LOWELL HOUSE, INC.

☐ Second Offender Aftercare (SOA) Program Packet

New Client Information

Date: ___________

Client Name ___________________________ DOB ___________

Social Security#: ______________________________

Address: ____

City/Town: ______________________ State: _____ Zip: _____

Phone#: _____________________________________

Additional Phone #: ________________________

Emergency Contact Name: ___________________________

Phone#: _______________________________

Email: _______________________________________

Insurance: ____

Member#: _______________________Group#: ____________

Please make sure to bring the following with you on your first appointment:

- **Driver's License/Identification**
- **Insurance Card**
- **Referral (if any)**
- **Any pertinent information**

Please be prepared to have your photo taken.

Please make sure to sign and date all pages that have signature lines

INTAKE FORM
Second Offender Aftercare

ESM# ________________________________ Date ____________________________

Name ________________________________Date of Birth ______________________
Address ____________________________ City/Sate/Zip ______________________
Home # ______________Work # ______________ Cell Phone # __________________
Date of Arrest ______________ Date of Conviction _____________ BAC __________

Court in which convicted ___________________Probation Officer ________________

Marital Status__________ With whom do you live? Please list the first names and ages of people you live with: ____

____

Have any members of your family, or your significant other's family, ever had any ever had any alcohol and/or other drug problems? _________ If yes, please identify their relationship to you, whether they received treatment, and their present alcohol/other drug use status in the chart below:

Relationship	Treatment (Yes/No)	Current use Status

Have you ever been **arrested** for any other **alcohol/drug related offenses**, other than this current OUI?_________ If yes, please list offenses, date and courts or police departments involved:

Offense(s)	Date	Court/Police Department

Have you ever been arrested for any other offenses? __________If yes, please list:

Offenses(s)	Date	Court/Police Department

Have you ever been taken into protective custody? ______________If yes, please list:
Police Department Date

____

____

____

Have you ever had a hearing at the Department of Motor Vehicles in this state or any other state? __________If yes, please list:

State Reason for Hearing Date Outcome

____

____

Where do you work?_________________What do you do for work_______________

How long have you been employed in your current job?_________________________

Have you ever been fired from a job? ______If yes, please list the type of job and the reason: ____

Highest grade completed (include college, if any)___________________________

Have you ever been in the military?_______ If yes, what branch? _______________

What type of discharge did you receive?___________________________________

What type of alcohol and/or drug(s) were you using just prior to your arrest?

____

How much of this alcohol and/or drug(s) did you use?_________________________

How long were you drinking/using prior to your arrest?_______________________

Did you feel drunk/high at the time of your arrest?__________________________

At what age did you first use alcohol and/or other drugs?_____________________

Please fill out chart below as it relates to your drug (including alcohol) use: Please base this on your normal use in the past year. Do not include any prescription medications.

Drug/Alcohol	Often	How Much	How Taken	How Much in Last 30 Days	Last Use

Have you ever been involved in any self-help programs such as AA, ALANON, NA, or ACOA groups?_____How often do you attend?________________

____

Are you currently, or have you ever been, involved in any form of treatment or counseling for any reason?_______ If yes, please list below:

Place of treatment Reason For How Long

____

____

____

Do you currently, or have you ever, had any serious injuries or illnesses for which you have received any medical treatment?________ If yes, please explain:

____

____

Are you currently taking any prescription medications?________ If yes, please list:

Drug Dosage Reason for Taking

____

____

____

Has anyone ever shown any concern related to your alcohol and/or other drug use? _______ If yes, who has shown concern and why? ______________________________

____

Do you think any problems in your life are related to drinking or drugging?________ If yes, why? ____

____

What High School did you attend: ______________________________________

Did you Graduate? YES NO GED

Years you were in High School? (ex.1988-1992): ___________________________

Did you attend college? YES NO If so, where did you attend? ______________________

List degree/certification and year of graduation: ________________________________

____

Where were you born and raised? ____

Who raised you? ____

Do you have siblings? YES NO
If so, please list:

____

____

____

Where are you in the birth order? ____________________________

Do you maintain in contact with family members? YES NO

Is there any family history of mental illness or addiction? YES NO
If yes, please list relationship to you as well as addiction or illness: _________________
____

Verified by LHI Staff _______________________ Date ______________

Second Offender Aftercare
Person Served/Agency Agreement

Person Served: ____
Print Name

Second Offender Aftercare Program Overview

The Second Offender Aftercare Program (SOA) at Lowell House, Inc. is a year-long outpatient-counseling program. The program begins with an initial Individual Action Plan (IAP) that you will develop with a clinician at LHI. Upon completion of your IAP, you will complete 8 weeks of treatment either in individual and/or group settings which will be determined at the intake appointment. In these sessions, your clinician and you will determine your clinical needs going forward. The next step in the process will be to address the clinical needs that were outlined in your IAP. You will be required to participate in an individual IAP appointment every 90 days to review your treatment plan with your clinician.

Specific Program Components

1. Attend and complete your Intake Appointment/Initial Assessment
   During the intake, you will complete your initial intake and participate in writing your Initial Individual Service Plan (ISP).
2. Attend and complete 8 weekly Assessment/ Treatment Sessions
   Types of sessions (group or 1:1) are based upon your individual clinical needs identified during your intake appointment/initial assessment.
3. Independently complete 4 self-help meetings
   You must attend four (4) self-help meetings. It is your responsibility to obtain an authorized signature on the attendance sheets provided by Lowell House, Inc, in order to document your presence at the meeting. These self-help meetings must be completed by the end of your 8-week sessions, and only original signature sheets will be accepted (no photocopies).
4. Completion of mandatory random urine screens
   Results of the urine screen along with any subsequent recommendations generated from the screen will be submitted to the court as long as written consent is signed. Urine screens will be conducted randomly throughout the course of the program by LHI. The cost of these screens is $30.00 per screen.
5. Completion of at least one (1) Breathalyzer every 90 days throughout your SOA Program
   The results of the Breathalyzer will be submitted to the court and may include recommendations generated as a result of the Breathalyzer results. The cost of the breathalyzer is $12.00 per test.

6. At the conclusion of your 8-week sessions, you will be required to attend a 1:1 session in order to write a new Individual Service Plan. IAP's need to be reviewed every 90 days.
7. At the end of the 8-week sessions, Lowell House Inc. will generate a report for the court that will communicate your participation in the program and your Individual Service Plan for the remainder of the program.

Lowell House, Inc. will be sending monthly reports to your Probation Officer detailing your status in the Second Offender Aftercare Program. You must complete all the requirements prior to the 1:1 Individual Service Plan planning session. Failure to complete all requirements within the time frames described above may lead to termination by the Second Offender Aftercare Program and Lowell House, Inc. will return you to the court/referral source.

The remainder of the program will consist of:

1. Participate and complete all counseling recommendations and requirements, as stated in the Individual Action Plan (IAP) formulated at the end of the 8-week evaluation period. The counseling recommendations (subject to re-evaluation every 90 days) will extend through your one-year probation period. The minimum requirement for this component of the SOA is a once-a-month outpatient counseling session, however IAP's may include additional treatment sessions and/or modalities.
2. Completion of random urine screen
   Results of the urine screen, along with any subsequent recommendations generated from the screen will also be submitted to the court.
3. Attend and complete 1:1 Individual Action Planning session every 90 days.
4. Completion of a Breathalyzer every 90 days throughout your Second Offender Aftercare outpatient counseling program. The results of the Breathalyzer will be submitted to the court/source of referral and may include recommendations as a result of the Breathalyzer results.
5. Attend and participate in an individual (1:1) Discharge Planning Session This appointment is scheduled 35 days prior to your actual discharge.

I ________________________________ have read the above Second Offender Aftercare
(Print Name)
outpatient counseling components and requirements and I understand my responsibilities for completion of this program.

________________________________ ____________________
Person Served Date

________________________________ ____________________
Lowell House, Inc. Staff Signature Date

Second Offender Aftercare (SOA) Payment Contract

Outpatient Second Offender Aftercare Rates

$129.00 Intake Session
$110.00 Per Individual Session
$26.00 Per Group Session
$30.00 Per urine screen administered.

Payments are to be made before the beginning of each appointment or session. ***Only the following payment methods are accepted: Cash, money order, or credit/debit card. NO personal checks allowed.***

As a client of the Second Offender Aftercare Program at Lowell House Inc (LHI), I understand and agree to the following:

- I am responsible for payment of all SOA services provided to me by LHI that are not covered by my insurance.
- I have reviewed the SOA/Outpatient rates.
- I must pay for all my appointments at the time of the appointment.
- It is my responsibility to formally notify LHI of any change to my health insurance plan.
- I am responsible for completing CHI's. Insurance/Income Verification forms and assist in the verification process, when necessary.
- Until my insurance is presented and verified, I am responsible for the cost of any services I receive from LHI.
- If my insurance company denies payment to LHI for a service that was delivered or an outstanding balance exists after LHI receives payment from my insurance company, I am responsible for any and all balances due.
- I am responsible for making all required co-payments at the time services are rendered.

*Final program completion letters will not be sent to the referral source/court until all fees are paid in full. LHI staff may wave charges in certain circumstances and documentation will be required within 24 hours for consideration.

____

Person Served Date

SECOND OFFENDER AFTERCARE POLICIES

1. Attendance

Attendance in the SOA Program is mandatory; this also includes any Individual Service Plans (ISP) that are scheduled for you during the program. ISP appointments cannot be rescheduled or canceled. If you cancel/reschedule any ISP this will count as a missed session. Failure to adhere to Absence Policy will result in your being terminated from the program and referred to the court. If you are referred to LHI for re-instatement to the SOA program at Lowell House, Inc. you will need to participate in a re-evaluation process. From this reevaluation your new ISP will be developed.

* You must arrive on time. If you are late, you will not be admitted to your session (Group/individual) this will count as an unexcused absence.

No more than three (3) unexcused absences are allowed during Phases II and III, and you must make up any and all missed sessions. An excused absence is defined by the following:

1. You are in the hospital.
2. You are sick and can provide medical documentation from a doctor.
3. If you are the primary caregiver for someone (child, elder parent), and that person is sick and/or is hospitalized and requires you to care for them. You must provide medical documentation that the person you are caring for required your presence.
4. Someone close to you (family, loved one) has deceased and you are attending services. You must provide some type of documentation (bereavement card, obituary).

In the event of an approved absence, you must notify the SOA Coordinator and provide the required documentation before your next scheduled appointment. Missed sessions cannot run consecutively unless appropriate documentation is provided. Any documentation must be provided before your next session to the SOA Program Coordinator, if you have a missed session in your monthly part of your Phase III-B program a makeup is required.

2. Self Help Attendance

You must attend 4 self-help meetings (AA, NA and/or Smart Recovery) during Phase II of the SOA Program and provide appropriate original documentation as required. NO PHOTOCOPIES WILL BE ACCEPTED. Documentation of attended Meetings must be submitted by your 4th group/individual session. Failure to submit documentation may result in termination from the SAO Program.

3. Breathalyzers and Drug Screens

You must comply with all random drug screens while in the SOA program. Urine Screens are administered by LHI. The cost for each urine screen is $30.00, The Optional Request and Disclosure Statement must be completed identifying any prescription medication (ex. pain medication). Upon completion of the Disclosure, you must provide Lowell House, Inc. with the physicians' order or copies of the prescription within 72 hours. If your urine screen results are positive for any substance and you have failed to complete the Disclosure Form and/or provide Lowell House, Inc. with copies of the physician's order or copies of the prescription, you will be terminated from the program and will be returned to the court Lowell House, Inc. will notify your source of referral/court that you have failed a random drug screen. If you refuse to comply with any random urine screen this will result in termination from the program.

You must participate in all Breathalyzer tests/ Drug Screens administered by LHI staff. The cost for each Breathalyzer is $12.00. Refusal of any Breathalyzer or Drug Screen administered, walking out of group while a Breathalyzer or Drug Screen is being administered and/or any positive result, excluding approved prescribed medication, will result in termination from the SOA Program.

4. Sobriety

You must be alcohol/drug free for all sessions and appointments conducted at LHI. No one may attend an individual/group session while under the influence of/or in possession of alcohol or any other drug. Violation of this policy will lead to termination of your services at LHI, and you will be referred to the court/referral source. LHI will notify your court/referral source **immediately**.

5. Communication

As a part of the SOA program and with your signed consent, LHI will communicate at least monthly to your referral source/probation officer about your progress in the program. A Completion letter will not be sent to the court/referral source until all program requirements are met and any outstanding balance is paid in full.

It is the responsibility of each person served to provide a current mailing address and phone number to LHI. It is your responsibility to inform LHI of any change in address or phone number so that we can ensure that we can communicate to you any pertinent program information.

6. Payment

You must meet all financial obligations prior to program completion as described on previous pages in order to successfully complete the program.

7. Safety

- No weapons of any kind are allowed on LHI property, or during any activities associated with LHI.
- You must refrain from assaultive or abusive verbal or physical behavior toward any person or property associated with LHI.
- Possession of alcohol and drugs is prohibited on LHI property.

Violation of a safety policy will result in immediate termination of your services and your referral source/court will be notified.

8. Termination

If you are terminated from the Second Offenders Program for any reason you must start the program over. You must complete all SOA requirements as outlined in the agreement. If you fail to meet any or all SOA requirements, a report will be submitted to the court/referral source **immediately**.

Formal Complaint and Grievance Procedure:

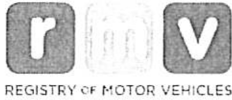
Complaints are handled whenever they arise by bringing them to the attending staff. If satisfactory resolution cannot be reached, the person served should submit complaint documentation to the Ambulatory Services Director for further review.

____

Person Served Print Name		Person Served Signature		Date

____

Lowell House, Inc. Staff Signature		Date



Multiple Offense OUI Hardship License Criteria

Before applying for a hardship license at the Registry of Motor Vehicles, please review the requirements below to determine if you are eligible. Although you may meet all requirements, issuance of a hardship license is only granted at the reasonable discretion of the RMV, based on the facts of the case.

☐ There is NO evidence of any operation of a motor vehicle since the effective date of the OUI suspension/revocation.

☐ The MINIMUM amount of time, reflected in the chart below and depending on the type of hardship requested, has been served on the suspension.

OUI Eligibility Time

Length of Suspension	Work/Education Hardship	General Hardship
1 yr. (365 days)	3 months into OUI suspension	6 months into OUI suspension
2 yrs. (730 days)	1 yr. into OUI suspension	18 months into OUI suspension
8 yrs. (2920 days)	2 yrs. into OUI suspension	4 yrs. into OUI suspension
10 yrs. (3650 days)	5 yrs. into OUI suspension	8 yrs. into OUI suspension

☐ All other active suspension/revocation periods have been COMPLETED.

☐ You must provide documented proof of completion of the proper alcohol treatment program for second offense OUI and above: 2-week in-house program for 2nd offense, 90 day in-house program for 3rd and 4th offenses.

☐ You must provide the Discharge Summary from the treatment program, stating the risk factor or recidivism rate.

☐ You must provide proof of compliance with all ordered after care. Second offenders must provide the "2nd Offender Completion Letter Needed for Hardship Consideration" issued by the after care provider. Further, please note that the risk assessment portion of this letter expires 90 DAYS from the date issued. Failure to submit this letter in a timely manner will result in the RMV Hearings Officer requiring a new risk assessment, at your expense, and to be completed by the agency noted on the letter. If further substance abuse treatment is recommended, a Progress Review must be submitted from the substance abuse treatment center/counselor. In addition, a new Discharge Summary may be requested to clarify a recidivism rate.

☐ You have provided a letter from probation, not more than 30 days old, stating that you are in compliance with any current probation or conditions of release. If you are not on probation or subject to any form of court supervision at the time of the hardship license application, this requirement may be waived.

☐ You have documented a legitimate hardship. You must provide a letter from your employer, on letterhead, which is dated within the 30 days preceding the hardship license request. The letter must state your need for a hardship license and the work hours. Note: The RMV may only grant an identical 12-hour, 7-day license.

If you are self-employed, you must present proof of self-employment. Acceptable forms of proof consist of a business certificate, tax forms indicating self-employment, and/or a current professional license. You must also present a letter on your own behalf explaining your need for a hardship license and the hours requested. Note: The RMV may only grant an identical 12-hour, 7-day license.

If you are applying for a hardship license for other purpose (i.e., education, medical treatments), the RMV requires third party documentation of the hardship. Note: The RMV may only grant an identical 12-hour, 7-day license.

☐ You are responsible for providing proof regarding the availability of public transportation. This proof may be included within your employer's letter. You may also provide local bus/transit routes, MapQuest etc. Hardship

requests may be denied if you may access employment, school, or medical treatments via public transportation unless the proof of hardship articulates public transportation will not satisfy the request and the reason, therefore.

☐ Installation of an Ignition Interlock Device (IID) is required for all hardship licenses which include a second or subsequent OUI offense, and for certain first time offenders who, at the time of arrest, had a Blood Alcohol Content which registered at or above .15. Multiple offenders are required to maintain the IID in a vehicle for two years following removal of the hardship restriction. See https://www.mass.gov/guides/ignition-interlock-device-program for further details.

☐ If you are required to install an Ignition Interlock Device, please visit https://www.mass.qov/quides/ignition-interlockdevice-program to review whether you are eligible to apply for indigency status. Approval includes waived costs for installation, device, monitoring, and service, but not costs related to violations or any RMV fees or services.

☐ All requests for a hardship license for a 3rd or 4th offense must be approved by the Director of the Driver Control Unit and will be taken under advisement if the RMV Hearings Officer is inclined to approve such request.

NOTE: Reinstatement is only allowed once the proof of installation of the IID and affidavits have been returned to an RMV Hearings Officer. A learner's permit exam and road test may be required if you have been suspended or otherwise inactive for more than two years.

Application for a hardship license will be subject to the requirements in place on the date of application. These requirements are subject to change at the RMV's discretion.

ADULT SUBSTANCE USE AND DRIVING SURVEY – REVISED MODIFIED (ASUDS-RM)

TO BE COMPLETED BY CLIENT				
NAME:	DATE:	AGE:	Gender: ☐ MALE ☐ FEMALE	YEARS SCHOOLING:

ETHNIC GROUP: ☐ AFRICAN AM. / BLACK ☐ ANGLO / WHITE – NON-HISPANIC ☐ HISPANIC ☐ NATIVE AM. ☐ ASIAN ☐ OTHER

MARITAL STATUS: ☐ SINGLE (NEVER MARRIED) ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EMPLOYMENT: ☐ EMPLOYED ☐ EMPLOYED PART TIME ☐ UNEMPLOYED ☐ STUDENT ☐ RETIRED ☐ HOUSE SPOUSE ☐ OTHER

PRIOR ALCOHOL / DRUG OUTPATIENT AND/OR INPATIENT TREATMENT ADMISSIONS: ☐ NONE ☐ 1 ADMISSION ☐ 2 OR MORE ADMISSIONS

NUMBER OF PRIOR DWI ARRESTS AND/OR CONVICTIONS: ☐ NONE ☐ 1 ☐ 2 ☐ 3 OR MORE | ARREST BAC: | TEST REFUSED: ☐

THIS BOOKLET CONTAINS QUESTIONS ABOUT YOUR USE OF ALCOHOL AND OTHER DRUGS. SOME QUESTIONS HAVE TO DO WITH PROBLEMS YOU MAY HAVE HAD IN YOUR COMMUNITY. OTHER QUESTIONS HAVE TO DO WITH YOUR FEELINGS AND EMOTIONS. FOR EACH QUESTION, CIRCLE THE LETTER UNDER THE ANSWER THAT BEST FITS YOU. PLEASE ANSWER EVERY QUESTION AND GIVE ONLY ONE ANSWER FOR EACH QUESTION.

For the list of drugs below, circle the letter under the answer that best fits you. For alcohol, it is the number of times in your lifetime that you have been intoxicated. For all other drugs, it is the number of times in your lifetime that you have used the drug. Then, on the right side of the page, for each drug, indicate the number of times in the 6 months before and including your current DWI arrest that you were intoxicated on alcohol and the number of times you used each of the other drugs. For that 6 month period, circle "a" if you did not use alcohol and circle "a" for each of the other drugs you did not use. Circle "b" if you were intoxicated on alcohol and used the other drugs from 1 to 10 times. Circle "c" if from 11 to 25 times, etc. Then, for each drug you used in your lifetime, put your age you last used that drug.

Circle the letter for the answer for each question that best fits you.	Total Number of Times in Lifetime: Never Used	One to 10 times	11-25 times	26-50 times	More than 50 times	Times in the 6 months before your DWI arrest	Age last used
1. Number of times intoxicated or drunk on alcohol (beer, wine, hard liquor, mixed drinks).	a ☐	b ☐	c ☐	d ☐	e ☐	a b c d e	___
2. Marijuana (pot, hashish, hash, THC, bud, dope, etc.) used when not approved by a doctor or medical specialist under state medical marijuana laws/rules.	a ☐	b ☐	c ☐	d ☐	e ☐	a b c d e	___
3. Cocaine (coke, snow, crack, rock, blow, candy, etc.).	a ☐	b ☐	c ☐	d ☐	e ☐	a b c d e	___
4. Amphetamines/methamphetamine/stimulants (Dexedrine, Desoxyn, Ritalin, Adderall, meth, ice, crystal, speed, diet pills, uppers, black beauties, white crosses, bennies, bath salts, Flakka, spice, K2, etc.), used when not prescribed for medical reasons.	a ☐	b ☐	c ☐	d ☐	e ☐	a b c d e	___
5. Hallucinogens (LSD/acid, PCP/angel dust, ketamine/ Kit Kat/K, MDMA/ecstasy/molly, salvia/magic mint, mescaline/peyote, mushrooms, etc,).	a ☐	b ☐	c ☐	d ☐	e ☐	a b c d e	___
6. Inhalants (rush, gasoline, paint, glue, nitrous oxide, whiteout, aerosol, whippets, amyl nitrate, poppers).	a ☐	b ☐	c ☐	d ☐	e ☐	a b c d e	___
7. Heroin (H, smack, junk, horse, skag, skunk, etc.).	a ☐	b ☐	c ☐	d ☐	e ☐	a b c d e	___
8. Other opiates/pain killers (codeine, opium, Vicodin, morphine, fentanyl, Percodan, Dilaudid, Demerol, methadone, oxycodone, Oxycontin, Darvon, etc.) used when not prescribed for medical reasons.	a ☐	b ☐	c ☐	d ☐	e ☐	a b c d e	___
9. Barbiturates/sedatives (Seconal, Nembutal, Amytal, Phenobarbital, Dalmane, sleeping medicines, blues, reds, yellows, ludes, downers, barbs, Z-drugs, etc.) used when not prescribed for medical reasons.	a ☐	b ☐	c ☐	d ☐	e ☐	a b c d e	___
10. Tranquilizers (Librium, Valium, Ativan, Xanax, serax, Halcion, meprobamates/Mltown/Equanil, Klonopin benzos) when not prescribed for medical reasons..	a ☐	b ☐	c ☐	d ☐	e ☐	a b c d e	___

11. As to your use of cigarettes (tobacco)	Never Smoked	Do not smoke now	Up to half pack a day	About a pack a day	More than a pack a day	
	a ☐	b ☐	c ☐	d ☐	e ☐	1___

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Please choose the answer to each question that best fits how you see yourself.

12. Do you drink (alcohol) to have fun or to be happy?
- a. No
- b. Occasionally
- c. Often
- d. Very often

13. Do you drink to relax socially?
- a. No
- b. Sometimes
- c. Often
- d. Very often

14. Do you take a drink or two to relieve yourself of worries?
- a. No, never
- b. Yes, sometimes
- c. Often
- d. Very often

15. Have you had a bad headache because of having too much to drink?
- a. No
- b. Yes, once or twice
- c. Yes, a few times
- d. Many times

16. How many times have you been drunk?
- a. Never
- b. Once or twice
- c. Several times
- d. Many times

17. Have you been "half with it" at work or "called in sick" because you drank too much?
- a. No
- b. It happened once
- c. It happened two or three times
- d. It has happened more than three times

18. Have you ever been unable to concentrate or think clearly after drinking too much?
- a. No
- b. Once
- c. A couple of times
- d. Several times

19. Do you drink when feeling down and depressed?
- a. Never
- b. Yes, sometimes I take a couple of drinks when I feel down
- c. Yes, often I drink when I feel down
- d. Yes, almost every time I feel down or depressed I drink

20. Did you ever drive an automobile knowing that you had too much to drink?
- a. No
- b. Yes, once
- c. Yes, a few times
- d. Many times

21. Have you ever passed out as a result of drinking?
- a. No
- b. Once
- c. Two or three times
- d. Four or five times or more

22. Have you ever felt down in the dumps after drinking?
- a. No
- b. Once
- c. A couple of times
- d. Several times

23. Have there been times when you could not recall what you did when you were drinking?
- a. No
- b. Yes, once
- c. Yes, two times
- d. Yes, three or more times

24. Do you drink to relieve tension or stress?
- a. No
- b. Yes, sometimes I do
- c. Yes, often
- d. Yes, very often

2_____

25. I exceed the speed limit if road conditions are safe.
- a. Not true
- b. Sometimes true
- c. Usually true
- d. Always true

26. I have found myself driving fast without realizing it.
- a. Never
- b. Seldom
- c. Often
- d. Very often

27. When other drivers do stupid things, I lose my temper.
- a. Never
- b. Seldom
- c. Often
- d. Very often

28. I drive fast and take my chances of getting caught.
- a. Never
- b. Sometimes
- c. Often
- d. Very often

29. High speed driving gives me a sense of power.
- a. Never
- b. Sometimes
- c. Often
- d. Very often

30. I have taken a risk when driving just for the sake of it.
- a. Never
- b. Seldom
- c. Often
- d. Very often

31. I swear out loud or cuss under my breath at other drivers.
- a. Never
- b. Seldom
- c. Often
- d. Very often

32. I have outrun other drivers.
- a. Never
- b. Seldom
- c. Often
- d. Very often

33. I pass other drivers when not in a hurry.
- a. Never
- b. Seldom
- c. Often
- d. Very often

34. I am a driver who likes to stay ahead of or out in front of traffic.
- a. Not true
- b. Sometimes true
- c. Usually true
- d. Always true

35. I have tried to beat a red light.
- a. Never
- b. Seldom
- c. Often
- d. Very often

36. I dodge and weave through traffic.
- a. Never
- b. Seldom
- c. Often
- d. Very often

3_____

When using or as a result of using any of the drugs on Page 1, including alcohol, indicate how often any of the following have happened to you in your lifetime. Then, for each of the following statements, in the column on the right side of the page, indicate how many times it has happened to you in the six months before and including your current DWI arrest. Circle an "a" if it did not happen to you in that six-month period. Circle a "b" if it happened to you 1-3 times. Circle a "c" if it happened to you 4-6 times. Circle a "d" if it happened to you 7-10 times. Circle an "e" if it happened more than 10 times.

Circle the letter for the answer for each question that best fits you.	Total Number of Times in Lifetime					Times during the 6 months before and including DWI arrest
	Never	1-3 times	4-6 times	7-10 times	More than 10 times	
37. Had a blackout (forgot what you did but were still awake).	a	b	c	d	e	a b c d e
38. Became physically violent.	a	b	c	d	e	a b c d e
39. Staggered and stumbled around.	a	b	c	d	e	a b c d e
40. Passed out (became unconscious).	a	b	c	d	e	a b c d e
41. Tried to take your own life.	a	b	c	d	e	a b c d e
42. Became physically sick or nauseated.	a	b	c	d	e	a b c d e
43. Saw or heard things not there.	a	b	c	d	e	a b c d e
44. Became mentally confused.	a	b	c	d	e	a b c d e
45. Thought people were out to get you or wanted to harm you.	a	b	c	d	e	a b c d e
46. Had physical shakes or tremors.	a	b	c	d	e	a b c d e
47. Had a seizure or a convulsion.	a	b	c	d	e	a b c d e
48. Had rapid or fast heartbeat.	a	b	c	d	e	a b c d e
49. Became very anxious, nervous and tense.	a	b	c	d	e	a b c d e
50. Became feverish, hot or sweaty.	a	b	c	d	e	a b c d e
51. Did not eat or sleep.	a	b	c	d	e	a b c d e
52. Were weak, tired and fatigued.	a	b	c	d	e	a b c d e
53. Unable to go to work or school.	a	b	c	d	e	a b c d e
54. Neglected your family.	a	b	c	d	e	a b c d e
55. Broke the law or committed a crime.	a	b	c	d	e	a b c d e
56. Could not pay your bills.	a	b	c	d	e	a b c d e
	16	17	18		4	5

Circle the letter for the answer for each question that best fits you.	Never	1-2 times	3-4 times	5 or more times
57. When I was in my teen years, I got into trouble with the law.	a	b	c	d
58. I was suspended or expelled from school when I was a child or teenager.	a	b	c	d
59. I have been in fights or brawls.	a	b	c	d
60. I have been charged with driving while impaired or under the influence of alcohol or other drugs.	a	b	c	d
61. As an adult, I have been in trouble with the law other than while driving a motor vehicle.	a	b	c	d

Please circle the letter for the answer for each question that best fits you.

		Not true	Somewhat true	Usually true	Always true
62.	I have had trouble because I don't follow the rules.	a	b	c	d
63.	I don't like police officers.	a	b	c	d
64.	There are too many laws in society.	a	b	c	d
65.	It is all right to break the law if it doesn't hurt anyone.	a	b	c	d
66.	Usually, no one tells me what to do.	a	b	c	d

6____

Please answer these questions as to how they apply to you during your lifetime and during the <u>last six months you were in the community</u>. Circle the letter under the answer of your choice.

		During Your Lifetime: None	1-2 times	3-4 times	5 or more times	During the last 6 months
67.	Number of times that I have been arrested and charged with a crime.	a	b	c	d	a b c d
68.	Number of times that I have been convicted of a crime (misdemeanor or felony).	a	b	c	d	a b c d
69.	Number of times I have been arrested for a crime committed against a person (such as robbery, burglary, assault, rape, manslaughter, murder).	a	b	c	d	a b c d
70.	Number of times I have been arrested for a domestic violence related offense.	a	b	c	d	a b c d
71.	Number of times I have been in jail or prison.	a	b	c	d	a b c d

Please answer these questions as to how they apply to you during your lifetime and during <u>the last six months</u>. Circle the letter under the answer of your choice.

		During Your Lifetime: Never	1-6 months	7-12 months	1-3 years	4 or more years	During the last 6 months
72.	Total amount of time I have spent on probation.	a	b	c	d	e	a b
73.	Total amount of time I have spent on parole.	a	b	c	d	e	a b
74.	Total amount of time I have spent in jail or prison.	a	b	c	d	e	a b

Please answer these questions as to how they apply to you during your lifetime and during <u>the last six months you were in the community</u>. Circle the letter under the answer of your choice.

		During Your Lifetime: No never	Sometimes	A lot	Most of the time	During the last 6 months
75.	When in the community, I have spent time with people who have been in trouble with the law.	a	b	c	d	a b c d
76.	I have a hard time staying out of trouble with the law.	a	b	c	d	a b c d
77.	I have been violent in my behavior or actions.	a	b	c	d	a b c d
78.	I have planned the crimes that I have committed.	a	b	c	d	a b c d
79.	When I have broken the law, I have been high or under the influence of alcohol or other drugs.	a	b	c	d	a b c d

7____ 8____

For the following questions, circle the letter for the answer that best fits you.

		No	Yes sometimes	Yes a lot	Yes, all the time
80.	Have you felt down and depressed?	a	b	c	d
81.	Have you been nervous and tense?	a	b	c	d
82.	Have you been irritated and angry?	a	b	c	d
83.	Have your moods been up and down – from very happy to very depressed?	a	b	c	d
84.	Do you tend to worry about things?	a	b	c	d
85.	Have you felt like not wanting to live or like taking your life?	a	b	c	d
86.	Have you had problems sleeping?	a	b	c	d
87.	Have you had thoughts that upset or disturb you?	a	b	c	d
88.	Have you been discouraged about your future?	a	b	c	d

9__

For the following questions, choose the answer that best fits you.

		No never	Hardly at all	A few times	Yes a lot
89.	Have you ever gotten angry at someone?	a	b	c	d
90.	Have you lied about something or not told the truth?	a	b	c	d
91.	Do you ever find yourself unhappy?	a	b	c	d
92.	Have you felt frustrated about a job?	a	b	c	d
93.	Do you hold things in and not tell others what you think or feel?	a	b	c	d
94.	Have you been unkind or rude to someone?	a	b	c	d
95.	Have you ever cried about someone or something?	a	b	c	d

10__

Answer the following questions as to how you see yourself at this time.

		No not at all	Yes maybe	Yes most likely	Yes for sure
96.	Do you think you need to make changes in your use of alcohol and drugs?	a	b	c	d
97.	Do you want to stop using alcohol or if you have stopped, do you want to continue to not use alcohol?	a	b	c	d
98.	Do you want to stop using other drugs or if you have stopped, do you want to continue to not use other drugs?	a	b	c	d
99.	Do you think that you need help for problems having to do with alcohol use?	a	b	c	d
100.	Do you think you need help for problems with the use of other drugs?	a	b	c	d
101.	Is it important for you to make changes around the use of alcohol or other drugs?	a	b	c	d
102.	Would you be willing to come to (or continue in) a program where people get help for alcohol and other drug use problems?	a	b	c	d

11__

END OF SURVEY

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Outpatient Department Individual Counseling

You will be scheduled for a 1-hour intake with one of our clinicians where you will be asked to provide your reason for seeking services and sharing some of your history. At a later meeting you and the clinician will create your individualized treatment plan. Il is your choice and, in your power, to identify your treatment goals, You and your clinician will also agree upon the expectations of your treatment here:

- How often you will meet, when those days and times are, how long your treatment will last, and what would happen for treatment to be terminated early.
- Early termination of treatment may be voluntary (your choice), or it may be involuntary (decided by the clinician due to factors such as consecutive cancellations or no-shows).

Privacy and Confidentiality:

We are committed to respecting and protecting your privacy and the confidentiality of your health care information. The code of ethics; HIPAA (Health Insurance Portability and Accountability Act); as well as CHAPTER 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records) mandates that all information about you be protected; and that any disclosure of your protected Health Information (PHI) requires your written consent.

Payments and Fee:

You may choose to self-pay or use health insurance. The following payment methods are accepted; Cash, money order, or credit/debit care. NO personal checks are allowed. If you are experiencing financial difficulties, you may qualify for certain special payment schedules or options that can be afforded on a limited income - such as a sliding scale.

Insurance:

We accept most MassHealth insurance policies and generally our services are covered in full. Our staff are available to assist you in determining your available coverage. Your insurance policy is not accepted, you may call your carrier directly to see if our providers may be covered or if there is an out-of-network benefit available. Staff may assist you with an alternative agency for referral as well.

Cancellations:

Failure to show up for or notify LHI within 24 hrs. of a scheduled appointment or group will result in a no-show fee. Cancellation notification must be made during regular business hours Monday-Friday 9am to 5pm. *Under special circumstances missed appointments/classes may be excused.* Notification of the missed session will be sent to the court/source of referral within 48 hrs. and may jeopardize your status in the program. All missed services must be rescheduled within 5 business days. Failure to do so may result in termination from the program.

Additional Fees:

Fee Type:	Cost:
Urine Screen	$30.00 each
Breathalyzer	$12.00 each

I have received, read, and understand the information provided on this document about my rights and expectations around treatment in the outpatient department.

Signature: ______________________________ Date: ______________

____

ALLERGY IDENTIFIER Date: ____________

Lowell House, Inc.
Person Served Emergency/Contact Sheet

Name ______________________________ DOB ___________ SS# _________________

Address ____
Street Name City State Zip Code

Telephone: Home __________________Cell _________________Work ______________

Email Address____

Marital Status Single Married Divorced Separated Widowed

Interpreter Needed: Yes No

Health Insurance _______________________________ Policy ___________________

Adolescents — If you are under the age of 18, please fill out this section:

Parent/Guardian Name: ____

Address: ____

Phone: Home __________________Work _________________ Cell _______________

Medical Information

Physician's Name/PCC ____

Physician's Address ____

Physician's Telephone ____

Blood Type ____

Allergies ____

Medication/Dosages ______________________ ______________________

______________________ ______________________

______________________ ______________________

Psychiatrist's Name ____

Psychiatrist's Address ____

Psychiatrist's Telephone ____

Emergency Contact— Person to contact in case of Emergency.

Name __________________________ Relationship ________________

Address____

Telephone. Home _____________Cell ____________ Work _________

Consent For the Release of Confidential Information

(Please Print)

I, ____ authorize Lowell House Inc (LHI) and its affiliates to disclose to
(Person Served/Guardian of Person Served) and/or receive from:

____ ____
(Name of person/Organization to which disclosure is to be made) (Email/Phone)

Any of the following substance use disorder information (please check the box next to each form of information you are consenting disclosure for):

- ☐ Attendance
- ☐ Urine screen results
- ☐ Breathalyzer results
- ☐ Oral swab results
- ☐ Intake data
- ☐ Assessment data
- ☐ Evaluation results
- ☐ Treatment status
- ☐ Treatment plan
- ☐ Progress notes
- ☐ Completion confirmation
- ☐ Discharge summary
- ☐ Other ________________
- ☐ Other ________________

The purpose of the disclosure authorization herein is to:

____
(Purpose of disclosure, as specific as possible)

I understand that my records are protected under federal regulations governing Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. 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. I agree that this release is set to expire on the following date, event, or condition:

____
(Date, event, or condition)

________________ ____
(Date) (Person Served/Guardian signature)

________________ ____
(Date) (LHI Staff signature)

Client Telehealth Consent Form

I, ___________________________ (client name), hereby consent to participate in Telemental health with Lowell House INC. __________________________ (program)as a part of my treatment. I understand that Telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to Telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that I have voluntarily entered Telemental health services and that if I am under the supervision of a court or other agency (identified as "Collateral" below), they have already approved my accommodation to participate in the above mentioned services remotely.

3) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

4) I understand that any disruptions, breaches, and/or situations that impact my ability to virtually attend or remain present during my session may impact my attendance record, and it is my responsibility to communicate these situations to Lowell House and seek to rectify, potentially through a make up session. This may result in me having to pay a missed session fee or make up fee.

5) I understand it is an expectation that I make personal accommodations with my own technology to ensure I can be visible and heard (a working camera and microphone on the technology I am using) throughout the sessions, and that I am able to locate myself physically in a location which protects my own and others' (if in a group setting) confidentiality.

6) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted/ and or required by law.

7) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless exception to confidentiality applies

(i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/ emotional health as an issue in legal proceeding)

8) I understand if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a more intensive or alternative level of care is required.

I have read the information provided above and discussed with my collateral/ referral source. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

____ _________________________

Client signature Date

____ _________________________

Collateral signature Date

____ _________________________

Lowell House INC Staff signature Date

TB Risk Assessment and Screening Form

Name: ______________________________ DOB: ____________ Date: ______________

Medical Record Number: ____________

TB History and Triage (to be completed by medical provider)

TB History	Yes	No
1) Has the person had a TB test (skin test or blood test)? TB test result: ☐ Positive ☐ Negative ☐ Unknown TB test date: ______________(MM/YY) Where______________________(facility)	☐	☐
2) Did the person get a chest x-ray after the TB test? X-ray result ______________________________ X-ray date:____________(MM/YY)	☐	☐
3) Did the person take medication for TB infection?	☐	☐
4) Does the person remember being sick with TB? If yes, when __________ (MM/YY) Where: Country ___________ State:____________	☐	☐

Triage Plan	
☐	**Person has TB risk and has one or more TB symptoms:** Refer the person for **prompt clinical evaluation** including a chest x-ray to rule out active TB
☐	**Person has TB risk, no symptoms and has no history of previous positive TB test:** Test for TB infection or refer for testing and evaluation
☐	**Person has a history of previous positive TB test, but has no evidence of treatment:** Refer for TB evaluation and treatment

TB Test Documentation

Tuberculin Skin Test (TST) plant date:__________ (MM/DD/YY) / TST read date: __________ (MM/DD/YY)

TST Result: __________ *(Millimeters of Induration)* / TST Interpretation: ☐ Positive* ☐ Negative ☐ Unknown

Interferon-Gamma Release Assay (IGRA) performed: ___ / ___ / ___ *(MM/DD/YY)*

IGRA Interpretation: ☐ Positive* ☐ Negative ☐ Indeterminate/Borderline (requires repeat test)

* **Report all persons with positive TB test to the Massachusetts Department of Public Health (DPH)**

http://www.mass.gov/eohhs/gov/departments/dph/programs/id/isis/case-report-forms.html

Medical Provider Signature: ________________________ Date: ____________

Adult TB Risk Assessment and Screening Form
(For Patient Record)

Name: ______________________ DOB: ______________ Date: ______________

TB Risk Assessment	Yes	No
1) Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East? In what country were you born? ______________________	☐	☐
2) In the past 5 years, have you lived or traveled in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East for more than one month?	☐	☐
3) In the last 2 years, have you lived with or spent time with someone who has been sick with TB?	☐	☐
4) Do you have (or have you had) any of these medical conditions? Diabetes / Kidney disease HIV infection / Colitis Cancer / Stomach or intestine surgery Rheumatoid arthritis	☐	☐
5) Are you taking any medications that your doctor said could weaken your immune system or increase your risk for infections?	☐	☐
6) In the past 1 year, have you injected drugs that your doctor did not prescribe?	☐	☐
7) Have you ever lived or worked in a prison, jail, homeless shelter or long-term care facility? (example: nursing home, substance abuse treatment, rehabilitation facility)	☐	☐

Symptom Screening – At this time, do you have any of these symptoms?	Yes	No
1) Coughing for more than 2-3 weeks?	☐	☐
2) Coughing up blood?	☐	☐
3) Weight loss of more than 10 pounds for no known reason?	☐	☐
4) Fever of 100°F (or 38°C) for over 2 weeks?	☐	☐
5) Unusual or heavy sweating at night?	☐	☐
6) Unusual weakness or extreme fatigue?	☐	☐

If you answer "yes" to any of the questions above, you may be at increased risk for TB infection. Please give this form to your medical provider.

Adult TB Risk Assessment and Screening Form

Instructions to Medical Providers

The purpose of the TB risk assessment and screening form is to identify persons with **increased risk for TB** who may require further testing and evaluation. Persons born in countries where TB is common are at increased risk for TB (especially, but not limited to those who arrived in the last 5 years).

The **TB Self-Assessment of TB Risk section** can be completed by the patient/client/guardian alone or with provider's assistance. The provider should review the information and discuss TB risks, symptoms, previous TB testing and treatment with the patient/client.

If the person with TB risk describes or exhibits symptoms suggestive of possible active TB:

- Isolate the patient/client immediately (if possible) and have the patient/client wear a mask.
- Refer the patient/client for prompt clinical evaluation including a chest x-ray. Ensure that the patient/client wears a mask during transport to the provider.
- Consult the Massachusetts Department of Public Health/Bureau of Infectious Disease/ Division of Global Populations and Infectious Disease Prevention at 617-983-6970.

If the person has a history of TB or TB risk, but has no symptoms suggestive of TB:

- Educate the patient/client about signs and symptoms of TB and should such symptoms develop, instruct them to seek medical follow-up.
- Consider testing the patient/client for TB infection or refer to primary care provider.
- Consult the Massachusetts Department of Public Health/Bureau of Infectious Disease, Division of Global Populations and Infectious Disease Prevention at 617-983-6970, if needed.

Resources

Information about TB evaluation, testing and treatment can be found at http://www.cdc.gov/tb/ and http://www.mass.gov/dph/cdc/tb

Guideline on the use of Interferon-Gamma Release Assay can be found at http://www.mass.gov/eohhs/gov/departments/dph/programs/id/tb/testing-screening/

Cases of suspect active or confirmed cases of active TB and TB infection are reportable to the Massachusetts Department of Public Health per Chapter 105, Code of Massachusetts Regulations (CMR), Section 300.000: Reportable Diseases, Surveillance, and Isolation & Quarantine Requirements.) http://www.mass.gov/eohhs/gov/departments/dph/programs/id/epidemiology/rdiq/reporting-diseases-and-surveillance-information.html

DPH-supported TB clinics http://www.mass.gov/eohhs/docs/dph/cdc/tb/regional-clinic-list.pdf

DAST-10 Questionnaire

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right.
You may choose to answer or not answer any of the questions in this section.

These questions refer to the past 12 months.	**No**	**Yes**
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes."	0	1
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

The MAST Test

The MAST Test is a simple, self-scoring test that helps assess if you have a drinking problem. Answer yes or no to the following questions:

1. Do you feel you are a normal drinker? ("normal" is defined as drinking as much or less than most other people)

___ Yes ___ No

2. Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening?

___ Yes ___ No

3. Does any near relative or close friend ever worry or complain about your drinking?

___ Yes ___ No

4. Can you stop drinking without difficulty after one or two drinks?

___ Yes ___ No

5. Do you ever feel guilty about your drinking?

___ Yes ___ No

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?

___ Yes ___ No

7. Have you ever gotten into physical fights when drinking?

___ Yes ___ No

8. Has drinking ever created problems between you and a near relative or close friend?

___ Yes ___ No

9. Has any family member or close friend gone to anyone for help about your drinking?

___ Yes ___ No

10. Have you ever lost friends because of your drinking?

___ Yes ___ No

11. Have you ever gotten into trouble at work because of drinking?

___ Yes ___ No

12. Have you ever lost a job because of drinking?

___ Yes ___ No

13. Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking?
___ Yes ___ No

14. Do you drink before noon fairly often?
___ Yes ___ No

15. Have you ever been told you have liver trouble, such as cirrhosis?
___ Yes ___ No

16. After heavy drinking, have you ever had delirium tremens (DTs)[2], severe shaking, visual or auditory (hearing) hallucinations?
___ Yes ___ No

17. Have you ever gone to anyone for help about your drinking?
___ Yes ___ No

18. Have you ever been hospitalized because of drinking?
___ Yes ___ No

19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?
___ Yes ___ No

20. Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problem in which drinking was part of the problem?
___ Yes ___ No

21. Have you been arrested more than once for driving under the influence of alcohol?
___ Yes ___ No

22. Have you ever been arrested, or detained by an official for a few hours, because of other behavior while drinking?
___ Yes ___ No

C.A.G.E.

1. Have you ever thought about cutting down on drinking?
___ Yes ___ No

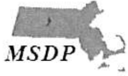
2. Have you ever felt annoyed when friends or members of your family expressed concern about your drinking?
___ Yes ___ No

3. Have you ever felt bad or guilty about drinking?

___ Yes ___ No

4. Do you ever drink in the morning before breakfast or before going to work?

___ Yes ___ No



Person's Name (First MI Last):	Record #:	Date of Admission:
Organization/Program Name: Lowell House Inc.	DOB:	Gender: ☐ Male ☐ Female ☐ Transgender

(Check all that apply below)

1. What drugs do you usually use? ☐ N/A
☐ Heroin ☐ Other Opiates ☐ Cocaine ☐ Alcohol ☐ Methadone ☐ Benzodiazepines
☐ Inhalants ☐ Marijuana ☐ Amphetamines ☐ Other: _____

2. How do you use your drugs? ☐ N/A
☐ Inject ☐ Oral ☐ Smoke ☐ Snort ☐ Other: _____

3. If you inject drugs, how often do you use new needles? ☐ N/A
☐ Sometimes ☐ Always ☐ Never

4. If you use new needles, where do you get them? ☐ N/A
☐ Pharmacy ☐ Friends ☐ Needle Exchange ☐ Other _____

5. If you use needles, how do you dispose of them? ☐ N/A
☐ Throw Away ☐ Needle Exchange ☐ Bring to Pharmacy ☐ Disposal Site ☐ Other _____

6. Do you ever share needles/injection equipment? ☐ N/A
☐ Yes ☐ No

7. In the last five years, about how many people have you had sex with?
☐ 20 or more ☐ 10-19 ☐ 3-9 ☐ 0-2

8. How often do you use protection against infections? ☐ N/A
☐ Sometimes ☐ Never ☐ Always

9. Have you had sex for money, drugs or something you needed?
☐ Yes ☐ No

10. When was the last time you were tested for HIV?
☐ _____ ☐ Never

11. Did you receive your results? ☐ N/A
☐ Yes ☐ No

12. Would you like more information about HIV where to get tested / treated?
☐ Yes ☐ No

Please check what was provided to Person Served below:
☐ HIV Fact Sheet ☐ Discussion Only ☐ Referral ☐ Viral Hepatitis Information
☐ Other STI Information ☐ Other: _____

Other Notes / Recommendations:

Person's Name (First MI Last):	**Record #:**

Person's Signature (Optional, if clinically appropriate)	**Date:**	**Parent/Guardian Signature** (If appropriate):	**Date:**
Clinician/Provider - Print Name/Credential:	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Clinician/Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**
Psychiatrist/MD/DO (If required):	**Date:**		

Person's Name (First MI Last):	**Record #:**	**Date of Admission:**
Organization/Program Name: Lowell House Inc.	**DOB:**	**Gender:** ☐ Male ☐ Female ☐ Transgender

ASK – Systematically identify all tobacco users at every visit.

☐ Never used tobacco →	Encourage continued abstinence / Proceed to the signature section.	
☐ Recovering tobacco user →	Do you need any further help at this time?	☐ No, Proceed to the signature section. ☐ Yes - Proceed to the Assist section.

☐ Average number of Cigarettes _____ / Cigars _____ / Pipe Bowls _____ smoked per day?
☐ Average use of Snuff _____ / Chew _____ / Other: _____ - _____ per day?
How soon after waking do you use tobacco? _____

ADVISE – Strongly urge all tobacco users to quit.

☐ This program cares about all aspects of your health and addictions, including nicotine addiction, especially because there are special risks for tobacco users with histories of alcohol and other drug abuse. I encourage you to consider quitting either now or in the future.

ASSESS – Determine willingness and readiness to make an attempt to quit.

1. On a scale of 1-10, with 1 being not at all important and 10 being extremely important, how important would you say it is for you to stop using tobacco?	*Not at all* … *Extremely* ☐*1* ☐*2* ☐*3* ☐*4* ☐*5* ☐*6* ☐*7* ☐*8* ☐*9* ☐*10*
2. On the same scale, how interested are you in quitting?	☐*1* ☐*2* ☐*3* ☐*4* ☐*5* ☐*6* ☐*7* ☐*8* ☐*9* ☐*10*
If uninterested, ask: What would make you more interested?	
If you decided to be tobacco free, on a scale of 1-10, how confident are you that you could successfully do it?	*Not at all* … *Extremely* ☐*1* ☐*2* ☐*3* ☐*4* ☐*5* ☐*6* ☐*7* ☐*8* ☐*9* ☐*10*
If unconfident, ask: How could the program help you become more confident?	
If you were to quit, what would be some reasons?	

STAGE OF CHANGE
☐ Not considering quitting (*Pre-contemplation*)
☐ Thinking about quitting *(Contemplation*)
☐ Ready to quit in next 30 days *(Preparation)*
☐ Tobacco Free 1 day to 6 months *(Action)*
☐ Tobacco Free 6 mos or more *(Maintenance)*

If in preparation, ask: What steps have you taken to prepare for your attempt to quit?

ASSIST – Aid the person served in quitting or planning for the future.

☐ Evaluate past quitting experience:
How many times have you tried to quit using tobacco?
What kinds of Nicotine Replacement Therapy (NRT) have you tried? (gum, patches, inhaler, Zyban/Wellbutrin)
☐ Discuss available programs: * Individual counseling and NRT on site * Referral to local tobacco treatment specialist off-site * Support for tapering * Support for going "cold turkey" * Self-help materials * Nicotine Anonymous Information

Give materials and encourage support including the use of telephone counseling at:
Tobacco-Free Helpline 1-800-QUIT-NOW or website www.makesmokinghistory.org

ARRANGE – Schedule follow-up contact.

☐ Offered referral for on-site tobacco treatment:	☐ The person served would like to be referred ☐ The person served does not want to be referred
☐ Will follow-up as part of regular treatment planning.	

Person's Name (First MI Last):			**Record #:**
Person's Signature (Optional, if clinically appropriate)	**Date:**	**Parent/Guardian Signature** (If appropriate):	**Date:**
Clinician/Provider - Print Name/Credential:	**Date:**	**Supervisor - Print Name/Credential** (if needed):	**Date:**
Clinician/Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**
Psychiatrist/MD/DO (If required):	**Date:**		

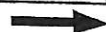
Massachusetts Gambling Screen (MAGS)

Please circle the response that best represents your answer.

Questions	*Responses*		
1. Have you ever gambled (for example, bet money on the lottery, bingo, sporting events, casino games, cards, racing or other games of chance)?	1. No		Yes
2. Have you ever experienced social, psychological or financial pressure to start gambling or increase how much you gamble?	2. No		Yes
3. How much do you usually gamble compared with most other people?	3. Less	About the same	More
4. Do you feel that the amount or frequency of your gambling is "normal"?	4. Yes		No
5. Do friends or relatives think of you as a "normal" gambler?	5. Yes		No
6. Do you ever feel pressure to gamble when you do not gamble?	6. No		Yes

If you never have gambled, please skip to question #29 now.

Questions	Responses	
7. Do you ever feel guilty about your gambling	7. No	Yes
8. Does any member of your family ever worry or complain about your gambling?	8. No	Yes
9. Have you ever thought that you should reduce or stop gambling?	9. No	Yes
10. Are you always able to stop gambling when you want?	10. Yes	No
11. Has your gambling ever created problems between you and any member of your family or friends?	11. No	Yes
12. Have you ever gotten into trouble at work or school because of your gambling?	12. No	Yes
13. Have you ever neglected your obligations (e.g., family, work or school) for two or more days in a row because you were gambling?	13. No	Yes
14. Have you ever gone to anyone for help about your gambling?	14. No	Yes
15. Have you ever been arrested for a gambling related activity?	15. No	Yes
16. Have you been preoccupied during the past 12 months with thinking of ways to get money for gambling or reliving past gambling experiences (e.g., handicapping, selecting a number)?	16. No	Yes
17. During the past 12 months, have you gambled increasingly larger amounts of money to experience your desired level of gambling excitement?	17. No	Yes
18. During the past 12 months, did you find that the same amount of gambling had less effect on you than before?	18. No	Yes
19. Has stopping gambling or cutting down how much you gamble made you feel restless or irritable during the past 12 months?	19. No	Yes



Massachusetts Gambling Screen (MAGS)

Questions	Responses
20. During the past 12 months, did you gamble to reduce any uncomfortable feelings (e.g., restlessness or irritability) that resulted from having previously stopped or reduced gambling?	20. No Yes
21. Have you gambled as a way of escaping from problems or relieving feelings of helplessness, guilt, anxiety or depression during the past 12 months?	21. No Yes
22. During the past 12 months, after losing money gambling, have you returned to gambling on another day to win back your lost money?	22. No Yes
23. Have you lied to family members or others to conceal the extent to which you have been gambling during the past 12 months ?	23. No Yes
24. Have you committed any illegal acts (e.g., forgery, fraud, theft, embezzlement, etc.) during the past 12 months to finance your gambling?	24. No Yes
25. During the past 12 months, have you jeopardized or lost a significant relationship, job, educational or career opportunity because of your gambling?	25. No Yes
26. During the past 12 months, have you relied on other sources (e.g., family, friends, coworkers, bank) to provide you with money to resolve a desperate financial situation caused by your gambling?	26. No Yes
27. During the past 12 months, have you made efforts unsuccessfully to limit, reduce or stop gambling?	27. No Yes
28. How old were you when you placed your first bet?	28. ☐
29. What is your sex?	29. Female Male
30. What is your age as of your last birthday?	30. ☐
31. How honest were your responses to each of the questions on this survey?	31. Not at all honest Somewhat dishonest Somewhat honest Very honest

Thank you for your cooperation!

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An affiliate of The National Council on Problem Gambling Inc.

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APPENDIX C

SELF-DECLARATION OF INCOME REPORT/ FY2018-19

(Effective May 2018)

Federal regulations require we obtain this information to document assistance is being provided to low and moderate-income households. The Participant/Guardian should complete this form indicating all persons residing within their household, regardless of whether they are related. The Grantee should retain this form for monthly reporting requirements as well as for on-site monitoring visits.

INFORMATION PROVIDED ON THIS FORM IS KEPT CONFIDENTIAL AND IS NOT SHARED WITH ANY OTHER AGENCIES

PLEASE NOTE: ALL FOUR SECTIONS OF THIS FORM MUST BE COMPLETED TO RECEIVE REIMBURSEMSENT

PARTICIPANT INFORMATION

I. PARTICIPANT STATUS: ☐ FAMILY ☐ INDIVIDUAL

Participant Name: ____________________

Address: ____________________ City, State, Zip Code: ____________________

2. ETHNICITY (*please select only one*):

☐ Hispanic or Latino ☐ Not Hispanic or Latino

3. RACE (*please select only one*):

☐ White
☐ Black/African American
☐ Asian
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaskan Native and White
☐ Asian and White
☐ Black/African American and White
☐ American Indian/Alaskan Native and Black/African American
☐ Other Multi-Racial: ____________________

4. HOUSEHOLD INFORMATION

l) Circle the number of family and non-family members living in your household below.

2) Circle the corresponding income level (FY2018-19 Median Family Income) Note: Does not need to be on same row as number of household size - should be accurate yearly household income.

Household Size		(0% - 30%)	(31% - 50%)	(51% - 80%)	(5l% and above)
1		$0-$22, 150	$22,151-$36,900	$36,901-$50,350	$50,351+
2		$0-$25,300	$25,301-$42,200	$42,201-57,550	$57,551+
3		$0-$28,450	$28,451-$47,450	$47,451-$64,750	$64,751+
4		$0-$31,600	$31 601-$52,700	$52,701-$71,900	$71,901+
5		$0-34,150	$34,151-56,950	$56,951-$77,700	$77,701+
6		$0-$36,700	$36,701-$61,150	$61,151-$83,450	$83,451+
7		$0-$39,200	$39,201-$65,350	$65,351-$89,200	$89,201+
8		$0-$42,380	$42,381-$69,600	$69,601-$94,950	$94,951+

I certify the above information is true and correct to the best of my knowledge.

Participant/Guardian: ____________________ Date: ____________________

(Original signature is required)