

BRIDGES OF IOWA, INC.

1211 Vine St., West Des Moines, IA. 50265 (515) 222-0910 Fax (515) 222-1298

WOMEN'S RE-ENTRY PROGRAM Referral and Acceptance Process

Bridges of Iowa is a long-term faith-based reentry program for women involved in the criminal justice system as a result of alcohol or drug problems. The Bridges Women's Program, unlike our men's program, is not a substance abuse treatment program. Women referred to Bridges of Iowa are expected to have completed drug treatment and should be in the action or maintenance stage of their recovery. Bridges of Iowa women will actively work with local churches, volunteers, and 12-step support groups through mentoring and sponsorship programs. This mentoring begins while in our reentry program, but is expected to continue as she transitions into the community of work, family, and friends. Our hope and our commitment is that every Bridges of Iowa client will be given the support and direction needed to begin their own "Spiritual Journey" and change their lives for the better. Bridges of Iowa is a faith-based program, but it is not necessary to be a "Christian" or have any affiliation with any organized religion to be accepted and welcomed into our program.

The attached application asks a multitude of alcohol and substance use related questions, but is not intended as a substance abuse evaluation. We require this information to verify that you have completed your primary substance abuse treatment goals and to help us determine your appropriateness for the program. You may complete the written portion of the application on your own, but an authority figure such as your correctional counselor, PO, or substance abuse counselor must sign-off on the application verifying that the information you provided regarding your commitment to change and your appropriateness for our program is accurate. It's important for you to know we put great emphasis on your letter "Why I Want to Enroll in the Bridges of Iowa Women's Re-Entry Program." We want you to know we only accept women who are serious about change and want to be in the program.

Once the application process is complete and you have been accepted, your name will be placed on a waiting list, and Bridges of Iowa staff will inform your referral source of the approximate available placement dates. If the court or parole board should order placement at Bridges prior to completion of the application and acceptance process, and if we find that you do not meet the qualifications for our program, we will be unable to accommodate the referral.

If you are accepted into the program and we discover that the application information was inaccurate you may be discharged from Bridges and returned to the referral source.

UNSUCCESSFUL DISCHARGE

When a resident displays unacceptable behavior or fails to have satisfactory progress in the program, the community and staff will work with her to provide an opportunity to improve. If the resident fails to improve she will be unsuccessfully discharged from the program, her Probation/Parole Officer, or referral source will be notified. If a client is not on probation or parole and is unsuccessfully discharged, she will have one hour to arrange transportation and must leave the facility.

If the behavior is dangerous, illegal, or staff deems it very serious in nature, the resident may be immediately discharged. The supervising officer or appropriate authorities may be notified. An arrest or warrant may ensue.

**BRIDGES OF IOWA, INC
APPLICATION**

Name of Applicant _____

Date _____

Phone number for Applicant _____

Email for Applicant _____

SS#: _____ Date of Birth: _____ Race: _____ Judicial District: _____

Name of referral source: _____

Presenting Problem/Reason for referral: _____

Current Legal Charge(s) or original conviction(s): _____

Criminal history/prior convictions/incarcerations. (Attach copy of ICON criminal history.)
(PSI, LSI, and Jesness if available): _____

Date placed on Supervision: _____ Tentative Discharge Date: _____

Gang Participation? Yes No History of violence or assaults? Yes No

(If yes) _____

BEP or Anger Management completed? Yes No (Date completed) _____

Known enemies in the community or correctional system? (please list) _____

Any "No Contact" orders? Yes No If Yes, registered victim(s) name(s)
relationship(s): _____

Name of Applicant _____

Date _____

ALCOHOL/DRUG USE HISTORY

Drug	Amount	Method	Duration/ History	Age of First Use	Date of Last Use

Previous Substance Abuse Treatment or Education ____ Yes ____ No **If yes, where, when, successful or unsuccessful completion:** _____

Reading Writing Ability: ____ No Problem ____ Good ____ Fair ____ Needs Assistance

Grades Completed: ____ K-11 ____ HS Diploma ____ GED ____ College

Other Need Areas (Please list at least top three): _____

Name of Applicant

Date

FAMILY/VISITOR INFORMATION

Significant Other: _____

Children (names & ages): _____

Contact with Children ____ Yes ____ No (Comments): _____

Family Recommended as Potential Visitors:

NAME	RELATIONSHIP	RECOMMENDATIONS/COMMENTS

Any Visitors You Would Deny:

NAME	RELATIONSHIP	RECOMMENDATIONS/COMMENTS

HEALTH/PSYCHIATRIC/ENVIRONMENTAL/ MOTIVATION INFORMATION

TB Test Administered? ____ Yes ____ No (If yes) _____ Results _____ Location

Intoxication or Withdrawal Potential:

Are there current symptoms of withdrawal. Is there current substance use or risk of withdrawal? Is there a history of withdrawal? _____

Biomedical Conditions/Complications:

Are there current or past physical illnesses that need to be addressed? Are there Chronic Health Conditions? Is the applicant taking any medication? If yes, please list _____

Name of Applicant

Date

Emotional/Behavioral/Cognitive/Conditions or Complications:

Is there a current psychiatric diagnosis? Does applicant take psychiatric medications? Is there current or past suicidal ideation? Is there a history of suicide attempts? _____

Readiness to Change:

Does the applicant feel coerced into the program. Is the applicant agreeing to participate in order to avoid incarceration or other negative consequences? Does the applicant appear internally or externally motivated? How ready is the applicant to change? _____

Relapse Continue Use or Problems Potential:

Does the applicant have any knowledge of relapse triggers, dangers, methods to cope with urges or cravings? Does the applicant have any recognition, understanding, or skills to cope with relapse warning signs and addiction problems? Is the applicant in immediate danger of relapse? _____

Recovery Environment:

Are there any dangerous family members, living, work or school, situations threatening success? Does the applicant have supportive family, friends, vocational, or educational resources to improve the likelihood of success? Are there legal or criminal justice mandates that may enhance motivation? _____

Any Other Information/Comments/Assessment/Recommendations we need to be aware of:

Applicant Signature

Referral Source Signature

Date

ReferralSourcePhone#: _____

Email: _____

Signature

Date

BRIDGES OF IOWA, INC.
CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION

I, _____, authorize:

Bridges of Iowa, Inc.
1211 Vine Street, Suite 1110
West Des Moines, IA 50265

TO RELEASE THE INFORMATION SPECIFIED BELOW TO:

(Name of person or organization to whom information is to be released)

(Street Address)

(City) (State) (Zip Code)

Information to be released (nature and amount of information as limited as possible):

	<u>YES</u>	<u>NO</u>
Duration of involvement with program.....	_____	_____
Attendance at counseling sessions.....	_____	_____
Evaluation/Assessment and recommendations.....	_____	_____
Summary of treatment participation.....	_____	_____
Medical history.....	_____	_____
Social history.....	_____	_____
Alcohol and other drug history.....	_____	_____
Legal history.....	_____	_____
Urinalysis results.....	_____	_____
Psychological/psychiatric testing.....	_____	_____
Other (specify)_____	_____	_____

The purpose or need for the disclosure of the above information is:

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") 45 C.F.R. Pts. 160 & 164. 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 I will not be denied services if I refuse to consent to a disclosure.

I have voluntarily allowed the release of the above information. No threat or other coercive measures have induced me to sign this consent form. I understand this information will not be further released to anyone else by the recipient without my written consent and I have been provided a copy of this form.

I understand that in any event this consent expires automatically as follows:

Six (6) months after discharge _____
(Date or condition upon which release expires)

(Resident signature) (Date)

(Witness signature & Title) (Date)

BRIDGES OF IOWA, INC.
CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION
Criminal Justice System Referral

I, _____, authorize (initial whichever parties apply):

Bridges of Iowa
1211 Vine Street
West Des Moines, IA 50265

Department of Corrections (Name of PPO: _____)
5th Judicial District, Probation & Parole
1000 Washington/910 Washington
Des Moines, IA 50314
515-242-6680 515-242-6603

to communicate with and disclose to one another the following information (nature and amount of information as limited as possible):

_____ my diagnosis, urinalysis results, information about my attendance or lack of attendance, at treatment sessions, my progress/cooperation with the treatment program, prognosis, and discharge summary.

The purpose of the disclosure is to inform the person(s) listed above of my attendance and progress in treatment.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") 45 C.F.R. Pts. 160 & 164. 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 automatically as follows:

_____ there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

_____ (specify other time consent can be released)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

_____ (Resident signature)

_____ (Date)

_____ (Witness signature)

_____ (Date)

BRIDGES OF IOWA, INC.
CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION

I, _____, authorize:

(Name of person or organization to whom information is to be released)

(Street Address)

(City)

(State)

(Zip Code)

TO RELEASE THE INFORMATION SPECIFIED BELOW TO:

Bridges of Iowa, Inc.

1211 Vine Street, Suite 1110

West Des Moines, IA. 50265

Information to be released (nature and amount of information as limited as possible):

	<u>YES</u>	<u>NO</u>
Duration of involvement with program.....	_____	_____
Attendance at counseling sessions.....	_____	_____
Evaluation/Assessment and recommendations.....	_____	_____
Summary of treatment participation.....	_____	_____
Medical history.....	_____	_____
Social history.....	_____	_____
Alcohol and other drug history.....	_____	_____
Legal history.....	_____	_____
Urinalysis results.....	_____	_____
Psychological/psychiatric testing.....	_____	_____
Other (specify)_____	_____	_____

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I understand that in any event this consent expires automatically as follows:

Six (6) months after discharge

(Date or condition upon which release expires)

(Resident signature)

(Date)

(Witness signature & Title)

(Date)

BRIDGES OF IOWA, INC.
CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION
Criminal Justice System Referral

I, _____, authorize (initial whichever parties apply):

Bridges of Iowa
1211 Vine Street
West Des Moines, IA 50265

Iowa Department of Corrections (Name of correctional counselor _____)

(Name of prison/institution)

(Street Address)

(City, state, zip)

to communicate with and disclose to one another the following information (nature and amount of information as limited as possible):

_____ my diagnosis, urinalysis results, information about my attendance or lack of attendance, at treatment sessions, my progress/cooperation with the treatment program, prognosis, and discharge summary.

The purpose of the disclosure is to inform the person(s) listed above of my attendance and progress in treatment.

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(specify other time consent can be released)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

(Resident signature)

(Date)

(Witness signature)

(Date)