Break Free

Break Free Foundation In-Patient and Out-Patient Rehabilitation Scholarship Application

Based on the availability of scholarships awarded by the Recovery Centers of America and the Realization Center, the Break Free Foundation is pleased to be able to offer scholarships to attend a rehabilitation and outpatient program to individuals who otherwise would not be able to afford these recovery resources.

In order to apply for a Break Free Foundation Scholarship, the applicant must complete the following application and return it to the Break Free by the last Monday of the Month. Applications are to be submitted via email to **team@breakfreenyfw.com**.

PLEASE NOTE: Break Free does not pay for or assist in paying for treatment in any way. We partner with inpatient and outpatient programs across the nation who donate a minimum of one treatment “bed” per year.

Name:_____ Address: _____

State: _____ City: _____ Zip Code: _____

Phone #: _____ Email: _____

A complete application includes the following:
(a) a completed and signed Scholarship Agreement,
(b) a completed Intake Form, and
(c) documentation of U.S. citizenship or legal permanent resident status

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1. Personal Data Intake Information Form

Today's Date: _____

Demographics
First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____ DOB: _____ Age: _____

Sex (Assigned at Birth): ☐ Male ☐ Female Gender Identity: _____

Social Security Number: _____-_____-_____

Name of person completing this form: _____

Relationship to Applicant: _____

What are your interests and hobbies? _____

_____

What helps you to feel calm? _____

_____

Applicants's Phone Numbers: (Check YES or NO if I can call and identify myself or leave messages on each phone)

Home: _____ Call and identify: ☐YES ☐NO Leave message: ☐YES ☐NO

Cell: _____ Call and identify: ☐YES ☐NO Leave message: ☐YES ☐NO
Text Reminders: ☐YES ☐NO

Work: _____ ___ Call and identify: ☐YES ☐NO Leave message: ☐YES ☐NO

Current Marital Status:
☐ Single – Never Married
☐ Married
☐ Separated
☐ Living together, but not legally married
☐ Divorced
☐ Widowed
☐ Minor Child

Race:
☐ White
☐ Black
☐ Native American
☐ Hispanic
☐ Asian
☐ Pacific Islander
☐ Other _____

Highest Education Completed:
☐ Grade _____
☐ Associate Degree
☐ Certificate Program
☐ Bachelors Degree
☐ Masters Degree
☐ Professional Degree
☐ PhD

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Number of Marriages: _____ ☐ More than one race

What is your primary language? _____

Military History
Are you a military veteran? ☐ Yes ☐ No

Are you currently on active duty in the military? ☐ Yes ☐ No

If you have military history, what branch? _____

Have you ever been deployed? ☐ Yes ☐ No

Legal
Have you ever been arrested? ☐Yes ☐No If yes, what charges?
_____

Have you ever been convicted? ☐Yes ☐No If yes, what charges?
_____

Do you have any current legal concerns? _____

Is there a corrections officer that you are currently working with? _____

Are you a registered violent or sexual offender? ☐YES ☐NO

Can you legally attend a treatment program outside of your home state? ☐YES ☐NO

Current level of employment

☐ Unemployed ☐ Part-time: Paid work less than 30 hrs/wk

☐ Full-time: Paid work more than 30 hrs/wk ☐ Homemaker ☐ Day laborer: No consistent work

☐ Retired from active employment ☐ Child under 15 ☐ Full-time student

☐ Disabled and unable to work ☐ Other (please indicate):
_____

How long have you been at your current job? _____

Are you unhoused/ homeless? _____

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Do you have any employment concerns? _____

Are you a first responder? _____

Do you have financial concerns? _____

What is your annual household income? _____

Will you, your friends, or your family be willing to pay for all or part of transportation costs from where you are to a treatment center? ☐ Yes ☐ No ☐ Maybe ☐ Other:

_____

Family Life
Do you have children? ☐YES ☐NO How many? _____

Is there anyone that you want involved in your treatment?_____

Do any of your family members have any diagnosed mental health concerns? (Please list your relationship to the family member and their diagnosis)

_____

_____

Why isn't your family providing financial support for treatment, either by paying or through insurance? _____

_____

Who referred you to Break Free?

☐ Self	☐ Police/ Law Enforcement	☐ Another Counselor
☐ Family/ Friend	☐ Court/ Judge	☐ Hospital
☐ School	☐ Probation Officer	☐ Clergy
☐ Employer	☐ Inpatient SA/ MA Facility	☐ Attorney
☐ EAP	☐ Doctor/ Medical Professional	☐ Other

_____

Current Medical Conditions:

☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Seizures ☐ Tuberculosis ☐ Activity Restrictions

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☐ Dietary Restrictions ☐ Allergies_____ ☐ Infections Disease _____

☐ Other _____

Are you on MAT (Medication Assisted Treatment) such as methadone, suboxone, etc? If yes, please list them here: _____

Current Medications	Dose	Prescribed for?	Side Effects?	Helpful?

Substance Abuse Screening Self Report

Have you used or are you currently using: **Please check if current**

Alcohol Frequency/ Amount: _____ ☐

Marijuana Frequency/ Amount: _____ ☐

Cocaine Frequency/ Amount: _____ ☐

Meth Frequency/ Amount: _____ ☐

Pain Pills Frequency/ Amount: _____ ☐

Heroin Frequency/ Amount: _____ ☐

Sleeping Pills Frequency/ Amount: _____ ☐

Tranquilizers Frequency/Amount: _____ ☐

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Nicotine Frequency/Amount: _____ ☐

Caffeine Frequency/Amount: _____ ☐

Diet Pills Frequency/Amount: _____ ☐

Spice Frequency/Amount: _____ ☐

Bath Salts Frequency/Amount: _____ ☐

LSD/PCP Frequency/Amount: _____ ☐

Ecstasy/Molly Frequency/Amount: _____ ☐

_____ Frequency/Amount: _____ ☐
(other)

If you checked yes to any of the above answer the following: **Please check if yes**

Have other people said you have a problem with drugs and/or alcohol? ☐

Has your use of drugs and/ or alcohol interfered with school, work or social functioning? ☐

Have you ever tried to cut back on your use of drugs and/or alcohol and been unsuccessful? ☐

Have you noticed that it takes more of your drug or alcohol to have the same effect? ☐

When you stop using your drug and/ or alcohol do you have any side effects? ☐

Do you focus a lot on getting drugs and/or alcohol? ☐

Are you preoccupied with your next use or obtaining the drug? ☐

Have you stopped doing activities because you were using drugs and/ or alcohol? ☐

Are you willing to go to an inpatient treatment center for 30 days? ☐

Previous Treatment (when, where, outcomes): _____

_____

_____

Substance Use

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Have you used street drugs in the past 3 months? ☐YES ☐NO

Have you ever abused prescription medication? ☐YES ☐NO

If YES, which one(s) and for how long? _____

_____

What is your financial situation? _____

Where do you feel your addiction started? _____
Will you need detox? ☐YES ☐NO

When are you able to admit? _____

Have you experienced a traumatic or life changing experience? _____

_____

What are your plans for after treatment? _____

2. Informed Consent
The purpose of this agreement is to set forth the basic guidelines concerning being a recipient of the scholarship from the Break Free Foundation. Recovery is a process that happens one day at a time.

There are many different treatment approaches that may be used to help treat the problems that you want to address. Recovery requires an active effort on your part. In order for your recovery to be successful, one important part is you working on the things discussed in group both during the session and between sessions.

There are no guarantees of what you will experience. Participation in this program is voluntary and you can end your involvement any time for any reason.

Treatment methods, benefits, and possible alternatives will be explained to you, as well as the possible consequences of not receiving treatment. The risks and benefits will be explained to you. You have the right to evaluate all this information, along with your own opinions of whether or not you feel comfortable attending the rehabilitation and outpatient programs the scholarship program has available to you.

In addition to this there are a few other things that are important to note:

- You will not be recorded or videotaped without your written consent or knowledge.
- Any testing, reports, and/ or referral procedures will be explained to you.

- Treatment information is considered confidential within certain state and federal limitations. Consent for release of information must be both provided and withdrawn in writing.
- You have the right to refuse electronic communication and to providing emergency medical contacts. Be aware that you are welcome to communicate via electronic means, but understand that there are risks involved in using the communication. Also note that any emails are considered part of your legal record.
- You are entitled to receive a copy of your records, or a prepared summary. Because these are professional records, they can be misinterpreted and be upsetting to untrained readers. If you wish to see your records, I recommend you review them with me.

I have been given the opportunity to question the above information about consents and releases of information. I voluntarily agree to the treatment available to me through the Break Free Foundation.

Your signature below indicates that you have read this information and agree to abide by its terms as a scholarship recipient.

_____

Client Signature Client Printed Name Date

Informed Consent of Electronic Messaging

Unsecured Electronic Messaging may be used with clients for communicating that has minimal privacy related consequences. The Break Free Foundation can respond to electronic queries, but is not obligated to respond electronically and such responses must be conducted with care.

To communicate with you electronically, you must provide your consent, recognizing that email and text messages, for example, are not a secure form of communication. There is some risk that any protected health information that may be contained in such an email may be disclosed to, or intercepted by unauthorized third parties.

Break Free will use the minimum necessary amount of protected health information in electronic communication. In addition to this informed consent, any correspondence between a client and Break Free staff will require the clinician to respond to your request within the parameters of the information provided below. I acknowledge that I understand the risks associated with electronic messaging and consent to its use, as minimally necessary.

The email address I give consent to use in electronic communication is below: _____

_____

3. Mental Health and Wellness Intake Form

Primary Care Physician (PCP): _____

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Are you receiving mental health treatment at this time? ☐YES ☐NO

If YES, where: _____

INSURANCE INFORMATION

_____

PRIMARY INSURANCE POLICY HOLDER

_____

POLICY HOLDER DOB RELATIONSHIP

_____

POLICY HOLDER ADDRESS CITY STATE ZIP

_____

POLICY GROUP NUMBER

SECONDARY INSURANCE INFORMATION

_____

SECONDARY INSURANCE POLICY HOLDER

_____

POLICY HOLDER DOB RELATIONSHIP

_____

POLICY HOLDER ADDRESS CITY STATE ZIP

_____

POLICY NUMBER GROUP NUMBER

What mental health services are you seeking? (Check all that apply.)

☐ Psychiatry Therapy/ Counseling ☐ Intensive Outpatient Treatment

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Current Symptoms Checklist: (check for any symptoms present, twice for major symptoms)

☐ Depressed Mood ☐ Unable to enjoy activities ☐ Increased need for sleep
☐ Decreased need for sleep ☐ Loss of interest ☐ Decrease in energy
☐ Concentration/ forgetfulness ☐ Change in appetite ☐ Excessive guilt
☐ Fatigue ☐ Decreased libido ☐ Increased libido
☐ Racing thoughts ☐ Impulsivity ☐ Risky behavior (explain,_____
☐ Excessive energy
☐ Increased irritability ☐ Crying spells
☐ Excessive worry ☐ Anxiety attacks
_____)
☐ Avoidance ☐ Hallucinations ☐ Suspiciousness
☐ Suicidal thoughts ☐ Self-harm (explain,_____ ☐ Violent thoughts
☐ Other, _____
_____)

Violence toward others (anyone specific?) _____

Suicide Risk Assessment
Have you ever had feelings or thoughts that you didn't want to live? ☐YES ☐NO

If YES, please, answer the following. If NO, please, skip to the next section.

Do you currently feel that you don't want to live? ☐YES ☐NO

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

Do you have a plan to kill yourself? _____

Is the method you would use readily available? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill yourself before? _____

Do you have access to guns, weapons, medications, or anything you can hurt yourself

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with?_____

Medical Information

Allergies: _____ Current Weight: _____ Current Height: _____

For women only: Are you currently pregnant or do you think you may be pregnant? ☐YES ☐NO

Do you have any concerns about your physical health that you would like to discuss with us? ☐YES ☐NO

Open Wounds/ History of MRSA? ☐YES ☐NO

Ambulation/ Disabilities: ☐YES ☐NO

Stairs Ok? ☐YES ☐NO

Mental Health Status

Have you participated in outpatient mental health treatment before? ☐YES ☐NO

If YES, describe: _____

Reason for outpatient mental health treatment: _____

Have you been hospitalized for mental health treatment before? ☐YES ☐NO

If YES, describe: _____

Reason for inpatient mental health treatment: _____