Wichita and Affiliated Tribes
Intake Application
PO BOX 729,
Anadarko, OK 73005
(405) 247-2425

STATEMENT OF PURPOSE: The Tribal Opioid Response and Health Department provide substance abuse and mental health services to adults and minor children, who are enrolled with the Wichita and Affiliated Tribes.

A. POLICY

1. Adults must contact the Case Manager personally to request services and schedule an appointment for an assessment and initial paperwork.
2. Parents/Guardians must contact the program to request services for minor children and sign all required initial paperwork.
3. Clients seeking services must have the following documents and complete each form in this application:
    - CDIB
    - State-Issued Identification
    - Court Orders (if applicable)
    - Proof of residence or residence information
    - Employer information
    - Medical History
    - Emergency Contact Information
4. The Program is not responsible for any expenses, such as DUI related costs, legal fees, personal items, clothing etc. Funds are ONLY available for treatment.

B. PROCEDURE

1. When clients seek services with the TOR Case Manager, the Case Manager will conduct an initial intake appointment and collect demographic and background information. Once the client has submitted all necessary paperwork, the client will be

set-up with an initial appointment with the contracted Licensed and Alcohol Drug Counselor, who will do an official assessment and diagnosis, as well as a treatment plan, if necessary.

2. If the client is diagnosed with an Opioid related diagnosis, treatment will be referred and fully funded through TOR funds. However, if a client is diagnosed with any other chemical dependent diagnosis, treatment will be funded through CHR funds.
3. It is the responsibility of the Case Manager to provide intense case management, including follow-up and discharge when treatment is successfully completed.

C. CLIENT ACKNOWLEDGEMENT

1. I understand as a client of the Program, I am responsible for my transportation to and from my scheduled appointments, unless other arrangements are made.
2. I understand that under no circumstance am I to use vulgar language or threaten or harm any Case Manager.
3. I understand the Program Counselor or staff member will visit any clients while incarcerated.
4. I understand as a client I must keep my scheduled appointments, if I am unable to attend, I will make every effort possible to notify my Case Manager. If I am a no-call/no-show for two consecutive appointments, I will be forced to fill out a new application and begin the process over again.

TREATMENT

5. If I am court-ordered to treatment, I am responsible for notifying other agencies that need to be informed of my whereabouts.

6. During my stay at a treatment facility, I understand that I must comply with the rules of the facility and conduct myself in a respectful manner.
7. I agree to sign a “Release of Confidential Information” with the facility. This will authorize communication between programs/counselors regarding my progress and well-being.
8. I understand I will be placed on a “waiting list” for admission to a treatment facility, during this time I will call the facility once a week as directed.
9. I understand I must inform the TOR/Health Program should I choose to leave the facility before completing my program and I will be responsible for my own transportation.
10. The TOR/Health Program will provide transportation to the treatment facility and from treatment, only if I have successfully completed the program.
11. I understand non-client passengers will not be allowed to travel with clients, unless the client is a minor, parents will be required to sign consent forms.

AFTERCARE

12. I understand should I choose to enter a half-way house to continue my care; I will be required to seek employment within one month, post arrival. TOR funds do not provide rent or pay for any half-way housing.
13. I understand the Health Program will not be responsible for my rent payment after one month.
14. I understand I will explore other options to meet my goal of independent living. I will utilize all available resources, in order to become self-sufficient from any state or tribal program.

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The Policy and Procedures for the TOR/Health Program have been explained to me by the Case Manager and by signing this form, I acknowledge that I have read and understand this policy.

CLIENT SIGNATURE	DATE
PARENT OR GUARDIAN SIGNATURE	DATE
COUNSELOR SIGNATURE	DATE

I am applying for services from the Wichita and Affiliated Tribes TOR/Health Programs. I understand that to receive and maintain services. I am responsible for the following:

A. I must keep all scheduled appointments. If I cannot keep an appointment, I will make every effort possible to let the program know and to reschedule.
B. I understand that services from the TOR/Health program are dependent upon the availability of funds and the appropriate staff to meet my individual needs.
C. I am responsible for transportation to and from scheduled appointments unless other arrangements have been made.
D. I must provide all necessary information for all documents utilized in the intake, diagnosis, and treatment planning process of my individual treatment plan.
    a. CDIB
    b. State-Issued Identification
    c. Court Orders (if applicable)
    d. Proof of residence or residence information
    e. Employer information
    f. Medical History
    g. Emergency Contact
E. I will be involved in the development of my Treatment Plan and will make every effort to complete my plan successfully.
F. I will attend virtual appointments regularly or otherwise stated in my treatment plan via telehealth with a LADC contracted by TOR/Health program.
G. Other agencies, activities, and persons must be involved in my treatment program and I must be responsible in keeping appointments with those entities.

H. I understand that all information will be treated in a confidential manner.

The Policy and Procedures for the TOR/Health Program have been explained to me by the Case Manager and by signing this form, I acknowledge that I have read and understand what is expected of me as a client of the TOR/Health program.

CLIENT SIGNATURE	DATE
PARENT OR GUARDIAN SIGNATURE	DATE
CASE MANAGER	DATE

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CLIENT INFORMATION			
FULL NAME:		DATE OF BIRTH:	
ADDRESS:			
REFERRED BY:			
DESCRIBE THE PROBLEM THAT BROUGHT YOU HERE:			
DESCRIBE HOW WE CAN HELP YOU WITH YOUR PROBLEM:			
EMERGENCY CONTACT INFORMATION			
FULL NAME:		RELATIONSHIP:	
ADDRESS:			
PHONE #:		MOBILE #:	
FULL NAME:		RELATIONSHIP:	
ADDRESS:			
PHONE #:		MOBILE #:	
EMPLOYER:			
SUPERVISOR:		WORK HOURS:	
ADDRESS:			
PHONE #:			

Employer contact information is for information purposes only. Client information will not be released to employer without the client's expressed written consent.

THIS FORM IS TO BE COMPLETED BEFORE SERVICES ARE RENDERED. THE COMPLETED FORM MUST BE SUBMITTED TO THE PROGRAM DIRECTOR.

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MEDICAL HISTORY		
NAME OF PHYSICIAN:		
Are you currently on any medications? Yes or No	Are the prescriptions up-to-date? Yes or No	
Please list all medications:		
Do you have any medical conditions or allergies?		
Have you ever had any of the following?	YES	NO
Seizures		
Convulsions		
Hallucinating		
DT's		
Shakes		
Blackouts		
Do you have any of the following:	YES	NO
Mental abuse		
Physical abuse		
Sexual abuse		
Suicide attempts		
Have you been diagnosed with any mental health disorders by a professional?		

Have you ever been hospitalized for the following and how many times for each?

Drug/Alcohol abuse? _____ Mental abuse? _____

Physical abuse? _____ Sexual abuse? _____

How many treatment facilities have you been in for drug/alcohol abuse? _____

Welcome to the TOR/Health Program. Please read the rights listed below and, if you need to, ask questions. If you agree, please sign this form for your case file. You may request a photocopy of this record.

As a client, you have the right

- To considerate and respectful care.
- To consideration of your privacy and individuality, and to be treated with consideration, respect, and full recognition of your dignity and individuality including privacy in caring for your needs.
- To obtain information as to any relationship of the TOR/Health Program to other health care and related institutions insofar as your care is concerned.
- To respectfulness as it relates to your program. Case discussions, consultations, and treatment are confidential and are conducted discreetly.
- To expect reasonable continuity of care, which includes schedules of activities and at what times, staff and services are available.
- To be refused treatment only for therapeutic reasons, for your welfare, or that of other clients.
- To be assured of confidential treatment of your personal records and to approve or refuse their release to any individual outside of the Wichita Chemical Dependency/Mental Health Program not included in the therapeutic purpose in your treatment plan.
- To not be required to perform services for the Wichita Chemical Dependency/Mental Health Program, which are not in your treatment plan.
- TO REFUSE TREATMENT

- To be fully informed as evidenced by your written acknowledgement, of the rights, responsibilities set forth herein, and regulations governing client conduct and responsibilities.

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I, _____, the undersigned, hereby agree to participate in the TOR/Health Program voluntarily, give permission for all professional services rendered by the TOR/Health Program. I understand that such services may include, but not be limited to, routine diagnostic procedures, education and psychological treatment which is to include whatever procedures deemed necessary to confirm the objectives of the TOR/Health Program.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the client or is authorized by the client to execute the above provisions and accept its terms. By his/her signature the client acknowledges receipt of the copy.

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

This document authorizes the Wichita and Affiliated Tribes TOR/Health Program to disclose information concerning the following client/tribal member:

_____

Client/Tribal Member

To the following persons or agencies:

1. _____
2. _____
3. _____

I understand that I may revoke in writing, my consent to release information at any time, except to the extent that action will have taken place on information released before the revocation of my consent. Otherwise, this consent form is valid until:

_____

Condition, Date, or Event Expressed by Client

CLIENT SIGNATURE	DATE
PARENT OR GUARDIAN SIGNATURE	DATE
CASE MANAGER	DATE