

Santa Monica Halfway House

130 N. 39th Street

Omaha Ne 68131

402-558-7088

Fax 402-558-7133

Pre Treatment Assessment

York Application

Date:

I. Client Identification:

NAME	
PREVIOUS ADDRESS	
PREVIOUS PHONE NUMBER	
D.O.B	
SEXUAL ORIENTATION	
GENDER EXPRESSION	
AGE	
SOCIAL SECURITY	
HEIGHT	
WEIGHT	
HAIR COLOR	
EYE COLOR	
TATTOOS- DESCRIBE	
PIERCING - DESCRIBE	
EMERGENCY CONTACT NAME, ADDRESS, PHONE, RELATION TO YOU	
WHO REFERRED YOU, NAME, ADDRESS, PHONE	
MEDICAID ID NUMBER	
MARITAL/RELATIONSHIP STATUS	
ETHNICITY	
CULTURAL BACKGROUND/PRACTICES	
SPIRITUAL BELIEFS/PRACTICES	
PREFERRED LANGUAGE	
ARE YOU YOUR OWN GUARDIAN?	

II. Presenting Problem/Primary Needs:

Why are you seeking treatment? What has led you to your current situation? In your own words please describe why you are applying for Santa Monica.

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Have you experienced or witnessed any of the following traumas in your lifetime? Please specify whether it was as a child, and adult or both and specify if experienced or witnessed.

	Sexual Abuse		Physical Assault		Victim of terrorism
	Physical Abuse		Serious Accident		War/political violence
	Emotional Abuse		Sexual Assault/Rape		Disaster
	Neglect		Prostitution or Trafficking		Sanctuary Trauma (trauma in institution)
	Witness to Domestic Violence		Life Threatening Medical Issue		Other:
	Witness to Community Violence		Traumatic loss of loved one		

III. Medical History

Physician		Last Seen:
Dentist		Last Seen:

Hospitalizations:

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	Problems sleeping		Allergies		Tremors
	Frequent Headaches		Excessive Sweating		Menstrual Problems
	Stomach problems		Rapid weight gain		Vomiting
	Hearing difficulties		Rapid weight loss		Unusual Bleeding
	Eyesight problems		Twitching/tics		Lack of Energy
	Numbness		Dry Mouth		Hyper
	Chest Pain		Heart Irregularity		Dizziness/Fainting
	Skin Irritations		Watery Eyes		Blackouts

[illegible]

If you answered No to any of your medications being effective please explain which medications and reasons you feel they are not effective:

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Prior Medication(s) History

Name & Dose	Why discontinued	Start date	Discontinue date	Effective Y/N

Any medication compliance concerns past/current? Have you in the past or do you currently take you meds as prescribed and on regular basis?

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Please describe any adverse effects or allergic reactions to any medications:

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IV. Employment/Education/Military History

High School Graduate or GED?	
Highest Grade Completed?	
Describe any training/education beyond High School. Including certificates, licenses, etc.(What skills /Dates)	
Employment History (Where, job title, when, how long)	

Military Service	
Strengths/Abilities	
Current Literacy Level, learning disabilities, troubles reading, writing, comprehension? Explain	
Do you have a need for assistive technologies in provision of services? Please explain	

V. Alcohol/Drug History

History of Drug Use	Drug of Choice	Age of first use	How often were you using when you quit?	How much were you using when you quit?	What method were you using your drug?	Date of last use?
Primary						
Secondary						
Tertiary						

Have you used IV Drug in the past? Last Date used IV?

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List prior treatment experiences: (Most recent to oldest)

Program	Type (Outpatient/Inpatient)	Year	Length	Outcome

What is the longest period of abstinence you have had since you started using? Please explain the circumstances surrounding that time, including supports utilized. (Incarceration, utilizing self-help program, treatment, pregnancy etc.)

Tolerance level/withdrawal/history of complications from withdrawal (summarize concerns):

Are you currently ever experienced any of the following emotional/behavioral problems related to substance abuse? If yes please specify how long ago.

	Overeating		Self-Harm (cutting etc.)		Workaholic
	Malnourishment		Smoking		Unhealthy sexual activity
	Excessive drinking		Unreasonable fears		Illegal Activity
	Drug Use		Problem concentrating		Auditory Hallucinations
	Needle Use		Gambling		Visual Hallucinations
	Risk Taking		Aggressiveness		Maintaining employment
	Impulsivity		Outbursts		Other

Family History of Substance Abuse: Please explain for example, who or relation to you, what substance, living or deceased, currently or past use of substances, did they utilize treatment, what is the relationship like with this person today.

VI. Legal History

Do you have any pending criminal charges, or warrants? Include pending Child Protective Cases.

Charge/Warrant	Date Incurred	Pending Court Dates/Location	Connection to substance use

Who is the Attorney/CPS worker assigned to your current case? (Name and contact information)

Please list prior criminal charges and convictions from most recent to oldest:

Charges and/or Convictions	Year	What State/County or Federal Court	Outcome	Connection to substance use

Total length of time spent incarcerated during your life time? (In years, months or days)

VII. Family/Social/Peer

Describe your family history including siblings, parents, living situations, where you were born or raised and by who, how you would describe you childhood, etc.:

Describe your current relationship with family, community members, friends or others:

What was your primary living situation during the six months prior to incarceration? Where did you live, with who, etc.?

Do you consider your primary living arrangement during the six months prior to incarceration to be stable/safe? Why or Why not?

If applicable, were your children with you during the majority of the last six months? If not, where were they?

If applicable, where do your children reside now and with whom? Do you have contact, and how much?

Rate and describe your parenting knowledge or skill level, describe your relationship with your children:

Please identify activities, hobbies, interests and or outlets that you have enjoyed in your life time:

Please identify areas of your life where you have feel connected and/or persons you consider to be supportive, include any support systems or community connections:

Strengths:

	Honest		Calm/Serene		Loyal
	Dependable		Strong Willed		Experienced
	Independent		Problem Solver		Intuitive
	Hard Working		Organized		Insightful
	Self-Motivated		Creative		Focused
	Loving		Sense of Humor		Serious Minded
	Intelligent		Trustworthy		Carefree
	Quality Parent		Athletic		Obedient
	Compassionate		Moral		Attractive
	Sensitive		Resourceful		Personal Cleanliness

	Risk Taker		Wise		Other
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Abilities and/or interests that can include skills, aptitudes, capabilities, talents and competencies:

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VIII. Psychiatric/Behavioral History:

Have you ever been given a Mental Health Diagnosis? For example; bipolar, depression, PTSD etc. (Identify what diagnosis and when)

DIAGNOSIS	YEAR

Have you received previous Mental Health Treatment? (Identify where, when and type)

WHERE	YEAR	INPATIENT/OUTPATIENT

Any Family History of Mental Health? Please explain for example, who or relation to you, what diagnosis, living or deceased, etc.

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Suicidal/Homicidal Ideations during your lifetime:

YES	NO	Description	When and Method
		Thoughts of suicide?	
		Attempt at suicide?	
		Thoughts of harming others?	
		Attempts at harming others?	

Current or Past Board of Mental Health Commitments:

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IX. Goals/Needs/Preferences:

What would you like to work on if you came to Santa Monica? What needs could be addressed? Include some of your expectations for treatment or any preferences that you feel will enhance your treatment experience? These will be used to create treatment goals. Please be specific.

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Please tell us why you are interested in Santa Monica and what being accepted would mean for you?

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Can you describe how does it make you feel and how do you handle conflict, including when you are being held accountable? For example if a peer, friend, family member or staff member bring to your attention behaviors that need to be addressed?

Is there anything else you would like to share about yourself?

Signature_____Date_____

**Santa Monica Inc. Treatment Program
Client Authorization to Release Information**

I, _____ give consent to release the following selected below of records and information pertaining to my treatment at Santa Monica. I authorize disclosure of my personal records to:

Name: Staff members Relationship: providers
 Address/Agency Nebraska Correctional Services P.O. Box 94661
 City Lincoln State: Ne Zip 68509 Phone # 402-471-2654
 Fax# 402-479-5623

I authorize Santa Monica, Inc, to release to and/or request and receive from the above person or agency the following information as described below (check as many as do apply).

Information	To be released by Santa Monica Inc.	Requested by Santa Monica, Inc.	Exchanged with
Medical History	_____	_____	<u>X</u>
Physical Exam/Lab results	_____	_____	<u>X</u>
Social History/Assessment	_____	_____	<u>X</u>
Chemical History/Assessment	_____	_____	<u>X</u>
Psychological Evaluations	_____	_____	<u>X</u>
Aftercare Planning	_____	_____	<u>X</u>
Change in condition or status	_____	_____	<u>X</u>
Discharge/Transfer Summary	_____	_____	<u>X</u>
Progress Reports	_____	_____	<u>X</u>
Other	_____	_____	<u>X</u>

The purpose of this release is: Coordinate

I understand that my records are protected under the Federal Regulations governing confidentiality of Alcohol and Drug Abuse patient records. 42CFR part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires in 6 months.

Client Signature _____ Date: _____

Staff Signature _____ Date: _____



Santa Monica was established in 1972 to provide long term residential care to women with substance use disorder. Santa Monica is a Halfway House program that continues the treatment of substance dependence, mental health and trauma while stabilizing women to reintegrate back into the community by seeking and maintaining employment, becoming a part of the recovery community, reunification with family, meeting legal and financial requirements.

Programming

Santa Monica is staffed 24/7 with Licensed Alcohol and Drug Counselors on staff. We provide up to 30 hours of programming a week depending on the phase. The program is a minimum of six months.

Admission

To consider you for admission we need a copy of a Chemical Dependency Evaluation, preferably done within the last 6 months. Eligibility criteria includes adult Female, primary substance use disorder diagnosis, including co-occurring diagnosis. Physically able to manage program structure. Preferably have some type of prior treatment experience.



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How long is the admission process?

Once we receive the Chemical Dependency evaluation, we will call within 1 to 2 business days to set up a screening within the next 1 to 2 days. Date of admission can be established following the screening if they are eligible. Our average wait time between screening and admission is 7 days.

Payment for Services

Cost of treatment depends on financial eligibility. A Nebraska resident can be assessed for use of state funds to pay for treatment costs, using the Nebraska Sliding Fee scale. The majority of women qualify for this funding. All women will pay \$105.00 a week for room and board. There is no upfront payment required for admission. Once they secure employment that is how they will pay room and board. Our program is funded in part by Region 6 Behavioral Health.

Collaboration

Santa Monica collaborates with other agencies in the community to provide a holistic treatment experience. This includes working with the legal system, DHHS/CPS, dental and medical services, Mental Health services and other Behavioral Health services identified as a need for the client.

Contact Information

Santa Monica, Inc.

130 N. 39th Street

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P 402-558-7088

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heather@santamonica.omhcoxmail.com

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