



**SERENITY HILLS
HUMAN SERVICE AGENCY**

Preadmission Application

Serenity Hills
1500 Highway 20 NW
Watertown, SD 57201-5746

Telephone: (605) 884-0650
Fax: (605) 884-0651

Please complete the following application for admission into the Serenity Hills Halfway House facility. Please address it: Attention: Deborah A. Hamer, Serenity Hills/Addictions Coordinator.

Today's Date: _____

IDENTIFYING INFORMATION:

Name: _____ DOB: _____ Age: _____

Male _____ Female _____ Social Security No.: _____

Home Address: _____
Number Street City State Zip County

Telephone Number: Home _____ Work _____

Current Address: _____
Number Street City State Zip County

Marital Status: Never Married _____ Married _____ Widowed _____ Divorced _____ Separated _____

Mother's First Name _____

REASON FOR REFERRAL:

Name of Referent or Agency: _____

Address of Referent: _____
City State Zip

Telephone Number of Referent: _____

Relationship to Referent: _____

Please briefly describe the reason that you or the person that you are referring needs a halfway house program:

How long do you estimate that you or the person that you are referring needs to receive halfway house services?

What date would applicant be available for admission? _____

CHEMICAL USE HISTORY: In the boxes below, please be very specific in indicating the type of chemicals that you have used, your first use and last use of these chemicals, and how much you typically used them.

What is your drug of choice? _____

Substance	Age of First Use	Frequency of Use (Most Recent Pattern)	Form of Use (Inhaling, Smoking, IV, etc.)	Usual Amount	Date of Last Use

DRUG & ALCOHOL TREATMENT HISTORY: Please fill in the following information regarding past chemical dependency treatment:

<u>Name of Center/City</u>	<u>When</u>	<u>How Long</u>	<u>Outcome/How Long Sober?</u>	<u>Inpatient or Outpatient?</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PSYCHOLOGICAL:

Please fill in the following information regarding past mental health counseling or treatment:

<u>Name of Center/City</u>	<u>When</u>	<u>How Long</u>	<u>Inpatient or Outpatient</u>	<u>Outcome</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If you are currently in treatment, when are you scheduled to be discharged? _____

Are you currently seeing a psychiatrist? _____ If yes, Name _____

FAMILY:

Please fill in the graph below:

PARENTS NAME	Age	Health	Lives in City/State	Occupation

Do you have any siblings? _____ How many? _____

Do any of them have problems with Drugs and or Alcohol,
or have a mental health diagnosis? _____

LIVING ARRANGEMENTS:

- _____ Alone
- _____ With Other Family Member
- _____ With Parent
- _____ With Spouse and Children
- _____ With Unrelated Person
- _____ With Spouse Only
- _____ Homeless
- _____ Incarcerated
- _____ Other _____

HEALTH/MEDICAL:

Name of personal or family physician: _____

Date of last physical examinations: _____

Date of last TB testing and results: _____ Where: _____

Current health or medical problems: _____

Do you have any limitations that require special assistance? Yes _____ No _____

If yes, explain: _____

Please list any allergies:

Medication: _____

Other Allergies: _____

Name of Current Medications	Reason	Prescribing Physician	Dosage	Frequency

Please list any major health or medical problems that you have had in the past including injuries, head traumas, surgeries, or infectious diseases: _____

EDUCATION:

What was the last year of formal education you completed? _____

Did you receive a high school diploma? Yes No (if no, do you have a GED? _____)

Please list any classes, degrees, or training that you received following high school: _____

EMPLOYMENT/VOCATIONAL:

Are you currently employed? Yes _____ No _____

If yes, where: _____ Position: _____

Have you ever been enrolled in Vocational Rehabilitation? Yes _____ No _____

When _____ Where _____

What type of job skills do you have? _____

Do you have any physical problem(s) that would limit the type of work you can do and the amount of work that you can do? _____

What type of career are you interested in long term? _____

What type of job do you plan to look for if you are admitted into Serenity Hills Halfway House? _____

Are you a veteran? Yes _____ No _____

LEGAL:

Do you currently have any legal difficulties? Yes _____ No _____

Please list: _____

Are you on parole or probation? Yes _____ No _____

Parole/Probation Officer's Name: _____

Phone Number: _____

Address: _____

Have you ever been arrested? Yes _____ No _____

If yes, please complete the following information:

Date of Arrest

Charge

Were you convicted?
Yes or No

Sentence/Outcome

Do you have any court dates pending? If so, when and for what reason: _____

FINANCIAL:

Do you receive SSI or SSDI? Yes _____ No _____ \$ _____ per month

Do you have health insurance? Yes _____ No _____

Are you on Medicare or Medicaid? Yes _____ No _____ Medicare/Medicaid # _____

What is your primary means of financial support at present? _____

OTHER INFORMATION:

What would you like to accomplish while you are at Serenity Hills Halfway House? _____

Please use the space below to provide any other information that you think would be important for us to know in considering your application? _____

**HUMAN SERVICE AGENCY
SERENITY HILLS
PROGRAM GUIDELINES**

Please review each of the following Program Guidelines very carefully and initial each one. Please keep in mind these Guidelines are subject to change.

- _____ New residents are expected to remain around the house for a 48-hour orientation period. This period of time is intended to give the new resident an opportunity to become acquainted with staff and other residents.
- _____ Residents must have a complete physical examination supervised by a licensed medical physician and current TB test within 3 months prior to admission.
- _____ Each resident is expected to search for employment after the initial 48-hour orientation period. Residents must continue searching until employment is found:
- a) Transportation for job searching is provided Monday through Thursday.
 - b) All residents are required to obtain full-time employment, 40 hours per week, unless psychiatrist or medical doctor recommend otherwise. If employment is not found within the first 2 weeks of admission, the resident is expected to work 10 hours per week at Serenity Hills for each week without a job.
 - c) Each resident is to sign out & check in with staff when leaving the premises.
 - d) Permission from the Program Coordinator must be obtained if a resident is unable to work 40 hours per week.
- _____ **Each resident is financially responsible for their stay at Serenity Hills:**
- a) Each resident is responsible for the residential fee of \$17.00 per day (the residential fee is not covered by state funding).
 - b) Each resident is scheduled for at least bi-weekly financial conference with a designated staff member. Failure to meet for the financial conference will result in restrictions, and/or loss of privileges and dropping a level.
 - c) Residents who fail to meet for bi-weekly financial conference will be required to have their payroll check sent from their employer to Serenity Hills. The payroll check will be dispersed to the resident following a financial conference.
 - d) Residents are expected to pay at least 70% of their paycheck up to their current balance. Failure to do so will result in loss of privileges by dropping a level.
 - e) Each resident is responsible for Outpatient Services at the Human Service Agency and any other services utilized at other medical facilities.
 - f) Each resident understands that Serenity Hills and the Human Service Agency utilize a collection agency if residents do not fulfill their financial obligations.
- _____ No resident is allowed to open a checking and/or savings account using the Serenity Hills address.

_____ Residents are discouraged from borrowing or lending money amongst themselves. Serenity Hills is not responsible for financial transactions between residents.

_____ Serenity Hills places emphasis on adherence to the Daily Schedule. Each resident will assume responsibility of following the Daily Schedule. It is the resident's responsibility to attend all activities as they are scheduled (See attached Daily Schedule).

_____ Residents are required to participate in the following scheduled activities:

- Weekly individual & group counseling (at least 5 hours weekly)
- Weekly education & work therapy
- Planned physical exercise
- Planned recreational and leisure time activity
- Psychosocial skills
- It is a mandatory that prescription medications be filled at our on-site pharmacy (Genoa) to allow medical staff to better monitor medications. Exceptions are residents who receive meds from IHS or the VA.
- Monthly med conferences

_____ Residents are expected to be up and dressed by 8:00 a.m., Monday through Friday, 9:00 a.m. on Saturdays, and 10:00 am on Sundays. Beds must be made by this time. Residents are not allowed to lounge in their pajamas.

_____ Each resident is expected to attend scheduled meals as a group. Those who choose not to eat are required to be present at the meal for 10 minutes.

_____ Residents are expected to maintain clean, healthy personal hygiene and appearance:

- Residents will dress appropriately at all times.
- Shoes or socks must be worn at all times.
- Work clothes are not to be worn in the lounge/living area.
- Feet are not allowed on the furniture.
- Residents are required to wear a top and bottom for bed attire.

_____ Bed checks are made routinely during the night.

_____ Each resident is required to complete individualized assignments designed to assist them in achieving treatment plan goals.

_____ Residents are prohibited from leaving Serenity Hills' property unless with the accompaniment of a staff member or with special approval from the Program Coordinator or counseling staff.

_____ Residents are required to sign out when leaving the property for any reason. Residents are to record their name, reason, destination, and estimated return time. **All residents are required to check in immediately upon return. Search of belongings will be done.**

_____ **Random or scheduled room searches and searched belongings will be at the staff's discretion.**

_____ Male residents are not allowed in female resident's room and vice versa.

_____ Each resident is required to help with routine housekeeping chores and for keeping their bedroom and bathrooms neat and clean. A schedule of assigned chores is posted weekly. Rooms & resident bathrooms are to be cleaned thoroughly on Saturdays.

_____ Smoking and chewing tobacco are **NOT** permitted in the house. Smoking is permitted outdoors.

_____ **The use of alcohol, any type of drug, gambling or OTC meds without prescription is strictly prohibited.**

_____ Random drug or alcohol screens are conducted. The resident is responsible for any charges.

_____ Romantic Involvement with another resident can result in immediate discharge.

_____ A resident phone is available, limit calls to 10 minutes. Phones are shut off at group time, meal time and overnight.

I have received, read, and initialed a copy of Serenity Hills Guidelines:

Yes: _____ No: _____

By signing below, I agree to follow these "Rules and Expectations":

Signature _____ Date _____

In particular, I understand and agree (please initial):

- a. To follow Serenity Hills "Rules and Expectations" and daily schedule: _____
- b. To have a physical examination completed within three months prior to admission or upon admission at my expense: _____
- c. I understand if I do not show up on my scheduled admission date into Serenity Hills and I do not call to schedule another date for admission, my bed may be given to another client on the waiting list: _____
- d. I understand that employment is required and that I am responsible to pay the \$17.00 per day residential fee: _____

**THIS SECTION TO BE COMPLETED BY THE REFERRAL SOURCE
(If other than yourself)**

1. What is your relationship with the person you are referring to Serenity Hills? _____

2. How long have you worked with this individual? _____
3. How would you describe their motivation for participating in a halfway house program? _____

4. How long would you recommend they participate in a halfway house program? _____
5. Are there any medical, psychiatric, or other special forms of care that this individual would need while staying at a halfway house? _____

6. Is this applicant court-ordered to participate in the halfway house program? **Please provide us with a copy of the legal documents, if possible.**
List any court dates: _____
7. Please use the space below to provide any other information you think would be important for us to know: _____

8. How confident are you that this person will follow through with Serenity Hills? _____

9. Please list any **mental disorders** formally diagnosed:

<u>Diagnosis:</u>	<u>Has Disorder Been Treated (yes/no)</u>	<u>Level Of Stabilization</u>

10. Please answer the following questions based on your current assessment of the client:

Can this client function in a reasonably appropriate and effective manner in group therapy and other group contexts? Yes: _____ No: _____

Is this client able and willing to attain and maintain meaningful employment? Yes: _____ No: _____

Is this client willing to comply with a psychotropic medication regimen that has been prescribed for him/her? Yes: _____ No: _____

Do you see any obstacles to the client adapting to a structured therapeutic residential environment? Yes: _____ No: _____

Please use the space below for any comments related to any item that you have checked no to above: _____

Name

Date

Telephone