Alcohol and Other Drugs Program
720 Wood St., Eureka, CA 95501
707-476-4054
Fax 707-441-3749

How to apply to the Alcohol and Other Drugs Program

Welcome!

1. You will need to complete this **entire** packet. Fill out as completely as you can. If something does not apply to you, write "N/A" for non-applicable. **Please use blue or black ink.**

2. Bring this application packet and any other paperwork you think might help us (such as proof of income, proof of allowable expenses, court-ordered payments, dependent support payments, medical expenses in excess of 3 percent of gross income, retirement deductions, and court minutes) to an Orientation Group.

3. **You can attend an Orientation Group on any Friday at 8:30 a.m.** This group meets in the main lobby of the Mental Health building at 720 Wood St. Enter the building through the main doors on the parking lot side and have a seat. A counselor will direct guests to an available conference room. It helps everyone to arrive on time.

At the Orientation Group you will receive your first appointment.

*Your completed application packet is valid for 90 days, including the day it is returned to the office. If for any reason you need to re-apply, you can use an application within the 90-day window after it has been completed. If more than 90 days pass, you will need to complete a new application.

Complete this application packet with blue or black ink and come to an **Orientation Group at 8:30 a.m. on a Friday.**

We look forward to meeting you!

Sincerely,

The Humboldt County Alcohol and Other Drugs Counseling Team

Alcohol and Other Drugs Program

Welcome to the Alcohol and Other Drug Program (AOD). Access is available if you or a family member is seeking alcohol or other drug treatment.

Our Adult Alcohol and Other Drug Program treats individuals who are experiencing substance use problems which are impacting their physical health, their interpersonal relationships or are causing employment or legal issues.

Our AOD treatment program offers Outpatient treatment conducted in treatment groups. Our Outpatient Treatment Group meets five days a week.

If an individual needs other services such as residential treatment, detox or other types of counseling, we will refer individuals to the appropriate available local treatment program.

Individuals will be assessed to ensure they meet medical criteria for treatment, but no one will be turned away if they desire treatment for ongoing recovery.

Office hours are 8 a.m. to noon, and 1 to 5 p.m., Monday through Friday, at Department of Health and Human Services Mental Health, 720 Wood St., Eureka, and at the Trimble House, 734 Russ St., Eureka.

For more information, call 707-476-4054.

It is easy to access services. Come to our Wood Street office, pick up a packet and fill it out. Orientation takes place every Friday at 8:30 a.m.

You may also print the packet from this Web page and bring the completed packet with you.

Links to Orientation Packet and Instructions for Orientation

Links:
Information sheet/Brochure
AOD services in Humboldt County

Alcohol and Other Drug Programs
720 Wood St., Eureka, CA 95501
707-476-4054

3008 "Drug Free" Outpatient Treatment Registration

Last Name: ____

First Name: ____

Middle Initial: ____

Maiden Name: ____

*****Birth Name*****

Last Name: ____

First Name: ____

Middle Initial: ____

Residential Address: ____

City, State and Zip Code: ____

Mailing Address: ____

City, State and Zip Code: ____

Phone Number: ____

Gender: Male Female Other (Circle one)

Birth Date: ____

SSN# | | | | | | | | | |

Current Marital Status: Single Separated Married Divorced Widowed

Number of Dependents: ____

Occupation: ____

Religious Preference: ____

Mother's First Name: ____

Alcohol and Other Drug Programs
720 Wood St., Eureka, CA 95501
707-476-4054

Emergency Contact or Guardian Record (Required Minors Only)

Last Name: ____

First Name: ____

Type of Contact: ____

Residential Address: ____

City, State and Zip Code: ____

Home Phone Number: ____

Work Phone Number: ____

Relationship to Client: ____

Other Contacts (Optional)

Last Name: ____

First Name: ____

Relationship to Client: ______________________Significant Other, Attorney, Parole Officer

Residential Address: ____

City, State and Zip Code: ____

Home Phone Number: ____

Work Phone Number: __________________________________Emergency Contact Yes/No

Staff Use Only
Date of First Service ____________________________________
Client Type ____________________________________
County of Responsibility ____________________________________
Case Type ____________________________________

COUNTY OF HUMBOLDT
Department of Health and Human Services

3063- AOD HEALTH HISTORY QUESTIONNAIRE

Client First Name ________________ Client Last Name ______________________ Client ID ___________
Date of Service: ________________

Allergies: Do you have allergies to, or have reacted adversely to, any of the following items? *(Please check box if yes)*

☐ Local anesthesia or dental anesthetics ☐ Penicillin ☐ Sulfa drugs
☐ Barbiturates, sedatives or sleeping pills ☐ Other antibiotics ☐ Iodine
☐ Aspirin
☐ Allergies/reactions to any other drugs or food: please list: ______________________________________

☐ **No Known Allergies**

Current Physical Health (client) is: ☐ Good ☐ Poor Has changed in past year? ☐ Yes ☐ No

Do you have or have you ever had any of the following medical conditions? *(Please check box if yes)*

☐ Allergies
☐ Anemia
☐ Arterial Sclerotic Disease
☐ Arthritis
☐ Asthma
☐ Birth Defects
☐ Blind/Visual Impairment
☐ Cancer ______________
☐ Carpal Tunnel Syndrome
☐ Chronic Lung Disorder
☐ Chronic Pain
☐ Cirrhosis
☐ Congestive Heart Failure
☐ Cystic Fibrosis
☐ Deaf/Hearing Impairment
☐ Diabetes
☐ Digestive Disorders (Reflux, Irritable Bowel Syndrome, Colitis)
☐ Ear Infections
☐ Epilepsy/Seizures
☐ Head Injury
☐ Heart Disease
☐ Hepatitis/Jaundice
☐ Hypercholesterolemia
☐ Hyperlipidemia
☐ Hypertension (High Blood Pressure)
☐ Hyperthyroidism
☐ HIV
☐ Infertility
☐ Meningitis
☐ Migraines
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Obesity
☐ Osteoporosis
☐ Other Neurological
☐ Parkinson's Disease
☐ Physical Disability
☐ Psoriasis
☐ Rheumatic Fever
☐ Sexually Transmitted Disease
☐ Stroke
☐ Tinnitus
☐ Tuberculosis
☐ Ulcers
☐ Other ______________________________

Comments: ____

WOMEN ONLY: are you currently pregnant? ☐ No ☐ Yes ☐ Don't know Last menstrual cycle was on: __________

1028 -cont'd Name: ______ Client ID or DOB: ______ Date: ______

Have you ever had any of the following problems?

- ☐ Eye Disease, injury or impaired sight
- ☐ Ear disease, injury, or impaired hearing
- ☐ Loss of Consciousness
- ☐ Fainting spells
- ☐ Convulsions
- ☐ Paralysis
- ☐ Dizziness
- ☐ Frequent or severe headaches
- ☐ Trouble with nose, sinuses, mouth or throat
- ☐ Enlarged thyroid or goiter
- ☐ Enlarged glands
- ☐ Loss of appetite
- ☐ Extreme tiredness or weakness
- ☐ Skin disease
- ☐ Chronic or frequent cough
- ☐ Chest pain or angina
- ☐ Coughing up blood
- ☐ Night sweats
- ☐ Varicose veins
- ☐ Shortness of breath
- ☐ Palpitations/fluttering heart
- ☐ Back, arm or leg problems
- ☐ Kidney disease or stones
- ☐ Bladder disease
- ☐ Swelling of hands, feet or ankles
- ☐ Protein, sugar, blood in urine
- ☐ Difficulty urinating
- ☐ Abnormal thirst
- ☐ Frequent urination
- ☐ Indigestion
- ☐ Depression or anxiety
- ☐ Suicidal thoughts
- ☐ Memory problems
- ☐ Difficulty concentrating
- ☐ Hallucinations
- ☐ Crying spells
- ☐ Appendicitis
- ☐ Liver or gallbladder disease
- ☐ Hemorrhoids/rectal bleeding
- ☐ Constipation or diarrhea
- ☐ Other: ______

Are you currently under the care of a primary health care provider (for example, doctor, nurse practitioner, clinic)?

☐Yes ☐No Condition for which you receive treatment from the PCP: ______

Current Primary Health Care Provider's Name: ______

Address: ______

Date of last physical exam: ______

Authorization for Release of Information signed to allow sharing of information? ☐Yes ☐No

Family History: Has anyone in your immediate family had any of the following illnesses? *(Please √ box if yes)*

☐Diabetes ☐Cancer ☐Heart Disease ☐Overweight ☐Stroke ☐High Blood Pressure ☐Seizure

☐Other Neurological disorder:

Additional Information, Other Significant Illnesses, etc: ______

Personal History: Please check & explain as appropriate if you have any history of treatment for the following illnesses listed below:

Depression	Schizophrenia	Bipolar	Substance Abuse	Suicide Attempt(s)	Other
☐	☐	☐	☐	☐	☐ ______

Treatment History: ______

# of Psychiatric Hospitalizations (best estimate) for self during: Past Year: ______ **Past Five Years**: ______ **Lifetime:** ______

Family History: Please check if there is any history or treatment for the following illnesses for your family members:

	Depression	Schizophrenia	Bipolar	Substance Abuse	Suicide Attempt(s)	Other
Parent	☐	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐
Aunt/Uncle	☐	☐	☐	☐	☐	☐
Grandparent	☐	☐	☐	☐	☐	☐

 Name: ____________________ Client ID or DOB: ____________ Date: ____________

Medication History:

Please provide medications for the past two years. Record the highest dose given	Currently taking? (check box)	Dose	Frequency	Start/Stop Dates	Prescribed By	How effective are these medications at treating your symptoms? (check box)	Well Tolerated? (check box)
1	☐Y ☐N					☐Full ☐Partial ☐Minimal ☐None	☐Y ☐N
2	☐Y ☐N					☐Full ☐Partial ☐Minimal ☐None	☐Y ☐N
3	☐Y ☐N					☐Full ☐Partial ☐Minimal ☐None	☐Y ☐N
4	☐Y ☐N					☐Full ☐Partial ☐Minimal ☐None	☐Y ☐N
5	☐Y ☐N					☐Full ☐Partial ☐Minimal ☐None	☐Y ☐N
6	☐Y ☐N					☐Full ☐Partial ☐Minimal ☐None	☐Y ☐N
7	☐Y ☐N					☐Full ☐Partial ☐Minimal ☐None	☐Y ☐N
8	☐Y ☐N					☐Full ☐Partial ☐Minimal ☐None	☐Y ☐N
9	☐Y ☐N					☐Full ☐Partial ☐Minimal ☐None	☐Y ☐N
10	☐Y ☐N					☐Full ☐Partial ☐Minimal ☐None	☐Y ☐N

Comments – Please make additional comments if needed to clarify: ____________________

____

____

____

Clients Signature: ____________________ Date: ____________

Guardian Signature: ____________________ Date: ____________

Staff Signature (reviewing with client): ____________________ Date: ____________

MD REVIEW and SIGNATURE (only if client has been referred to Medications Clinic):

____

____

____

____

____

____

MD Signature: ____________________ Date: ____________

Type of Drug Used:	How old where you when you first used this drug?	When did you last use this drug?	In the last 6 months:		Longer than 6 months ago:		Did you use the drug(s) alone (A), or with other users (W)?	All method(s) of use: ie, smoked, inhaled, injected, etc
			How much of the drug did you use?	How often did you use the drug?	How much of the drug did you use?	How often did you use the drug?		
Tobacco:								
Caffeine:								
Alcohol:								
Marijuana/Hashish: (Pot, Bud, Hash)								
Amphetamines/Uppers: (Speed, Ice, Meth, Crank)								
Cocaine: (Crack, Coke, etc)								
Heroin:								
Methadone:								
Other Opiates: (Codeine, Morpine)								
Downers, Barbiturates: (Tranquilizers, Muscle Relaxers)								
Hallucinogens: (LSD, Acid, Mushrooms, Peyote, Mescaline)								
PCP								
Inhalants: (Glue, Amyl, Poppers, Nitrous, Paint, Gas)								
Other:								

Client Name: (Last, First, Initial) ______________________ Client I.D. Number: ______________ Date of Birth: ______________

Humboldt County Department of Health and Human Services
Alcohol and Other Drugs Treatment Program

3010–CLIENT RIGHTS & PROGRAM RULES/ EXPECTATIONS

Welcome to the Adult Alcohol and Other Drug Program. We look forward to working with you.

Our goal is to assist you in obtaining your health and safety goals. If you need services that we do not provide, such as residential or detoxification treatment, or other types of counseling, we will refer you to the appropriate agencies.

Office hours are 8 a.m. to noon, and 1 to 5 p.m., Monday through Friday, and you may call us at 707-476-4054. You may leave a voicemail for your counselor after hours. If you have an emergency, please call the Mental Health Crisis number – **707-445-7715** or call "911." Go to your nearest emergency room if needed.

I. CLIENT RIGHTS:

- You cannot be refused service due to race, religion, ethnicity, age, disability, sexual preference or inability to pay.
- You will be treated without regard to physical or mental disability unless such disability makes treatment by the Adult Alcohol and Other Drug Program non-beneficial or hazardous.
- You can review your personal records with a staff person in attendance upon request.
- You will be treated in a manner that promotes dignity and self-respect.
- You have the right to be accorded safe, healthful and comfortable accommodations to meet your needs.
- You will be provided reasonable opportunity to practice the religion of choice, alone and in private, in so far as such religious practice does not infringe on the right of others. You will not be denied communication with significant others during emergencies.
- You will not be subjected by staff to verbal, emotional or physical abuse or sexually inappropriate behavior.
- If you have a complaint or concern about the services we are providing, please discuss it with your counselor. If this doesn't resolve the problem, your counselor will arrange for you to discuss your concern with the program manager who will make the final decision about the problem. If you are unable to resolve a complaint regarding a decision made about your treatment, you have the right to request a fair hearing.

II. CONFIDENTIALITY:

The confidentiality of alcohol and drug abuse clients and their records that we maintain are protected by federal law and regulations.

We will not release any information about you or your treatment without your written permission unless we are ordered to by a valid court order; in the case of a medical emergency and then only to valid medical personnel; to qualified Mental Health or AOD Program personnel for research, audit or program evaluation; in the case of a violent or potentially violent situation and we have need for assistance; or if we receive information about suspected abuse or neglect of children or elderly persons. We are mandated reporters and will answer any questions that you may have about this.

III. ABSENCES

Please notify us prior to missing a group. If there is a family emergency or crisis where prior notification is not possible, please notify us as soon as you can. Missed groups may result in discharge from the Adult Alcohol and Other Drug Program.

IV. DISCHARGE POLICY

We can stop providing services to you if you behave violently in the clinic or toward any person; if you bring a weapon (real or potential) on the campus; if you appear at the campus under the influence of any substance; if you attempt to manipulate a urine test; if you fail to comply with any reasonable requirement given by the counseling staff; or if you fail to keep the terms of your service agreement.

If the Adult Alcohol and Other Drug Program makes the decision to stop providing services, you will receive written notice explaining the action. Within 48 hours of receiving this notice, a fair hearing on the matter can be requested.

If a fair hearing is requested, the Adult Alcohol and Other Drug Program will schedule it within the next five working days. The fair hearing will be decided by a fair hearing officer who is an employee of the County of Humboldt, but not a member of the Adult Alcohol and Other Drug Program. The fair hearing officer will give a decision in writing. You can speak with the counseling staff about being readmitted to the program. Readmission will be on an individual basis.

V. PAYMENT

If you are on Medi-Cal, your services are paid in full every month. We can bill your insurance company if you bring in claim forms. Others will be charged a fee for services based on ability to pay.

Humboldt County Department of Health & Human Services
People helping people live better lives

VI. PROGRAM RULES / SERVICE AGREEMENT

These are the things we will expect you to do while in the program:

1. Participate in admission interview to determine the type of services needed.
2. Give the Adult Alcohol and Other Drug Program information regarding health status so that the program physician can assess medical status. This may require a physical examination; Inform your counselor about all medications prescribed to you by other doctors.
3. Refrain from using drugs (except such prescription drugs as prescribed by a physician and approved by Adult Alcohol and Other Drug Program medical director) and alcohol. No alcohol, illegal drugs or drug paraphernalia is allowed in or near the building or grounds occupied by the Adult Alcohol and Other Drug Program. You are not to come to the program under the influence. You are expected report any use of drugs or alcohol to Adult Alcohol and Other Drug Program counseling staff. If use of drugs or alcohol occurs, an appointment with a counselor must be made as soon as possible in order to assist you in relapse prevention. In some cases you may be asked to provide urine samples to help determine whether or not you are using drugs.
4. Bringing weapons onto the program grounds is strictly prohibited. Weapons include guns, knives (other than kitchen utensils), explosive devices, striking instruments, martial arts weapons, bows and arrows or other weapons (except for law enforcement officers or security guards acting in the line of duty). We may send you home or discharge you from the program if you do not remove or dispose of a weapon when asked to do so. You may be subject to referral to law enforcement for legal sanctions if you are in violation of this rule.
5. You must attend the Adult Alcohol and Other Drug Program as required. If you can't attend the program the required amount of time, you must notify us as soon as possible. The time required is dependent on your individual treatment plan.
6. Schedule and receive individual counseling with an assigned intake counselor as requested by program.
7. Arrive on time and participate in the counseling group.
9. Safeguard the confidentiality of other clients' identities, as well as all information stated within the treatment program.
10. If you suspect or know of someone violating these policies, we request that you bring the information to the attention of the Adult Alcohol and Other Drug Program staffers.

VII. COMPLAINTS

In accordance with Title 9, Chapter 4, Section 10544(c), of the California Code of Regulations, any individual may request an inspection of an alcoholism or drug abuse recovery or treatment facility. Complaints should be directed to:

Department of Alcohol and Drug Programs
Licensing and Certification Branch

1700 K Street, Sacramento, CA 95814-4037
Attention: Complaint Coordinator (916) 322-2911

VIII. GRIEVANCE PROCESS

You have the right to a fair hearing for the purpose of appealing our intended action related to the denial, involuntary discharge, or reduction in substance abuse services as it relates to your Medi-Cal benefits. To request a fair hearing, submit a written request to:

State Hearings Division
Department of Social Services
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

Telephone: 1-800-952-5253
TDD: 1-800-952-8349

The Adult Alcohol and Other Drug Program will continue to provide services to you pending a fair hearing decision only if you the beneficiary, appeal in writing to State of California Alcohol and Drug Programs for a hearing within 10 calendar days of the mailing or personal delivery of a notice of intended action. In order for us to know that you have requested a fair hearing, please send a copy of the letter you sent to the Administrative Adjudications Division to us. Address your letter copy to:

Program Manager
Adult Alcohol and Other Drug Program
720 Wood St.
Eureka, CA 95501

We expect participants to attend treatment groups and appointments on a consistent basis and to respond to communications regarding your treatment. Treatment is not possible without your participation. Failure to respond or participate will quickly result in a discontinuance of services for you, so that we can free up your “empty” spot for someone on the waiting list.

I have read and understand my rights and the program’s rules:

Printed Name: ____ **Date:** ___________

Signature: ____

*In accordance with the Executive Order #B-22/76, you may request access to your treatment files; a “Request for Access to Clinical Record” form will be needed.

Client Name: ____ **Client ID#:** ____________
CONFIDENTIAL PATIENT INFORMATION (SEE CA W & I CODE 5328, 42 CFR PART 2) DHHS–MHB
FORM # 3010 (Rev 6/4/2013)