successfully achieve individual goals	1 ½ hours	1 x weekly	12 weeks	client
4	Utilize group material to successfully achieve individual goals	1 ½ hours	1 x weekly	12 weeks	client

_____ _____ _____ _____ _____ _____
Client Signature Date Counselor Signature Date Qualified Professional Signature Date