MOUNTAIN MANOR RECOVERY SUPPORT SERVICES (MMRSS)

Greetings: MMRSS is a six to nine month housing & recovery support program offered to homeless Carroll County Residents with a history of substance abuse or co-occurring disorders. We offer individualized support that engages the Resident in the recovery process. There is no required fee upon admission; however, Residents must pay 30% of their gross income to the program upon employment. This covers all of their needs while at MMRSS including food, housing, case management services, and recovery support.

A referral to RSS requires specific documentation. The referral packet must be sent to the Bureau of Wellness and Prevention for review.
Contact person is Veronica Dietz- fax # 443-952-7599 or email veronica.dietz@maryland.gov

Check list for completing a referral to Mountain Manor Recovery Support Services:

- Universal Referral Form
- Mountain Manor Application
- Assessment/Evaluation
- Drug Matrix
- PPD (if available)
- Copy of Drivers License (if available)
- Copy of Social Security Card (if available)
- History & Physical (if available)
- Proof of Carroll County Residency
- Homelessness Documentation
- Signed Releases

Please note: Verification of Homelessness requires documentation. Examples include a letter from family/friends that referral person is not permitted to stay at their residence, letter from Shelter.

Mountain Manor Recovery Support Services (MMRSS)
Intake Application

Crisis Referral _____ Recovery Support Program Referral _____ Date of Referral: _____/_____/_____

Demographics

Name: ____ Date of Birth: _____/_____/_____ Age: ______
Last First MI

Gender: M __ F __ Soc Sec #: _______-_____-_______ Phone: (_____) ______-________ Marital Status: ☐NM ☐M ☐D ☐Sep ☐ W

Medical Insurance: ☐ Yes ☐ No If Yes, Name of Provider: ______________________________MA#: ____________________

Emergency Contact: __________________________________ Relationship: _______________ Phone #: (_____) ______-_______

Housing Status: ☐ Homeless now ☐ Homeless for more than 30 days ☐ Homeless for more than 6 months

Ambulatory: ☐ Yes ☐ No Needs Assistance with ADLs: ☐ Yes ☐ No Other Physical Disabilities: ☐ Yes ☐ No

Medical Information

Current Medications (or attach a medication list for more than six medications)

Name of Medication	Dosage	Frequency	Reason for Medication	Prescribing Doctor

(Please note below if applicant is out or nearly out of any medications listed above)

Able to Self-administer medications? ☐ Yes ☐ No **(RSS Staff DO NOT monitor or administer medications. Staff only observe.)**

Please use the following lines to describe any physical or mental health issue we should know about in order to serve you the best:

____

____

____

____

____

Explain Ambulatory/ADL/Other Disability Issues: ____

Legal Information

Military Veteran: ☐ Yes ☐ No If Yes, what is your current status: ______________________________

Currently at CCDC: ☐ Yes ☐ No Drug Treatment Court: ☐ Yes ☐ No ☐ Pending

Currently on Probation: ☐ Yes ☐ No Currently on Parole: ☐ Yes ☐ No Parole Release Date: ____/____/20___
If yes, Probation/Parole Officer:______________________________Phone:______________________________
Current Pending Charges: ☐ Yes ☐ No If Yes, Court Date: _____/_____/20_____ Charges: ____________________

____

Conviction of a violent crime: ☐ Yes ☐ No Explain: ____

Conviction of a sex offense: ☐ Yes ☐ No Explain: ____

Referral Source Information

Referral Agency: ☐ Carroll Co Health Department ☐ Carroll Co Detention Center ☐ Carroll Hospital Center

☐ Shoemaker Center ☐ Other Mountain Manor ☐ Other : ______________________________

Printed Name of Referring Person: ______________________________ Title: ____________________

Signature of Referring Person: ______________________________ Contact #: (_____) _____-________

Reason for Referral: ____

Substance Abuse Information

Drugs of Choice	Oral/IV/Inhale	Date Last Used	Amount Used

IV Drug User: ☐ Yes ☐ No ☐ Past Currently a Methadone or Suboxone client: ☐ Yes ☐ No If Yes, Current dose: __________

SA Provider Name: ____________________ Provider Phone: (___) ____-______ Counselor: ____________________

Current Withdrawal Symptoms: ____

Emotional/Behavioral/Psychiatric Information

Currently Receiving Mental Health Treatment: ☐ Yes ☐ No If Yes, name of Provider: ____________________

____

Mental Health Clinic: ☐ Yes ☐ No If Yes, Name of Clinic: ____________________ Psychiatrist/Therapist: __________

Any suicide attempts: ☐ Yes ☐ No If Yes, Date of Most Recent: _____/______/20_____ Number of Attempts: __________

Current Mental Health Diagnosis____

ICD Codes:____

Suicide Potential: Current Plan ☐ Yes ☐ No Recent Attempt: ☐ Yes ☐ No Intent: ☐ Yes ☐ No Means☐ Yes ☐ No

Explain in more detail: ____

Homicide Potential: Current Plan ☐ Yes ☐ No Recent Attempt: ☐ Yes ☐ No Intent: ☐ Yes ☐ No Means☐ Yes ☐ No

Explain in more detail: ____

Consent to Release Information

______________________________, consent that information about me may be released to Mountain Manor Recovery Support Services, Sykesville, Maryland. I further agree that The MMRSS program may forward this information to appropriate agencies in order to coordinate care for me. These consents will be authorized separately. This consent will remain in effect for one (1) year from date of my signature on this document. However, I may rescind my authorization, in writing, at any time.

______________________________ _____/______/20______ _____/______/20______

Signature Date Date Rescinded

______________________________ _____/______/20______ ____________________

Witness Signature Date Signature of Resident for Rescinding

Mountain Manor Recovery Support Services (RSS)
Supplement to Intake Application
Documentation of Homelessness

Name: ______________________________ Date: ____/____/20____

Please encourage the applicant, in a few words, to describe his/her current living situation, prior living situation. If the applicant is currently in an institution (jail, hospital, etc.), please have the applicant describe their living situation prior to this institutional placement.

Current Living Situation:

____

____

____

____

____

____

Prior Living Situation:

____

____

____

____

____

____

If coming from Jail, Hospital or Other Confined Program What was Your Living Situation Before?

____

____

____

______________________________ ____/____/20____
Prospective Resident Signature Date Completed

Verification of homelessness documentation:
(Typically via a Health Department Representative) ______________________________
Signature of person doing verification

For MMRSS Office Use Only

CARROLL COUNTY HEALTH DEPARTMENT
UNIVERSAL REFERRAL FORM

Name:
First: ____________________ Middle: ______________ Last: ____________________

Address: ____

City: ____ Zip Code: __________

Home Phone: ____________________ Cell Phone: ____________________

Email Address: ____________________

Social Security Number: ____________________ Sex: ☐ Male ☐ Female

Date of Birth ______________ Age _____ Marital Status ☐NM ☐M ☐D ☐Sep ☐Wid

Highest level of education completed: ______________

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White

Are you Hispanic or Latino? ☐ Yes ☐ No Citizenship ____________ Veteran Status ____________

Number of Dependents ____________ Income (Annual Gross) ____________________

Are you Pregnant? ☐ Yes ☐ No Primary Language ______________ Interpreter Needed ☐ Yes ☐ No

☐ Unemployed ☐ Employed ☐ FT ☐ PT by: ________________________________

Emergency Contact Person –
Name: ____________________________ Relationship ______________
Address: ____
Phone: ____________________
Are you currently in treatment? ☐ Yes ☐ No Where? ____________________
Diagnostic Impression: ____
ASAM criteria Level of Care: ____________________________ ☐ Unknown
Source of Referral: ____________________________ Phone # ____________________
Reason for Referral: ____
____
____

Do you have a regular medical doctor? Name: ________________________________

Have you visited an Emergency Department in the past 12 months? ☐ Yes ☐ No
Have you had any psychiatric admissions to a hospital in the past 12 months? ☐ Yes ☐ No
Check any that apply: Temporary Cash Assistance ☐ Medicare ☐ Medicaid ☐ None ☐
Date Obtained: ____________________

CARROLL COUNTY HEALTH DEPARTMENT
UNIVERSAL REFERRAL FORM

Please check off all services for which you are referring

Urgent Care Referral - BPWR ☐ Yes ☐ No

Mountain Manor RSSP*** ☐ Yes ☐ No

PATH – Outreach and CM ☐ Yes ☐ No

Walk-in substance abuse assessment - BPWR ☐ Yes ☐ No

Shoemaker*** (Medical Necessity Required) ☐ Yes ☐ No

Ambulatory Detox - BPWR ☐ Yes ☐ No

Collaboration for Homeless Enhancement (CHES) ☐ Yes ☐ No

Housing Opportunities for Individuals with HIV/AIDS (HOPWA) ☐ Yes ☐ No

*****<u>Referrals to Mountain Manor Recovery Support System Program (MMRSSP) and Shoemaker include:</u>**

(For MMRSSP please also attach referral form)

Drug Matrix ☐ Yes ☐ No
Assessment /TAP ☐ Yes ☐ No
History &Physical (if done) ☐ Yes (MMRSSP)
Readmission letter (if applicable) ☐ Yes ☐ No
Drug Treatment Court Letter ☐ Yes ☐ No
Court Order ☐ Yes ☐ No

Copy of Social Security Card ☐ Yes ☐ No
Copy of Driver's License ☐ Yes ☐ No
TB Assessment Form (for Shoemaker Only): ☐ Yes ☐ No
PPD results (if available): ____________
completed: ____________

<u>Recovery Services (Peer Support)</u>: (Coaching with Peers who have lived experience)
Does the individual need assistance with the following?

Food Stamps ☐ Yes ☐ No
Cash Assistance ☐ Yes ☐ No
SSI/SSDI ☐ Yes ☐ No
Unemployment ☐ Yes ☐ No

Peer Support ☐ Yes ☐ No
Housing Assistance ☐ Yes ☐ No
Medication Assistance ☐ Yes ☐ No

Admin. Care Coordinating Unit (ACCU – MA assistance) ☐ Yes ☐ No

CONSENT TO RELEASE INFORMATION

I, ______________________________, consent for ______________________________ to send the Universal Referral Form to the Bureau of Prevention, Wellness and Recovery. I further agree that Carroll County Health Department/Bureau of Prevention, Wellness and Recovery may forward the Universal Referral Form to the agencies checked above in order to coordinate care for me. This consent will remain in effect for 1 (one) year or may be rescinded in writing at any time.

______________________________ ______________________________
Client Date

______________________________ ______________________________
Referral Source Signature Date

For BPWR Office Use Only

Notes:

______________________________ ______________________________

Approved ☐ Yes ☐ No Signature Date

Revised 05/01/15

CARROLL COUNTY HEALTH DEPARTMENT
BUREAU OF PREVENTION, WELLNESS AND RECOVERY

DRUG MATRIX

DRUG	AGE AT 1ST USE	DATE OF LAST USE	ROUTE: Oral, IV, Snort, Smoke	PATTERN OF USE
ALCOHOL				
AMPHETAMINES				
BARBITURATES				
BATH SALTS				
BENZODIAZAPINES (Xanax, Valium, etc.)				
CAFFEINE				
CANNABIS				
COCAINE				
CRYSTAL METH				
ECSTACY				
HALLUCINOGENS				
HEROIN				
INHALANTS				
KETAMINE				
METHADONE				
NARCOTICS				
NICOTINE				
OVER THE COUNTER DRUGS				
PCP				
TRANQUILIZERS				
SUBOXONE				
SALVIA DORIA				
SPICE 2K				
OTHER "DESIGNER DRUGS"				
OTHER				

Staff Signature:_______________________________ Date: ______________

Updated Staff Signature:_______________________________ Date:______________

Patient/Client Name:_______________________ SS#:_______________ SAMIS #________

Drugmatrix.
Rev. 08/02, 03/03, 8/05, 3/07, 4/09, 7/11, 5/12

MOUNTAIN MANOR RECOVERY SUPPORT SERVICES
PRE-ADMISSION CHECKLIST

DO BRING:

- Clothing- No more than 7-10 days of clothing (if available). There are laundry facilities available on site.
- Personal Hygiene Items
- Identification (ID, Drivers License, SS card, etc)
- Prescribed medication/OTC Medication- Turn into staff immediately. May not be kept on person.
- Cell Phone/Ipad/Ipod/Laptop- stored at your own discretion
- Reading materials- recovery related or for leisure reading
- Towels- for bathing (if you have them)
- Linens for twin sized bed- sheet, pillow, blanket (if you have them, otherwise they will be provided)
- Writing materials – pens, pencils, coloring, paper
- Vehicle- must have drivers license, registration, and proof of income.

DO NOT BRING:

- Clothing with alcohol, drugs, sex, gangs, see through clothing, or otherwise inappropriate for a recovery oriented environment.
- Scissors, straight razors, tools, or other items that could be used as a weapon
- No products containing alcohol (perfume, mouthwash, etc.)

PROGRAM GOALS & OBJECTIVES:

- Improve Physical/Mental/Social/Behavioral Health through treatment, therapy, case management, and support.
- Develop a positive support system to break the cycles of addiction, homelessness, and incarceration.
- Become actively involved in a self help program of recovery.
- Develop positive working skills and gain employment.
- Establish a long term plan for recovery, relapse prevention plan and independent living.
- Become financially secure and independent (establish bank accounts, entitlements, etc.)

MOUNTAIN MANOR RECOVERY SUPPORT SERVICES
PRE-ADMISSION AGREEMENT

INTRODUCTION

When you request services from us, you are forming a relationship with the staff of MMRSS. You are committing to participate fully in this six to nine month housing and case management program. Our program believes in the individuality and dignity of all Residents. In line with that belief, we understand that the effort to be alcohol and drug free can only be your choice, a choice that you expressed when you voluntarily requested admission to our program. Our primary concern is the effect that substance abuse has had on your life and the lives of others and help that we are able to offer you in your recovery.

AGREEMENT

By deciding to accept admission and participate in the MMRSS program, I commit to the following:

- Abstain from alcohol and other drugs.
- Comply with all rules of this program.
- Find employment/stable income.
- Pay amount indicated for Supportive Living Fees (30% of any income). Report any changes in income to Life Skills Manager and Office Manager immediately.
- Respect the dignity, rights, and confidentiality of others.
- Exercise care for community property and agree not to alter or damage property and if such damage should occur, I understand that I am financially and legally responsible.
- Comply with intake and evaluation process.
- Participate fully with formation of service plan, discharge plan, and carry out agreements made and comply with goals established in service plan.
- RSS is not liable for personal possessions or property. Residents are encouraged to leave valuables with family or concerned person.
- Keep bedroom and living area clean.
- Meet with case manager and substance use treatment provider regularly and as requested.
- Attend all in house groups when in building and all OP provider groups as scheduled.
- Perform assigned daily chore of the facility.

I,____________________________________, a prospective MMRSS Resident have read and understand the Preadmission agreement. I understand that I am committing to up to nine months in this program. I commit to comply program rules and boundaries. I understand that I am required to participate in this program as well as select a substance abuse treatment provider and participate fully in treatment services.

Resident Signature__________________________________Date:____________________

Witness:____Date:____________________

CARROLL COUNTY HEALTH DEPARTMENT
BUREAU OF PREVENTION, WELLNESS & RECOVERY

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL & PROTECTED HEALTH INFORMATION

I, ____, authorize the Bureau of Prevention, Wellness & Recovery to disclose.

To: Mountain Manor Recovery Support Services at Carroll County
7295 Buttercup Road, Sykesville, MD 21784, 410-795-5767, Fax: 410-795-6770

The following information: Date of Admission, Date of Discharge, Behavior & Attitude in Treatment, TAP, and Treatment Records.

The purpose of the disclosure authorized herein is for: Continuing Care Referral

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and that any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations.

I understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure.

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

____

(Specification of the date, event, or condition upon which this consent expires)

I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it is signed.
I accept ________ (initials) I decline ________ (initials) a copy of this form.

Dated: ____________________ ____________________
Signature of patient

____
Signature of parent, guardian or authorized representative, when required

Dated: ____________________ ____________________
Signature of Witness

NOTE: Federal regulations prohibit you from making any further disclosure of this information, without the specific written consent of the patient.

CARROLL COUNTY HEALTH DEPARTMENT
BUREAU OF PREVENTION, WELLNESS AND RECOVERY

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL & PROTECTED HEALTH INFORMATION

REQUEST FOR CONFIDENTIAL INFORMATION

I, ____,

D.O.B. : ______________________; SS# : ______________________

Authorize:

NAME: ____

ORGANIZATION : Mountain Manor Recovery Support Services at Carroll County

ADDRESS: 7295 Buttercup Rd.

CITY: Sykesville, MD 21791

Phone: 410-795-5767 Fax: 410-795-6770

to release to the Bureau of Prevention, Wellness and Recovery the following information:

copy of service plan, housing, behavioral issues, discharge summary.

For the purpose of continuity of care

I understand that my records are protected under the Federal regulations governing ~~Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and that~~ any information that identifies me as a patient in an alcohol or other drug abuse program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations.

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

____

(Specification of the date, event, or condition upon which this consent expires)

I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it is signed. I accept ________ (initials) I decline ________ (initials) a copy of this form.

Dated: ____________________

____
Signature of defendant/patient

____
Signature of parent, guardian or authorized representative, when required

Dated: ____________________

____
Signature of Witness