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STEPPING STONE OF SAN DIEGO, INC.

TREATMENT SERVICES SCREENING PACKET

Thank you for your interest in Stepping Stone of San Diego's treatment program. Below you will find the admission procedures that must be followed in order to enter our program.

1. Complete a screening packet (enclosed) and bring with you in person to our orientation meeting which is held each Tuesday starting at 9:45am and every Friday starting at 12:45 at our Residential Facility located at 3767 Central Avenue, San Diego, CA 92105.
2. **SCREENING PACKET ARE ONLY ACCEPTED IN PERSON. PLEASE DO NOT MAIL IN OR EMAIL OR FAX IN**.
3. In addition to the screening packet, a current TB (tuberculosis) skin test must be submitted with screening packet. TB test cannot be older than 60 days. If your TB test is positive or if individual seeking treatment is HIV positive a chest exam will be required.
4. Individuals seeking treatment who are HIV positive will need to provide a third party verification of diagnosis from your physician at time of admission.
5. Individuals seeking treatment will be oriented and place on waiting list. Upon submission of completed screening packet individual will be screened by one of our counselors to determine that Stepping Stone will be able to serve your needs.
6. All P3, SASCA and Re-entry admissions must have a referral and if applicable report at the time schedule on their referral.
7. If you were in treatment here at Stepping Stone within the past year, our requirement is for all individuals wanting to re enter treatment must be on the waiting list for 6 months before admission can take place.

If Stepping Stone's programs are not the appropriate levels of treatment, you will be given referrals to the appropriate facilities.

We realize that finding services can be frustrating and difficult at times. When there are no openings for admissions, you will be asked to attend all of Tuesday and Friday meetings as well as 3 outside meetings until an opening is available.

The screening and intake group provides support and an overview of programming. Staff will answer any questions you may have at that time. Stepping Stone is committed to welcoming and assisting people who come to our doors.

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TREATMENT SERVICES WELCOMING POLICY

Stepping Stone welcomes all individuals for services related to alcohol and drug addiction, and those in need of life-threatening recovery from co-occurring conditions. It is our mission to primarily serve the Gay, Lesbian, Bi-Sexual and Transgender community as well as all individuals seeking recovery. However, we recognize that our clients often have other medical and psychiatric conditions that interact with and impact their addiction. We are committed to providing the most holistic and comprehensive recovery and treatment services for clients. In order to help clients achieve the best stabilization in all areas, we recognize the importance of integrating attention to these other medical and psychiatric issues throughout the treatment process at Stepping Stone. It is part of our program to provide referrals and support for linkages to services related to these other co-occurring conditions and to incorporate those services into the client's treatment plan and recovery process.

It is recognized that when a person enters Stepping Stone, he/she is reaching out for help and deserves a welcoming response. We take responsibility for assisting each person to make sure that he/she is connected to a relationship that integrates attention to his/her multiple needs while in addiction treatment. In addition, we are committed to making sure that the appropriate resources and referrals are made available whether the individual will be admitted to our treatment facility or not. The life of each person is precious, and we have an important part in welcoming him/her into sober, healthy living, including recovery from co-existing medical and psychiatric conditions.

If you have an experience that is different from what is described above, please feel free to contact the Case Manager, Charlotte Harris 619-278-0777 X132, charlotte@steppingstonesd.org. We appreciate and value your input.

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TREATMENT SERVICES SCREENING INFORMATION

Date: _____

Name: _____**DOB:**_____

Phone #: _____ **Alternate Phone #:** _____

Best time to call? _____ **Email Address:** _____

Current Address: _____

_____

Relationship of others living at this address: _____

_____

Total Monthly Income: _____

Source(s) of Income:

____ **Employed** **Where** _____
____ **Unemployment** **How long** _____
____ **SSI**
____ **SSDI**
____ **SDI**
____ **Family Support**
____ **Other** _____

Valid form of identification (must have both upon intake)/I-9 status documents:
Social Security Card: YES NO **Valid ID card or driver's license: YES NO**

Medical Insurance: (Circle, if yes provide following info) YES NO
Name of Carrier:_____ **Policy or Group #:**_____
Name of insurance policy holder, social security # and DOB:_____

Receiving Food Assistance: (Circle, if Yes mark all that apply) YES NO
____**EBT** ____**OTHER**
____**MOMMA'S KITCHEN**

LEGAL STATUS QUESTIONNAIRE

1. **Are you presently on parole or probation? (circle) YES NO**

2. **Number of arrests in the past 30 days? _____**

   - **Please list reason(s) for arrest(s). _____**

3. **Number of arrests since the age of 18? _____**

   - **Please list reason(s) for arrest(s). _____**

4. **Number of jail or prison days in the past 30 days? _____**

   - **Please list reason(s) for arrest(s). _____**

5. **Number of jail or prison days in your lifetime? _____**

   - **What was the incarceration for? _____**

HEALTH STATUS QUESTIONNAIRE

6. **Do you have any physical health issues that hamper or impede you in your daily activities?**
   (This information should not affect your status on suitability to residential, but will help us in the screening process to meet your needs)

_____

_____

_____

7. **Do you have any allergies to food or medication? (please list all)**
   (This information should not affect your status on suitability to residential, but will help us in the screening process to meet your needs)

_____

_____

_____

8. **Do you have any chronic life threatening illness such as HIV? _____Yes _____ No**

If yes, indicate diagnose: _____ Date of diagnosis _____

9. **I, _____ understand that the only service animals Stepping Stone accepts into their residential services are animals for the seeing or hearing or physically impaired. Do to the nature of the services provided all other service animals must be excluded.**

MENTAL HEALTH INFORMATION

Name: _____ **Date:** _____

Date of most recent hospitalization for psychological problems: _____

Reason for hospitalization: _____

_____

What psychiatric diagnosis have you received?

1. _____
2. _____
3. _____
4. _____

Agency of Psychiatrist/Therapist: _____

Name of Psychiatrist/Therapist: _____

Phone Number: _____ **Email:** _____

PRIOR PSYCHIATRIC TREATMENT HISTORY:

Type: Outpatient, Inpatient, Hospital, Therapy	Agency: UCSD, Scripps, Kaiser, Sharp, etc.	Date Started and Ended	Outcome

_____ **# of suicide attempts** _____ **# of hospitalization for suicide attempts**

Date: _____ **Agency of Hospitalization:** _____

Date: _____ **Agency of Hospitalization:** _____

Date: _____ **Agency of Hospitalization:** _____

Date: _____ **Agency of Hospitalization:** _____

Cont'd MENTAL HEALTH INFORMATION

Please list all Controlled Psychiatric Medications prescribed:
(Examples – Benzodiazepine aka Benzo's, Wellbutrin, Tramadol, Vicodin, Suboxone, Valium etc.)

Name of controlled medication	Prescribed dosage	Reason/Symptom it treats
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list below all controlled medication previously taken

Name of controlled medication	Reason of Dosage	When and why did you stop?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently in a methadone treatment therapy program? __ yes __ no If so, for how long? ____

When does treatment end? _____

Name of Facility: _____

Name of Physician: _____

SUBSTANCE ABUSE HISTORY

Date: _____

Name: _____

SUBSTANCE	**LAST MONTH** Total # of days used in the past 30-days	**LIFETIME USE** Total # of Years used	**Last Use**	**Route of Use** [*Circle all that apply*]
Alcohol				Oral, Smoked, IV, Snorted
Amphetamine				Oral, Smoked, IV, Snorted
Cocaine				Oral, Smoked, IV, Snorted
Heroin				Oral, Smoked, IV, Snorted
Marijuana				Oral, Smoked, IV, Snorted
Prescription Pain Medications **1.** **2.** **3.** **4.**	LIST ALL			 Oral, Smoked, IV, Snorted Oral, Smoked, IV, Snorted Oral, Smoked, IV, Snorted Oral, Smoked, IV, Snorted
Prescribed Psychiatric Medications **1.** **2.** **3.** **4.**	LIST ALL			 Oral, Smoked, IV, Snorted Oral, Smoked, IV, Snorted Oral, Smoked, IV, Snorted Oral, Smoked, IV, Snorted
Inhalants	*LIST ALL*			
Party & club drugs [GHB, Special K, Ecstasy]	*LIST ALL*			Oral, Smoked, IV, Snorted

History of IV use _____yes _____ no If yes, how many years _____

Prior Alcohol or Drug Treatment – (Include dates, location & modality [residential, outpatient, inpatient)

MOST RECENT: ____ / _____ through ____ /____ Location [city/state]: _____

Name: _____Type of Program: [residential, outpatient, inpatient]

Did you successfully complete the program? ☐Yes ☐No Comment: _____

Prior to That: ____ / _____ through ____ /____ Location [city/state]: _____

Name: _____Type of Program: [residential, outpatient, inpatient]

Did you successfully complete the program? ☐Yes ☐No Comment: _____

Prior to That: ____ / _____ through ____ /____ Location [city/state]: _____

Name: _____Type of Program: [residential, outpatient, inpatient]

Did you successfully complete the program? ☐Yes ☐No Comment: _____

MOST RECENT: ____ / _____ through ____ /____ Location [city/state]: _____

Name: _____Type of Program: [residential, outpatient, inpatient]

Did you successfully complete the program? ☐Yes ☐No Comment: _____

Prior to That: ____ / _____ through ____ /____ Location [city/state]: _____

Name: _____Type of Program: [residential, outpatient, inpatient]

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Limits on Client/Therapist/Treatment Team Confidentiality

Although confidentiality and privileged communication remain rights of all clients of mental health practitioners according to the law, there are conditions that the therapist/staff counselor is required to disclose confidential information to the appropriate persons.

- You have disclosed, or your therapist believes, that you are a danger to yourself.
- You have disclosed, or your therapist believes, that you are a danger to others.
- You have disclosed child neglect, sexual abuse, physical abuse, and/or emotional abuse in the home.
- You have disclosed knowledge of child neglect, sexual abuse, physical abuse, and/or emotional abuse in the home.
- You or someone else's child has witnessed domestic violence.
- You are a person over 65 and your therapist believes you are the victim of physical abuse and/or serious neglect.
- You disclose elder abuse either in your own home or in the community at large.
- You are unable to care for yourself and would be considered gravely disabled.
- You waive your rights of privilege or give consent to limited disclosure by your therapist.

Group – Staff group facilitators will maintain confidentiality with the exception of the above circumstances, but cannot guarantee your confidentiality by other group members. It is requested that group members maintain confidentiality with each other in order to provide safety. ***Any breach of confidentiality may be grounds for discharging from the program.***

Treatment Team – Confidentiality within the Treatment Team is maintained with the exception of the above circumstances. It is understood by the undersigned that confidentiality extends to the treatment team and that the treatment team consist of staff, interns, and clinical staff.

I _____ have read and understand the above information and consent

(Print Name)

the parameters of confidentiality in my treatment.

_____ _____

Signature of Client **Date**

_____ _____

Signature of Staff **Date**

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SCREENING NOTES

CLIENT NAME: _____

AOD COUNSELOR/PEI STAFF: _____

DATE	NOTES

Completed screening packet _____ TB Test attached _____ Letter of Diagnose_____