ADMISSION PACKET

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Kissimmee, Florida 34744
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REV: 12172014

House of Freedom

Admission Packet Contents

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PART I

Introduction

Thank you for choosing House of Freedom (HOF) as your behavioral health provider. We are committed to your treatment and expect that you will be equally committed. Please read all of the information carefully, including this introduction.

- HOF is a non-profit faith based residential substance abuse treatment center that is licensed by the Department of Children and Families and internationally accredited by CARF International. We offer a wide array of services in order to meet your individual needs.

- During your stay, you will receive group and individual counseling, educational and vocational training, life skills training, meditations and relaxation exercises, participation of religious services, and relapse prevention planning to help you prepare for a successful transition into the community.

- Our Mission is to provide each client the opportunity to achieve the highest physical, psychological, and spiritual well-being. **C**are, **C**ompassion, and **C**ompromise will be basic principles to attain this, sustained by a neat, secure, and reliable environment.

- We will not share any confidential information with any other person or organization without your written consent.

- Your participation in the services provided by HOF is purely voluntary and you may withdraw whenever you wish. We will staff your case with other therapists employed at HOF when you or your therapist feel it will be beneficial to your treatment.

- The parent/guardian is asked to be responsible for the client's medical and personal expenses. While HOF provides the counseling program, food, and living accommodations, we are not a medical facility. We cannot be responsible for a client's previous debt or third-party expenses such as doctors' appointments, hospitalizations, and medications costs incurred while the client is living in our facility.

- HOF is supported by the monthly tuitions made by the clients' families and provides services below its costs. Therefore, all clients are issued with government benefits to assist with their food provision while residing in our facilities. If the client and/or parent/guardian do not wish to participate in this type of assistance, arrangements will have to be made in order to adjust the monthly tuition amount.

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Instructions

Step 1 Introduction – Read the introduction on the previous page and then proceed to Step 2.

Step 2 **Parent(s)/Guardian/Financial Custodian** please read and sign the following documents:

- Psychotherapeutic Family Training Group **(optional for relatives living in Puerto Rico)**
- Dual Diagnosis
- Monthly Tuition
- Monthly Tuition Alternative
- To Parent(s)/Guardian Part 1
- To Parent(s)/Guardian Part 2
- Electronic Information Agreement

Step 3 **Parent(s)/Guardian and Client** please read and sign the following documents:

- General Rules and Information
- Authorization for Use or Disclosure of Information for Purposes Requested by HOF
- Participation of Occupational Workshops & Special Activities

Step 4 **Client** please read and complete/sign the following documents:

- Client Waiver of Liability
- EBT Assistance Questionnaire
- Authorized Benefit Representative (for food government benefits, sign at bottom on Signature of Head)
- Statement of Understanding (for food government benefits, sign on top on Signature of Adult Household Member)

Step 5 **Client's physician** should complete and sign Medical Screening form (pages 19 & 20), within 30 days prior to admission, **if possible**. If the client needs to be admitted immediately, **client** please fill out the medical screening and our Medical Director will review and sign such documents, once admitted.

Step 6 Send all completed/signed documents by fax to 1-888-702-0079 **prior to admission**.

Step 7 Call to confirm that all information has been received by the Admissions Coordinator.

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PART II

Psychotherapeutic Family Training Group

House of Freedom understands that addiction is a disease which affects the entire family. For this reason, we offer psychotherapeutic family training group services in Puerto Rico, as well as in the state of Florida. We offer 2 sessions programs live** and/or online***. If you would like to participate in this Group, please choose one of the following options (X):

_____ a. Basic Program (12 sessions – Cost $360.00) _____Live _____ Online

_____ b. Intensive Program (32 sessions – Cost $1000.00) _____Live _____ Online

**Meeting address in Puerto Rico - Carr. 838 Km. 4.8, Bo. Monacillos, Río Piedras, Puerto Rico 00926 (in front of Colegio Mater Salvatoris). Meeting address in Florida – 2311 North Orange Blossom Trail, Kissimmee, FL 34744.
***Process to access online will be provided.

1. ________: I understand that the registration cost only includes the participation of two family members. Additional family members will have a cost of $100 per registration.
   a. **Name of Participants: 1. ____________________ 2. ___________________**
   b. **Additional Participants: 3.____________________ 4. ___________________**
2. ________: I understand that it is my responsibility to sign my name in the attendance sheet each time that I attend the psychotherapeutic family training group, during live sessions.
3. ________: I understand that upon completing the sessions I will be a candidate to participate as an assistant of the psychotherapeutic family training group.
4. ________: I understand that in the event that my relative abandons the treatment of House of Freedom or is expulsed of such and that I decide not to continue attending the psychotherapeutic group of family training, the registration fee is nonrefundable.

I, __________________________, after being explained the process of family involvement, commit to fulfill each of the guidelines in this contract.

Name of Parent/Guardian:	Signature of Parent/Guardian:
Date:	Name of Client:

House of Freedom

Dual Diagnosis

House of Freedom consists of a clinical department with tools to assist the individual in the psychosocial aspect. Nevertheless, we do not consist of professionals capable of treating psychiatric conditions not influenced directly by the abuse of substances. This is why, as family and person in charge of the health of your relative, you must understand the following conditions:

____**1. Upon the completion of the first 30 days, I understand that the case of my family member will be re-evaluated to determine if such individual is in need of additional services. Therefore, there is a possibility that your monthly tuition is subject to change. If I do not agree with the readjustment of the monthly tuition, I will make the necessary arrangements to transfer my family member to another institution or place of living immediately.**

____**2. In the event that the client does not respond successfully to the treatment at any time once admitted, showing conducts or symptoms which alter the course of his own treatment or the treatment of the majority of the population of our program, the family member must make immediate arrangements to transfer the client to another institution or place of living.**

____3. We are not a psychiatric hospital; we are a facility of psychosocial adaption for people with problems of substance abuse.

____ 4. Our treatment plan does not include the stabilization and/or monitoring of a mental condition.

____ 5. In the event of a dual diagnosis, the client **prior to admission** must provide: (1) a recent psychiatric evaluation, (2) a registry of medication(s) which details the medication(s) prescribed, and (3)**at the time of admission, a 30-day supply of all medications.**

____ 6. HOF has a subcontracted psychiatrist who provides services to dually diagnosed clients, who require psychiatric follow-up during their treatment at HOF. The psychiatrist is responsible for reevaluating and monitoring any psychiatric condition that may be present in any of our clients.

____ 7. We are not responsible for any alteration of the mental condition of your family member.

____ 8. Our environment does not facilitate a therapeutic commodity for the mentally handicapped given that the majority of our clients do not have knowledge of mental disorders.

____ 9. In the event of abandonment, expulsion, or transfer to another program, the money will not be reimbursed under any circumstance.

Name of Parent/Guardian:	Signature of Parent/Guardian:

Date:	Name of Client:

House of Freedom

Monthly Tuition

I, __________________________, family member/relative of ______________________________,
(Name of person being admitted/client)
will be paying $__________ for the monthly tuition of the above named client. The monthly tuition is due each month on the day in which the admission is held.

Choose one (1) of the following payment methods for the MONTHLY TUITION:

________ Cash / Money Order / Cashier's Check deposit to *Banco Popular de Puerto Rico*
Circle one

To obtain account number and additional information, contact administrative office.
Send copy of receipt by fax to 1-888-702-7004. Please write client id# on the receipt and purpose of payment.

________ Cash / Money Order / Cashier's Check deposit to Bank of America.
Circle one
To obtain account number, contact administrative office.
Send copy of receipt by fax to 1-888-702-7004. Please write client id# on the receipt and purpose of payment.

________ Electronic Transfer to Bank of America. (To obtain account number, contact administrative office)

Please print confirmation receipt, include Client id# and purpose of payment on receipt and fax to 1-888-702-7004.

________ Electronic Transfer to *Banco Popular de PR*. (To obtain account number, contact administrative office)

Please print confirmation receipt, include Client id# and purpose of payment on receipt and fax to 1-888-702-7004.

________ Credit Card – I,______________________, authorize House of Freedom to charge my credit card the amount of $_________on or before the monthly tuition due date. (A transaction fee applies to all credit cards transactions)

My Credit Card information:
_____ Visa _____ Master Card _____ American Express

Credit card # ____

Expiration date _______/_______ Zip code _________________
Important Note: Please send a copy of driver's license or photo ID.

It has been explained to me and I understand that all money deposited to House of Freedom is **NONREFUNDABLE** in the event of abandonment, expulsion or any other situation where the client does not finish or start the program.

WE DO NOT ACCEPT PERSONAL CHECKS

Name of Parent/Guardian:	Signature of Parent/Guardian:

Authorized Date:	Name of Client:

House of Freedom

Monthly Tuition Alternative

The monthly tuition is due each month on the number of the day the client was admitted. In the event that the monthly tuition is not made within the established timeframe, we must have an alternate option to obtain the monthly tuition payment. For this reason, House of Freedom requires that all financial custodians or person in charge of clients provide an alternate credit card number to ensure the tuition payment of the client.

I, ___________________________, family member of the client___________________________, authorize HOUSE OF FREEDOM to charge my credit card the amount of $ _____________ for the monthly tuition of the client mentioned above, in the event that my monthly tuition is not made with the original payment method chosen on the due date. I understand that all applicable late fees will be added to this charge.

My Credit Card information:

_____ Visa _____ Master Card _____ American Express

Credit Card # ____

Expiration date _______/_______ Zip code _________________

It has been explained to me and I understand that all money deposited to House of Freedom is **NONREFUNDABLE** in the event of abandonment, expulsion or any other situation where the client does not finish or start their program. (A transaction fee applies to all transactions).

Important Note: Please send a copy of driver's license or photo ID.

Name of Parent/Guardian:	Signature of Parent/Guardian:

Authorized Date:	Name of Client:

House of Freedom

To Parent(s)/Guardian – Part 1

Please initial

1._____ House of Freedom is a Faith-based psychotherapeutic program for the rehabilitation of drugs and alcohol. This is why we offer biblical studies, conferences, counseling, etc., for the development of your spirit, body and soul.

2._____ House of Freedom's program is strictly inpatient and does not allow (unless there is an emergency) the constant entrance and exits of our premises. If your family member suffers from any pre-existing medical conditions and/or legal issues that require frequent medical and/or probation officer visits, you must notify this prior to admission of treatment. There will be an additional fee for all clients that require an escort for such appointments.

3._____ Within 14 days of admission clients undergo a physical examination, lab work, and sexually transmitted disease testing. In the event that a medical referral is deemed necessary due to the results of the aforementioned exams, the financial custodian will be notified. He/she will be responsible for providing the necessary follow-up and financing of such medical referrals.

4._____ All clients who wish to have access to private medical services may do so once they have completed six (6) months of treatment. HOF recommends that all clients make prior arrangements to visit the dentist and/or specialist before admission, since this type of medical visits are not considered emergencies and will not be allowed until the designated time of six months is completed. All non-emergency medical requests that are submitted by clients after the designated six month period will be forwarded to the financial custodian, who will be responsible for the scheduling and financing of such medical requests.

5._____ House of Freedom is supported with the monthly tuitions of each client admitted. Therefore, it is impossible to offer free medical services, such as psychiatric or general medicine services.

6._____ As part of the monthly tuition, the client will be provided with transportation services from the airport to our institution (unless pre-arranged), residency, indoor recreation, gym, biblical studies, counseling, educational chats, conferences and, above all, a family treatment. House of Freedom does not receive any government assistance for treatment services. Therefore, all clients should be willing to assist the institution in any workshop that the community may offer to help us meet our financial obligations. In addition, such workshops are utilized as therapy that go against idleness time that characterize persons with drugs and/or alcohol problems; we also teach them in their ambulatory phase to understand and to further help their family members with the economic burden of their treatment. Nonetheless, if you wish to avoid that your family member participates of such workshops, you may make arrangements with our office to increase your monthly tuition and this way exclude your family member from them.

Name of Parent/Guardian:	Signature of Parent/Guardian:

Authorized Date:	Name of Client:

House of Freedom

To Parent(s)/Guardian – Part 2

Please initial

7._____ The monthly tuition is due each month on the number of the day of the admission of your family member. If tuition is due on a weekend, your payment should be made by Friday before 4:00pm. Failure to receive payment on or before this date, will result on a $5.00 daily late fee. If late fees are not included with your payment, the money will be automatically deducted from the personal account of the client. If the client's account does not have any funds, the fee will continue to be deducted for each day that goes by without payment. If your payment is late more than a week, the services being offered to your family member will cease.

8._____ In addition, if your monthly tuition is not received within the indicated time, your family member will not receive any privileges, such as mail, packages, or phone calls, until such installment and all negative balances in your account are brought current. We ask your cooperation in this matter, as our experience has taught us that this situation may have a negative impact in the progress of the client bringing worries and ambivalence.

9._____ HOF will not administer prescription medication that is not properly labeled (i.e.: full name of person being admitted to treatment at HOF, directions for use, name of prescribing physician), that is not in its original packaging, or medication that has been prescribed 30 days prior to the client's admission to treatment. We will not administer any over-the-counter medication, with the exception of those clients who have a doctor's note stating that the medication must be taken and which specifies the amount and frequency of use.

10._____ House of Freedom ensures that during the time your family member remains in treatment at our facilities he will be surrounded by a positive environment. Due to this reason, all contact outside the institution that the client may encounter, will be strictly evaluated by the administration. This includes, but is not limited to, visitations and correspondence. The correspondence must be addressed to House of Freedom including the client's od number and it will be supervised. If there is any negative content, it will be returned to the sender.

11._____ Your family member will have a personal account, a $25 minimum must be kept at all times. Nevertheless, the client will have no knowledge of the balance of such account, only the financial custodian shall privy such information. These funds will be used for the purchase of basic need articles, offerings, outings and/or anything else that is requested by the client. <u>Being that this is a non-profit organization that offers a program below its cost, all money deposited in the personal account **will not be reimbursed** in the event of abandonment and/or expulsion, for it will be used for the grants of persons who do not have the resources, but desire to complete the 15-month treatment. Also, if your case received any type of financial assistance, the balance on the client's personal account **will not be reimbursed**, regardless of the discharge reason.</u>

12._____ Clients are prohibited to have any type of personal property of value in the institution (phones, cash, jewelry, iPod). At the time of admission, if the client has any of these types of articles, or any other article prohibited in the institution, including food items, they will be returned to the family member or person in charge, if present, or **they will be confiscated and will not be returned**.

Name of Parent/Guardian:	Signature of Parent/Guardian:

Authorized Date:	Name of Client:

House of Freedom

Electronic Information Agreement

I ,_________________________________, authorize House of Freedom personnel to contact me
(Parent/Guardian/Financial Custodian printed name)
through the following unsecured email(s):

____
Email address Name of Contact

____
Email address Name of Contact

____
Email address Name of Contact

I understand this information may contain personal information such as, but not limited to: Progress Reports, Visitation Details and Authorization, Packaging Contents and Authorization, Medical Information, Account Information and Complaint Reports.

By signing, I release House of Freedom of any responsibility. Neither House of Freedom, Inc., nor its subsidiaries or affiliates, will be liable for any lost or misused information, damages resulting from any modification or falsification of an e-mail that is originated by House of Freedom, Inc. Moreover, although precautions have been taken to ensure that the data included herein is free from viruses or other malicious content, House of Freedom, Inc. cannot assure that such is indeed the case and disclaim any responsibility attributable thereto.

____ ____________________
Signature Date

Name of Client: _______________________________

House of Freedom

PART III

General Rules and Information

- House of Freedom is a Christian-based residential treatment program for the rehabilitation of drugs and alcohol.
- This length of treatment may be extended depending on the progress of the client.
- If the client is being admitted for a complete program, he will receive individual and group therapies, counseling and biblical studies among others.
- The program consists of 5 phases:
  - Phase 1 – Integration and Adjustment
  - Phase 2 – Course of improvement of character and learning
  - Phase 3 – Leadership & Values
  - Phase 4 – Decision & Change
  - Phase 5– is the ambulatory phase that begins after the first year, which is dependant on the progress of the client.
- All of the phases include an indoor basketball court, racquetball, pool table, ping-pong table, computer access and a gym.
- During the first month of treatment the client does not have the right to phone calls or visits.
- The client will be a candidate for a pass once the first three months of the program have been completed, always depending on the client's progress.
- Smoking is prohibited in our institution.
- Earrings are not permitted.
- Under no circumstances is the client allowed to have/handle cash.
- It is prohibited to have any type of personal property of value in the institution (phones, cash, jewelry, iPod). At the time of admission, if the client has any of these types of articles, or any other article prohibited in the institution, they will be returned to the family member or person in charge, if present, or **they will be confiscated and will not be returned**.
- HOF will not administer prescription medication that is not properly labeled (i.e.: full name of person being admitted to treatment at HOF, directions for use, name of prescribing physician), that is not in its original packaging, or medication that has been prescribed 30 days prior to the client's admission to treatment. We will not administer any over-the-counter medication, with the exception of those clients who have a doctor's note stating that the medication must be taken and which specifies the amount and frequency of use.
- Being that this is a non-profit organization that offers a program below its cost, all money deposited in the personal account **will not be reimbursed** in the event of abandonment and/or expulsion, for it will be used for the grants of persons who do not have the resources, but desire to complete the 15-month treatment.

Name of Client:	Signature of Client:

Date:	Signature of person in charge/Parent/Guardian:

House of Freedom

Participation of Occupational Workshops & Special Activities

House of Freedom includes different types of the therapy in the occupational/vocational area. These will help me promote a mental, emotional, and physical stability. For this reason, during my treatment in House of Freedom, I will have access to the following areas of the program:

1. **Agro-therapy:** involves the participation in areas of landscaping design, includes the restoration of terrain and fertilization, sow and harvest, and the operation of lawn mowing equipment.
2. **Car Wash:** includes the development of working in groups, working with clients, and to gain knowledge and utilize innovative products regarding the care of automobiles.
3. **Laundry:** workshop that involves the cleaning and care of all clothing articles of the clients with the use of cleaning detergents.
4. **Culinary Arts:** involves the preparation of the menu, working in conjunction with the nutrition of the program, to prepare and distribute meals, and to operate cooking machinery.
5. **Remodeling projects:** occasionally there will be different opportunities to work in labors such as painting, carpentry, and light construction. Your participation in such workshops may include the use of tools and/or equipment that may cause severe injuries if utilized incorrectly and/or without precaution.
6. **Video production:** This includes the use of cameras, computers and programs to edit and produce videos and televised programs.
7. **Sound production:** the use of equipment to produce sound, recordings, and live concerts.
8. **Gym:** participation of the use of heavy equipment and weights with the purpose of physical improvement. The use of such equipment will be used strictly under the risk of the client.
9. **Special Activities:** this may include transportation outside of our facilities towards recreational parks (includes Disney World, YMCA, beaches, etc.) .

I, ___________________________, after being explained the process inside of these workshops, commit myself to follow the security policies in each of these areas. If I fail to follow these policies, House of Freedom, inc., will not be liable for accidents or medical bills that may arise, from my participation in any of these workshops.

Name of Client:	Signature of Client:

Date:	Signature of person in charge/Parent/Guardian:

PART IV

Client Waiver of Liability

Client's Name:	Social Security:	Date:

The undersigned or identified participant, being at least 18 years of age or obtaining consent from parent/guardian (if minor), has read and signed this release. The participant has voluntarily asked that House of Freedom, Inc. allow him/her to participate of the recreational areas (such as: horseback riding, swimming, basketball, volleyball, baseball, boat riding, racquetball, gymnasium, outings, field trips, etc.). I understand that these areas may be hazardous and involve risks. Such risks may involve serious injuries and even death.

I agree to not hold liable House of Freedom, its founders, its President, its trustees, or any of its members for any injury or death that may arise during my participation of any activity.

With my signature I am agreeing to assume any and all the risks of injury or death that may arise by my participation of this activity.

I declare that the information stated above has been read to me in a language that I understand. *Declaro que toda la información que se encuentra en este documento a sido leído en un lenguaje que entiendo.*

Client's Signature	Date Signed
Parent/guardian's Signature (if applicable)	Date Signed
Witness' Signature	Date Witnessed

EBT Assistance Questionnaire

1) Have you been convicted of a drug trafficking felony? *(¿Ha sido encontrado culpable de tráfico de drogas por la ley?)*

YES ☐ NO ☐

If yes, explain *(Si sí, Explique);*

____

2) Are you fleeing the law due to a felony or probation or parole violation? *(¿Está huyendo de la ley por violación de probatoria?)*

YES ☐ NO ☐

If yes explain *(Si sí, Explique);*

____

3) Have you been convicted of receiving food stamps, cash assistance, or Medicaid in more than one state at the same time? (¿Ha sido encontrado culpable de recibir cupones, Medicaid o asistencia de efectivo en 2 estados a la vez?)

YES ☐ NO ☐

If yes explain*(Si sí, Explique);*

____

__________________________________ __________________________________

Client's Name (Nombre del Cliente) Signature (Firma) Date (Fecha)

AUTHORIZED REPRESENTATIVE DESIGNATION

Individual/Assistance Group	Case Number/CAT/SEQ

I hereby designate ______________________________ residing at ______________________________
Name

____ to act as my authorized representative.
Address

TO: (check one or both boxes)

☐ Be interviewed in my place

☐ Receive and use the food assistance on behalf of my household

The reason I or my spouse cannot be interviewed is:

☐ Working hours are the same as food assistance office hours ☐ Health reasons ☐ Transportation problems

☐ Other problems – explain: ____

This individual is an adult who is sufficiently aware of my family's financial and other household circumstances to give any information required by the Food Assistance Program. I understand that I am responsible for any incorrect information given by my representative and may be prosecuted for fraud and be fined and/or sent to jail.

______________________________ ______________________________
Date Signature

______________________________ ______________________________
Witness if signed with an X Witness if signed with an X

Request For Waiver Of Food Assistance Office Application Interview

I am unable to appoint an authorized representative or have an adult member of my household attend the food assistance application interview because all adult household members are:

☐ 65 years of age or older ☐ Mentally or physically handicapped

☐ Other (such as illness, care of a household member, working hours, transportation problems)

Explain: ____

For the above reason(s) I request a waiver of the food assistance office interview and understand that an interview will be conducted either in my home or by telephone. I understand that if I do not give complete and accurate information and do not let the food assistance office know when changes happen, that I may be prosecuted for fraud and may be fined and/or sent to jail.

______________________________ ______________________________
Date Signature

______________________________ ______________________________
Witness if signed with an X Witness if signed with an X

Phone number where I can be reached: ______________________________