TownHome Health Intake Packet
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Collect a copy of ID and Insurance Card at this time

Billing Department Insurance#:_____
☐Medicaid ☐Medicare ☐Dual Eligibility ☐Uninsured
MCO:

TownHome Health Kings
Face Sheet

First Name:_____ **M.I.:**_____ **Last Name:**_____

D.O.B: _____ **Gender Identity:** ☐**Male** ☐ **Female** ☐ **Other:**_____

Ethnic Identity: _____ **Religious Identity:** _____

Address: _____

City: _____ **Zip Code:**_____ **Phone Number:** _____

Social Security Number:_____ **Medicaid #:**_____

Diagnosis(es):_____

_____

Medication(s): ***(Name, Dosage and Frequency)***

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Emergency or Collateral Contact:_____

Relationship: _____ **Phone Number:**_____

Address:_____

City: _____ **Zip Code:** _____

TownHome Health
Crisis Respite Intake Sheet

Date of Referral: _____ ☐ **New Guest** ☐ **Returning Guest**

Date of Enrollment: _____ **Time:** _____ **Remaining Days:** _____

What is your current emotional or psychiatric crisis (What led you to have to stay at the respite?

_____

_____

_____

What do you expect / hope to obtain from your stay at the crisis respite center?

_____

_____

_____

What are some strengths you have that may help both you and respite staff to manage your current crisis?

_____

_____

_____

What are your triggers? (We want you to feel comfortable and safe at the respite.)

_____

_____

Are you knowledgeable: of your diagnosis? ☐ Yes ☐ No of your medications and side effects? ☐ Yes ☐ No

What would you like to learn or improve on during your respite stay?

_____

_____

Peer Specialist Print: _____ **Peer Specialist Sign:** _____

TownHome Health

Acknowledgment of Receipt of Health & Wellness Plan

I _____ certify that the TownHome Health went over the Health & Wellness Plan with me. I was provided a copy of the Heath & Wellness Plan and I agree to complete this document and return it to the staff within 24 hours of my intake.

Guest Signature: _____

Date: _____

Peer Specialist: _____

Date: _____

TownHome Health
3402 Clarendon Rd
Brooklyn, NY 11203
(718) 473-9860

TownHome Health Clarendon

Acknowledgment of receipt of safety guidelines and house/regulations/ rules

I _____certify that the TownHome Health safety guidelines and house regulations/rules has been reviewed with me and I agree to comply with the safety guidelines and house rules/regulations. I was also provided with a copy of these rules.

Guest Signature: _____

Date: _____

Peer Specialist: _____

Date: _____

TownHome Health Residential Crisis Support Center
3402 Clarendon Road
Brooklyn, NY, 11203
(718) 473-9860

Townhome Health Residential Crisis Support Center Guest & Visitor Agreement

Guest Agreement

We, the staff of the Townhome Residential Crisis Support Center and _____ (guest) agree that the Townhome Residential Crisis Support Center is a temporary Residence/Respite, which can be utilized for up to 28 days.

We understand that the Townhome Residential Crisis Support Center is a place where all are welcome and agree to not discriminate against any person based on race, color, national origin/nationality, disability, sex, gender, gender identity/ expression and marital status.

We understand and agree that crisis beds must be occupied by the guest (You) each night of their stay, and beds cannot be held for longer than 24 hours. Guests are expected to inform staff and sign out when leaving residence/respite. Failure to follow this agreement can result in an administrative discharge.

We agree to meet and engage with a Peer Specialist each day we are here, develop a Health & Wellness Plan and work on goals identified to address/resolve/manage crisis. Not meeting with staff daily can and will result in an administrative discharge.

We agree to sign in and out whenever leaving and entering the building.

We agree and understand that the Townhome Residential Crisis Support Center is not responsible for guests' personal belongings. Personal items should be stored and locked in a guest's room when he/she is not present. It is the responsibility of a guest to ensure the room is locked. If/when personal belongings are left upon discharge, we will make reasonable effort to contact guests to arrange for pickup of any remaining belongings. Personal belongings will be held no more than 2 weeks. After 2 weeks any items left will be discarded.

We agree and understand that at the end of a guest's stay, the guest must return to housing, and or address, identified/documented on post discharge plan during the enrollment and intake process.

We agree and understand it is mandatory that guests participate in all fire drills (As required by FDNY) We also understand and agree that all guests must exit the building whenever the fire alarm goes off and cannot re-enter the building until directed by the fire department or staff. (NO EXCEPTION)

We agree that the guest is invited to move about the house freely but cannot enter another person's room whether it is locked or open.

We agree and understand that in accordance with HIPAA, and to respect the privacy and rights of other guests at the Townhome Residential Crisis Support Center, to not use any form of video chats/Facetime and speakerphone in common areas, including the garden or any outdoor space of the premise.

We agree to utilize headphones/earbuds while using cell phones, radio, I-Pod, tablets and laptops in common areas.

We agree that guests will not let anyone into the building and will notify staff when someone rings the doorbell.

We agree to be honest and not take or remove any item/food from the refrigerator and kitchen that does not belong to us.

We agree to not give, loan or borrow any money, bank/debit/credit cards, EBT card and personal items from other guests at the Townhome Residential Crisis Support Center. Townhome Residential Crisis Support Center is not

responsible for, and will not reimburse any money, bank/debit/credit cards, EBT card and personal item given or loan and not returned.

We agree to not smoke indoors, at the entrance/in front of the building, in the driveway, and in accordance with NYS smoking policies. We agree to smoke only in the designated area of the garden. We also agree and understand that Violation of this policy can and will result in an administrative discharge.

We agree not to use or abuse any drugs, be they prescription or nonprescription, alcohol or Marijuana while on the premises at Townhome Residential Crisis Support Center (This includes, anywhere within the building, garden, sidewalks, in front/entrance of the building and in the driveway).

We agree to be nonviolent and to talk any issue through. We understand that if a guest's behavior presents itself as a danger to self or others and is disruptive to the other guests, this may result in a referral for emergency services and an administrative discharge.

We agree there will always be someone available to speak with the guests and to reach out to each other as circumstances dictate, when we feel extremely distressed as a first response.

We agree to take advantage of the house resources and food items in a responsible way

We understand that the Townhome Residential Crisis Support Center is a shared space and agree to practice activities of daily living skills and be self-reliant in the areas of personal hygiene such as bathing/taking daily showers and cleaning up after ourselves.

We understand that the Townhome Residential Crisis Support Center is a shared space and agree to always be fully dressed in all common areas of the building, including outdoor spaces of the premises.

We agree and understand that the Townhome Residential Crisis Support Center is a shared space for all to enjoy and feel comfortable. Therefore, guests are not permitted to wear pajamas/sleeping clothes, underwear/ under garments of any kind, robes, tank tops/wife beaters, short shorts /daisy dukes, crop tops/belly shirts or any inappropriate outfits outside of their rooms and in all common areas of the Townhome Residential Crisis Support Center.

We understand and agree that all guest rooms will be inspected weekly and assistance will be provided with maintaining the cleanliness of spaces.

We understand and agree that the Townhome Residential Crisis Support Center provides staple food items in accordance with the NYC department of health food guidelines that guests can cook/prepare themselves.

We understand and agree to adhere to kitchen safety rules in accordance with the FDNY guidelines and the Crisis Residence/Respite safety rules.

We understand and agree to adhere/abide by the Townhome Residential Crisis Support Center house and safety rules/ guidelines. (A list of these rules and guidelines will be provided during intake) We also agree and understand that violation of these rules can and will result in an administrative discharge.

We agree that a guest has the right to request and obtain a copy of their file at any time.

We agree that if the guest has a grievance regarding program process, staff or services, at any time during grievance procedure, they are free to contact assistance outside the program including: Office of Mental Health (OMH) Customer Relations at 1-800-597-8481, NYS Justice Center for the Protection of People with Special Needs 1-800-624-4143 and The Mental Hygiene Legal Service (MHLS) 646-386-5891.

Townhome Health Residential Crisis Support Center Guest & Visitor Agreement

We agree and understand that if a guest (You) does not comply or adhere to this agreement, depending on the circumstances and within reason, the Townhome Residential Crisis Support Center has the right to discharge the guest.

Guest Signature _____Date:_____

Peer Specialist_____Date:_____

VISITOR'S POLICY

Based on the guest's goals, and consistent with the needs of Townhome's Crisis Support Program, counseling will be provided to assist guests in inviting visitors. Guests agree to show good judgment with regard to the rights and safety of themselves and others. All visitors are required to sign in with staff and are to remain in the designated area for visits. Visitors are restricted from entering private spaces and must follow the same safety guidelines as our guests. We reserve the right to refuse visitors at any time.

_____

DATE

_____

RESIDENT'S SIGNATURE

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health | PSYCKES

Consent Form

TownHome Health Inc.

Provider/Facility Name

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to **www.psyckes.org**, and click on **About PSYCKES**, to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
- Your health services paid for by Medicaid;
- Your health care history, such as illnesses or injuries treated, test results and medicines;
- Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

- "I GIVE CONSENT" if you want this provider, and their staff involved in your care, to see your PSYCKES information.
- "I DON'T GIVE CONSENT" if you don't want them to see it.

If you don't give consent, there are some times when this provider may be able to see your health information in PSYCKES – or get it from another provider – when state and federal laws and regulations allow it.[1] For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. *Please check 1 box only.*

○ **I GIVE CONSENT** for the provider, and their staff involved in my care, to access my health information in connection with my health care services.

○ **I DON'T GIVE CONSENT** for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

Print Name of Patient

Patient's Date of Birth

Patient's Medicaid ID Number

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative Patient (if applicable)

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

1 **How providers can use your health information.** They can use it only to:

- Provide medical treatment, care coordination, and related services.
- Evaluate and improve the quality of medical care.
- Notify your treatment providers in an emergency (e.g., you go to an emergency room).

2 **What information they can access.** If you give consent, TownHome Health Inc. can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (X-rays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advanced directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:

- Mental health conditions
- Alcohol or drug use
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Sexually transmitted diseases

3 **Where the information comes from.** Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: www.psyckes.org and see "About PSYCKES", or ask your provider to print the list for you.

4 **Who can access your information, with your consent.** TownHome Health Inc.'s doctors and other staff involved in your care, as well as health care providers who are covering or on call for TownHome Health Inc.. Staff members who perform the duties listed in #1 above also can access your information.

5 **Improper access or use of your information.** There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information – and they shouldn't have – call:

- TownHome Health Inc. at 718-473-9860, or
- the NYS Office of Mental Health Customer Relations at **800-597-8481**.

6 **Sharing of your information.** TownHome Health Inc. may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.[1]

7 **Effective period.** This Consent Form is in effect for 3 years after the last date you received services from TownHome Health Inc., or until the day you withdraw your consent, whichever comes first.

8 **Withdrawing your consent.** You can withdraw your consent at any time by signing and submitting a Withdrawal of Consent Form to TownHome Health Inc.. You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at **www.psyckes.org** or from your provider by calling TownHome Health Inc. at 718-473-9860. Please note, providers who get your health information through TownHome Health Inc. while this Consent Form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don't have to return the information or remove it from their records.

9 **Copy of form.** You can receive a copy of this Consent Form after you sign it.

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

Acknowledgement of Discharge Date and Time

Guest's Name: _____
D.O.B: _____
Date of Admission: _____
Projected Date of discharge: _____

I certify that the TownHome Health Clarendon Crisis Support Center Staff (Name) _____ and I (aka the guest) _____ have discussed my ~~**discharge date/time from the**~~ **Residence** on (Date) _____ at _____
_____ (Guest's Initials) _____ (Staff's Initials)

I ~~was in~~formed/notified that ~~I will b~~e discharged on _____ **at 12:00 noon.**
_____ (Guest's Initials) _____ (Staff's Initials)

I am aware that my stay ~~**cannot/will not be extended**~~ if my discharge location changes at any time during my stay. _____ (Guest's Initials)_____ (Staff's Initials)

I understand that **I am responsible for informing staff of any changes in my discharge plan** and I will ~~be expected to utilize any of the other~~ identified options/locations to discharge to. Ex: Shelter. _____ (Guest's Initials) _____ (Staff's Initials)

We have also discussed and confirmed my Post Respite Discharge Plan and location.
I will be discharging to:

- ☐ My Home
  My family Member's home
- ☐ My Friend's Home
- ☐ Shelter
- ☐ Other

Name of family member, Friend, Shelter or Other:
_____

Address/Location: _____

Guest Name (Print) _____ Signature: _____ Date: _____

Staff Name (Print) _____ Signature: _____ Date: _____

Acknowledgment of Fire Evacuation Procedures

I _____certify that I have been educated on TownHome Health's Fire Evacuation Procedures. I understand and will comply with the procedures to the best of my ability.

Guest Signature:_____

Date:_____

Peer Specialist:_____

Date:_____

TownHome Health
3402 Clarendon Rd
Brooklyn, NY 11203
(718) 473-9860

TOWN HOME HEALTH
Kind Crisis Care

GUEST GRIEVANCE PROCEDURE

Recipients of services may object to program function or process, staff, or services, without fear of retribution. The following grievance procedure shall apply, and is available to recipients:

(1) Objections or complaints should be submitted in writing to the Peer Supervisor. A meeting will be immediately arranged with the guest and primary peer and peer supervisor to define the problem.

(2) If the grievance cannot be satisfactorily resolved, among staff members, immediate supervisor, and recipient, the recipient should refer it in writing to the Program Director, who will bring it to the program's Quality Improvement/ Administrative Committee for special review and resolution.

(3) The complainant shall receive a written response within 5 business days of submitting the grievance.

(4) Appeal process: If the Agency's response is not satisfactory to the recipient, the recipient shall receive written information for appealing this response, by requesting a review by the Bronx Regional Office of the NYC Dept. of Mental Health and/or contacting Office of Mental Health (OMH) Customer Relations at 1-800-597-8481

(5) Documentation: All recipient grievances shall be documented in the recipient's chart. In addition, minutes of the special review committee or the Administrative/Quality Improvement Committee shall reflect its discussion of all grievances, and shall include copies of the recipient's grievance and the agency's response.

Documentation shall include: date of complaint, name of recipient, nature of complaint; disposition and date of disposition; date recipient is informed of disposition; recipient's response to disposition.

Throughout the procedure either the peer supervisor will assist the recipient(s) submitting a grievance. The peer supervisor will document the procedures taken. At any time throughout this process, the complainant can contact the Justice Center and the Mental Hygiene Legal Services that have been provided in their Guest agreement. In the event that an issue is unresolved, the recipient will be helped to obtain further assistance outside the program.

During checking in, recipients will be given the contact information for the NYS Justice Center for the Protection of People with Special Needs 1-800-624-4143, Office of Mental Health (OMH) Customer Relations 1-800-597-8481, as well as The Mental Hygiene Legal Service (MHLS) 646-386-5891

All grievances follow agency wide, Policy and Procedure Manual.

Acknowledgment of Receipt of

Guest Agreement and Grievance Procedure

I _____certify that the Guest Agreement and Grievance Procedures of

TownHome Health has been reviewed with me and I have also been provided a copy.

Guest Signature:_____

Date:_____

Peer Specialist:_____

Date:_____

TownHome Health
3402 Clarendon Rd
Brooklyn, NY 11203
(718) 473-9860

TownHome Health Residential Crisis Support Center

ACKNOWLEDGMENT OF POLICY REGARDING PERSONAL BELONGINGS LEFT AT THE RESPITE

I _____ agreed to pick up my personal belongings from TownHome Health within 7- 14 days of my discharge Date (_____) I was also informed that if I don't pick up my belongings as agreed, they will be discarded.

Guest Signature: _____

Date: _____

Peer Specialist: _____

Date: _____

Guest Contact List

In an effort to more effectively serve you, TownHome Health may need to find alternative methods of reaching you during and after your stay here. Could you please provide below contact information for any persons that you are comfortable having information communicated to by TownHome Health. If there is no one that you feel should be on this sheet, please write "CWR" and sign at the bottom. If at any point you would like one of the names removed from this list, please notify us and it will be reflected in our files. Thank you.

Name:	_____	Relationship to you	_____
Phone:	_____	Fax:	_____
Name:	_____	Relationship to you	_____
Phone:	_____	Fax:	_____
Name:	_____	Relationship to you	_____
Phone:	_____	Fax:	_____

My signature explicitly demonstrates that I understand the text and nature of this document.

_____ _____

Guest Signature Date

_____ _____

Peer Specialist Date

TownHome HealthKings
3402 Clarendon Road
Brooklyn, NY 11203
(718) 473-9860

Townhome Health Residential Crisis Support Center

Medication Management and Support Checklist

Guest's Name: _____

Date: _____

Our crisis residence offers the option of providing medication support to our guests.

Would you like any support with your medication(s) during your stay? Yes___ No___

If you would like support with your medications, **please check the appropriate box** that identifies the *type* of support you would like.

Yes___ No___ 1. Storage of medication

Yes___ No___ 2. Assistance with self-administering medication(s) / Supervised Medication Monitoring

Yes___ No___ 3. Daily reminders to take medication(s). Staff can knock on your door during medication distribution times (morning **7am-8am** and evening **6pm-7pm**)

Yes___ No___ 4. Assistance with / follow-up on obtaining prescriptions/refills from prescriber

Yes___ No___ 5. Assistance with coordinating delivery/pick-up of medications from pharmacy

Yes___ No___ 6. Provide general information/education around medication management.

If you decide to receive medication management support during your stay, please be advised of the following information:

1. **Storage**
   Medications must be kept in a secure, designated location that is easily accessible and

easily identifiable by guest's name.

2. **Supervised Medication Monitoring**

For residents receiving Supervised Medication Monitoring:

- Medications must be kept secured in a designated location and locked away at all times.
- Medication bottles and/or pill packs must be placed inside a plastic bin with guest's name.
- Guests must have a 7-day AM/PM pillbox with guest's name and guest will refill their pillbox every 7 days.

3. **Distribution**

- Medications are disbursed twice daily, once in the morning (between 7am-8am) and once in the evening (between 6pm-7pm) unless otherwise prescribed.

- Guests must be able to self-administer their own medications.

- All medication support is documented and logs are maintained each time medication is monitored or self-disbursed.

- Staff initial guest medication logs. Staff also monitor guests' temperature at time of medication disbursement on a daily basis (at least twice a day) and document this on the temperature log located (see attached) in medication chart.

- Staff are not responsible for prescribing medications or making any changes to medication regimen, etc..

Guest signature:_____ Date:_____

Staff signature:_____ Date:_____

Appendix A

Consumer Self-Report Tobacco Assessment

Name: _____ Gender:☐M ☐ F
Date of Birth: _____Age: _____ Today's date:_____

Tobacco Use –

1. Please check the appropriate box for each type of tobacco:

1a CIGARETTES	Never Used	☐
	Used in the Past	☐
	Currently Use	☐
1b E-CIGARETTES/VAPE	Never Used	☐
	Used in the Past	☐
	Currently Use	☐
1b PIPE	Never Used	☐
	Used in the Past	☐
	Currently Use	☐
1c CIGARS	Never Used	☐
	Used in the Past	☐
	Currently Use	☐
1d CHEWING TOBACCO	Never Used	☐
	Used in the Past	☐
	Never Used	☐
	Currently Use	☐
2. What **age** were you when you **first tried tobacco?**		
3. Age when you started using tobacco on a **regular basis**?		
4. How many cigarettes do you smoke each day?		
5. How often do you use e-cigs/vape each day?		
5. How many minutes after you wake up do you smoke your 1st cigarette (or use other tobacco products)?		
6. Do you sometimes awaken at night to smoke or use other tobacco products?		Yes ☐ No ☐

From the Learning about Healthy Living, Tobacco and You Manual. Edited and Revised February 2012. Appendix A. Rutgers, Robert Wood Johnson Medical School, Division of Addiction Psychiatry.

7. Who smokes in your household? Please check all that apply: No One	☐
Parents	☐
Brothers/Sisters	☐
Significant Other	☐
Roommates	☐
8. Do you **smoke indoors** at home?	Yes ☐ No ☐

9. How **important** is it to you to stop tobacco use now?
Please check one box.

☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

Not at All — Average Importance — Extremely Important

Tobacco-Related Illness

10. Have you in the past or do you now have any of the following?
(Check all that apply)

☐	Arrthymia/ Irregular Heart Beat	☐	Emphysema	☐	Obesity/ Overweight
☐	Asthma or Chronic Bronchitis	☐	Halitosis/ Bad Breath	☐	Peptic Ulcer
☐	Cancer (List Type Below)	☐	Heart Attack/ Disease	☐	Pneumonia
☐	Circulatory Problems	☐	Impotence	☐	Seizures
☐	Diabetes	☐	Infertility	☐	Stroke
☐	Early Menopause	☐	Influenza/ Frequent Flu	☐	Wrinkles
☐	Other illness (describe):				

Desire to Quit

11. Please check the number next to **the one statement that best describes** your current situation:

11a	I currently smoke/use tobacco and I do not want to quit in the next 6 months.	☐
11b	I am seriously considering quitting in the next 6 months, but not in the next 30 days	☐
11c	I am interested in drastically reducing the number of cigarettes I currently smoke (reduce by half or more), but am not interested in quitting totally.	☐
11d	I am interested in quitting smoking/tobacco use in the next month, and I would be interested in any assistance I could get.	☐

12. How **confident** are you that you will succeed in stopping your tobacco use now? Please check one box.

☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

Not at All — Average Importance — Extremely Important

Created by Sandra A. Springer, MD

Guest Name:_____

Rapid Opioid Dependence Screen (RODS)

Instructions: [Interviewer reads] The following questions are about your prior use of drugs. For each question, please indicate "yes" or "no" as it applies to your drug use during the last 12 months.

1. Have you ever taken any of the following drugs?

a. Heroin	☐ Yes	☐ No
b. Methadone	☐ Yes	☐ No
c. Buprenorphine	☐ Yes	☐ No
d. Morphine	☐ Yes	☐ No
e. MS CONTIN	☐ Yes	☐ No
f. Oxycontin	☐ Yes	☐ No
g. Oxycodone	☐ Yes	☐ No
e. Other opioid analgesics (e.g., Vicodin, Darvocet, etc.)	☐ Yes	☐ No

If any drug in question 1 is coded "yes", proceed to questions 2-8.

If all drugs in question 1 are "no", skip to end and code "no" for opioid dependent.

2. Did you ever need to use more opioids to get the same high as when you first started using opioids? ☐ Yes ☐ No

3. Did the idea of missing a fix (or dose) ever make you anxious or worried? ☐ Yes ☐ No

4. In the morning, did you ever use opioids to keep from feeling "dope sick" or did you ever feel "dope sick"? ☐ Yes ☐ No

5. Did you worry about your use of opioids? ☐ Yes ☐ No

6. Did you find it difficult to stop or not use opioids? ☐ Yes ☐ No

7. Did you ever need to spend a lot of time/energy on finding opioids or recovering from feeling high? ☐ Yes ☐ No

8. Did you ever miss important things like doctor's appointments, family/friend activities, or other things because of opioids? ☐ Yes ☐ No

Scoring Instructions: Add number of "yes" responses for questions 2-8. If total is ≥ 3, code "yes" for opioid dependent. If total is ≤ 2, code "no" for opioid dependent.

Opioid Dependent: ☐ Yes ☐ No

TownHome Health

Money Management Support

Guest Name:_____
Room #:_____

Goal of Money Management Support:
_____

Amount Held for Guest: $_____

Date	Amount In Box	Withdrawal Amount	Amount Left	Purpose	Signature