LOWELL HOUSE, INC.

☐ Massachusetts Impaired Drivers (MID) 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

Comprehensive Assessment

Massachusetts Impaired Driver Program

ESM# ______________________________ Date _________________________

Name _______________________________Date of Birth __________________

Address _______________________________ City/State/Zip ________________________

Best Phone Number to Contact you: ____________________________________

Date of Arrest ________________ Date of Conviction ______________ BAC ___________

Court in which convicted _________________ Probation Officer ______________________

Details of Current O.U.I.: (Description) ____

____

Reason for drinking that day: ____

____

Other substances used: ____

How much alcohol and/or drug(s) did you use on that occasion: ______________________

____

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

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

Substance Use History:

Alcohol Use:

Age of first use: _________Last Use: _________ Amount: __________

Frequency of Current Use: _____1-2 times per week _____3-6 times per week _____Daily

_____1-3 times per month _____ less than once a month

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	How Often	How Much	How Taken	How much in last 30 days	Last Use

Has anyone ever shown any concern related to your alcohol and/or other drug use?

_____ Yes _____ No If yes, who has shown concern and why?

____

____

Have you ever overdosed? _______________ If yes, what was the substance? ___________
How many overdoses have you experienced? _________________
Have you witnessed an overdose? _____ Yes _____No If yes, what was the relationship to the person who overdosed? ___________________ Did that overdose result in death? _____

Have you ever been involved in any self-help programs such as AA, ALANON, NA, or ACOA, SMART Recovery groups? ______ How often do you attend? ___________________
Do you Identify as being In Recovery from a substance or substances? _____Y _____ N If yes, how long have you been In Recovery? ______________

Are you currently, or have you ever been, involved in any form of treatment or counseling for any reason? _____ Yes _____ No If yes, please list below:

Type of Setting	Number of Treatment Experiences	Date of Last Treatment	Reason for Treatment	Completed Last Treatment
Inpatient Detoxification				___Yes___No
Residential				___Yes___No
Outpatient Counseling				___Yes___No
Medication Assisted Treatment				___Yes___No
Other				___Yes___No

Self-Assessment of Alcohol Use: _____ Social Drinker _____ Alcohol Misuse _____ Alcohol Dependent _____ Non-Drinker/ Abstinent _____ Other

Drug and Alcohol Use History:

As a result of substance use have you had any negative effects/consequences as a result of alcohol/drug use: (do not include current DUI)

Do you have health problems? ____ Yes ____ No If yes, describe ______________________
Do you have emotional problems? ____ Yes ____ No If yes, describe ______________________
Do you have legal problems? ____ Yes ____ No If yes, describe ______________________
Do you have employment problems? ____ Yes ____ No If yes, describe ____________________
Do you have financial problems? ____ Yes ____ No If yes, describe ______________________
Do you have other problems? ____ Yes ____ No If yes, describe ______________________

Do you think any problems in your life are related to drinking or drugging? ____ Yes ____ No
If yes, describe ____

Personal History:

Age: _____________ How do you identify your gender? ______________________________
Race: __________________________ Ethnicity: _________________________________
Marital Status: ____Single ____Divorced ____Married ____Separated
With whom do you live with? Please list names and ages of people you live with: _______________
____

Where were you born and raised? ____
Who raised you? ____________________________________

Do you have any children? ____Yes ____No If yes, please list name and ages: _________________
____

Do they live with you? ____Yes ____No
Do you have DCF involved with your children? __________________________________
If yes, name of Social Worker: ____

What High School did you attend? _______________________Did you graduate? ____Yes ____No
What year did you complete High School? ______________________________
Did you attend college? ____Yes ____No If yes, where did you attend? ______________________
List degree/certification and year of graduation ____
____

Have you ever been in the military? ____Yes ____No if yes, what branch? ____________________
What type of discharge did you receive? ____

Are you employed? ____Yes ____No If yes, what do you do for work? ___________________________
How long have you been employed in your current job? __________________________________
Have you ever been fired from a job? ____Yes ____No If yes, please list the type of job and the reason.
____

Are you on disability? ____Yes ____No If yes, please describe ____________________________________
Do you need any special services that the program should be aware of? __________________________
____

Family History:

Describe your family growing up (parents/who was in the home) ___________________________________
____

Do you have siblings? ____Yes ____No If yes, how many and what Is your birth order? _______________
____

Do you maintain contact with family members? ____Yes ____No
Is there any family history of mental illness? ____Yes ____No If yes, please list relationship to you as well as the mental illness ____
Is there any family history of addiction? ____Yes ____No If yes, please list relationship to you as well as addiction ____

Have any members of your family, or your significant other's family ever had any alcohol and/or other drug problems? ____Yes ____No If yes, please Identify their relationship to you, whether or not they received treatment, and their present alcohol/other' drug use status In the chart below:

Relationship	Treatment	Current Status
	____Yes ____No	
	____Yes ____No	
	____Yes ____No	
	____Yes ____No	
	____Yes ____No	

LEGAL HISTORY:

Have you ever been arrested for any other alcohol/drug related offenses, other than this current OUI?

____Yes ____No 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? ____Yes ____No If yes, please list:

Offense(s) Date Court/Police Department

____

____

____

Have you ever been taken into protective custody? ____Yes ____No If yes, please list:

Offense(s) Date Court/Police Department

____

____

____

Have you ever had a hearing at the Department of Motor Vehicles in this state or any other state?

____Yes ____No If yes, please list:

State Reason for Hearing Date Outcome

____

____

Medical History:

Are you currently taking any prescription medications for medical or psychiatric reasons? ____Yes ____No If yes, please list:

Medication Dosage Reason for taking.

____

____

____

____

Who is prescribing this medication?

____

____

Date of last Physical: ______________________________
Primary Care Physician: ____

Mental Health:

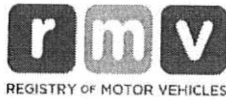
Do you have any emotional or psychological problems currently? Example: depression, anxiety, hallucinations, paranoia, mood swings: ____Yes ____No If yes, list and provide a description:

____

____

Have you been treated for any emotional or psychological problems? ____Yes ____No If yes, how many times in a hospital or inpatient setting? _________ How many times in an outpatient setting? ________
Please list most recent treatments below:

Type of Setting	Clinic/Agency	Reason for Treatment	Date of Treatment	Length of Treatement



First Offense (24D) 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 below, 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 suspension/revocation of either the OUI (24D), the Admin Per Se (Breath test failure), or the Chemical Test Refusal (CT R) suspensions.

☐ You qualify for an OUI (24D) disposition. A hardship license is available for "2nd chance" 24D assignments, providing the prior OUI finding (or conviction) is over 10 years from the most recent incident date.

☐ All other active suspension/revocation periods have been COMPLETED, excluding Chemical Test Refusal (CTRs), Youth Alcohol Program (YAPs), and suspensions under MGL Ch. 90 Sec. 24P Sec. 2.

☐ You have documented entry or enrollment, on program letterhead, verifying that you are enrolled in the court-ordered 90 24D Program, also called the Driver Alcohol Education Program. Note: The court may assign you to an out- of-state program, providing that you are legally domiciled out-of-state or are a full-time student residing out-of-state.

☐ You have documented a legitimate hardship. You must provide a letter from your employer, on letterhead, which cannot be more than 30 days old. 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 purposes (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 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.

☐ Ignition Interlock Devices are required for 2nd charges of Operating Under the Influence pursuant to MGL Ch. 90 Sec. 24D and for certain first offenders who, at the time of arrest, had a Blood Alcohol Concentration which registered at or above .15. Multiple offenders are required to maintain the device 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.gov/guides/ignition-interlock-deviceprogram 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.

NOTE: Reinstatement is only allowed once the proof of installation of the Ignition Interlock Device 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.

Massachusetts Impaired Driver (MID) Program

Statewide Client-Agency Agreement Contract

Welcome to Lowell House, Inc. Massachusetts Impaired Driver (MID) program. The goal of our program is to provide an educational experience related to alcohol and other drug use, its effect on driving and other life problems. It is the intent of our program to raise your awareness and to influence behavioral changes, thereby lowering your risk for any future DUI and/or other substance use-based problems. Although your enrollment is mandated, we hope your experience will nonetheless be positive. We are here to assist you in whatever way we can.

This document will serve as an agreement between you and our agency. It is intended to inform you of the rules and expectations of our program. Violation(s) of the rules/expectations often have serious consequences, so please read this document carefully before signing it. The intake counselor will clarify any questions you might have, and the MID Program Director is available to help you with any unresolved questions. You may reach the Program Director during regular business hours (9:00 a.m. to 5:00 p.m.) by calling 978-459-8656.

If you are refused admission into our program, it is because we feel you need a higher level of care than that provided by attending our MID Program; we must justify your refusal based on a clinical reason(s) and make alternative recommendation to the court (or referring agency) which may include additional clinical treatment and/or the MID program. Upon written request, you have a right to review your records. The time and place for the review will be arranged. The Program Director or Executive Director will be present at the review. You have the right to grieve any specific agency policy or procedure. State regulations require this agency to have a written grievance procedure, which is available for your review upon request. The Clinical Director may make periodic visits to a group, in order to ensure the quality of the service. The following expectations, rules and reporting procedures pertain to all MID Program in the state.

Program Content

You are expected to attend 40 hours of programming, as follows:

- One individual intake session (not to exceed 90 minutes)
- Thirty-two (32) hours of psycho-educational group sessions (one 2-hour session weekly for 16 weeks)
- Up to two (2) hours of victim impact awareness
- Up to four (4) hours of attendance at a community-based self-help meeting
- One individual discharge (exit) session (not less than 30 minutes)

It is your responsibility to complete each aspect of the MID Program. Failure to do so will result in a notification being sent to your referring court and possible suspension/termination. It is your responsibility to stay in contact with the program until you receive a formal certificate/letter of completion.

Attendance and Tardiness Policy

Your attendance at all groups is required. Attendance is taken at each group. In the unlikely event that you must miss a group because of an emergency (e.g., death in the family), you must contact your group facilitator immediately and documentation will be required. All absences must be made up. If you are absent more than two times during the course of the program your participation will be suspended until the matter can be reviewed. This might result in a court hearing as it is a violation of your probation. If the court allows you to return to the program, you may restart the program from Week one.

You are expected to schedule and attend your exit interview. If you need to cancel your appointment you must do so a minimum of 24 hours in advance. A limited number of cancellations will be permitted before the program suspends you.

You are required to be on time for all groups including the victim-impact sessions. If you are late for a group, you may not be allowed in, and a make-up group session will be required. If the tardiness results in your 3rd absence, then you will be suspended pending a court review.

Communication with your Probation Officer/Court

The participants' right to confidentiality is protected by Federal Law (42 C.F.R. Part 2). Your Probation Officer will be notified when there is a violation of program non-compliance. In general, the only information that is routinely communicated is 1) did you attend your intake session; 2) your attendance during the group process and 3) did you complete every aspect of the program, including your financial obligation. When necessary, your Probation Officer will be notified if you are deemed a high risk to yourself and others as a result of your current alcohol and/or drug use. The program will not disclose "confidential communications" reported by the client unless it pertains to the following: 1) it is necessary to protect against a threat to life or of serious bodily injury or 2) is necessary to investigate or prosecute an extremely serious crime or 3) in connection with a proceeding in which the client has already presented evidence concerning confidential communication.

Sobriety Policy

You are expected to abstain from alcohol and all illicit substances for a period of 24-hours prior to the start of any program activity. If you are suspected of drinking or using illicit substances you will be asked to take a breathalyzer or other form of toxicology test (e.g., urine test), if you are non-compliant the result will be your immediate suspension. If you are asked (at the client's expense) to take a urine test, the program staff will assist you with information on where one can be conducted. You will be expected to complete the urine test within a specified period of time set by the program. If a test indicates the presence of alcohol or an illicit substance(s), you will immediately be suspended from the program pending a court hearing and your probation officer will be notified. In addition, if during this incident you drove to class you will be asked to secure your car and arrange for alternative transportation (the program staff can assist you with this). If you insist on driving your car, the police will be notified. You will also be subject to a random breathalyzer test at any time as a means to ensure safety of all participants and the integrity of the program.

Suspension from the Program for Inappropriate Behavior

The following behaviors may result in suspension from the program:

- Possession of anything considered dangerous to self or others.
- Possession of alcohol or any illicit substance
- Verbal abuse, vulgarity, racial, ethnic, sexual, or religious slurs
- Disruptive behavior (talking, sleeping, etc.)
- Threats, negative gestures, or any acts of violence

- Continued (after being warned to discontinue) rudeness, demeaning or disrespectful speech or other behaviors that lead to the disruption of the group.
- Improper dress and/or poor hygiene, as determined by staff.
- Failure to adhere to the expectation that participants maintain the confidentiality of each group member's right to privacy.
- Cell phone usage, as determined by staff.

Smoking Policy

Smoking is not allowed anywhere on the property.

Class Cancellation Policy

In case of inclement weather or other emergency that may cause a group session to be canceled, it is your responsibility to contact the program to obtain information regarding cancellation. If a group is canceled, the expected timeframe for completion of the program will be extended.

Updated Client Information

You are required to inform the MID program of any changes to your home and mailing address and phone number(s).

Release of Information Forms and Confidentiality

MID programs have a dual service relationship between you and the District Court Probation Office from which you were referred. Because of this, you will be requested to sign a Release of Information form that will allow staff to disclose pertinent information to the court. You may also be asked to sign other release forms to assist staff with communicating and informing other pertinent parties. If you are under the age of 21 and attending this program to satisfy the court and/or the Registry of Motor Vehicles, you will be required to sign a Release of Information Form for the Registry. During the intake session you will have your confidentiality rights thoroughly explained to you, including areas of discussion in a group where information can be shared without your consent. You have the right to withdraw your release at any time; however, doing so may impact your continued participation in the program.

Documentation of Enrollment for Hardship License/Under 21 y/o – 180-day waiver

By this time, you should be aware of your eligibility for either a Hardship license or under 21 y/o — 180-day waiver or both. If you need a letter of enrollment for either consideration, a letter will be made available upon the completion of the intake session. Our program reserves the right to withhold this letter based on clinical findings in the initial intake.

Program Fees

Your payment options have been explained to you (either by the court or our fiscal department). The fee for this program is **$1343.00**, as established by the Massachusetts Rate Setting Commission. The program fee is inclusive except for costs for toxicology (drug) tests and breathalyzer tests. If you have been granted a program fee waiver by the court, you will be expected to pay additional fees. These fees will not exceed the established unit cost of the service by the Commission. The program may excuse make-up fees with legitimate and documented proof of the absence. You have agreed to a payment schedule. Failure to adhere to your payment schedule could result in your suspension from the program. Counselors and business staff are available to discuss any difficulties you have with making your payment. Completion certificates will be withheld until all fees are paid in full. If a Judge terminates you from further participation and you have paid for services not yet rendered, then you are entitled to a refund.

I have read the above statements and have had all of my questions answered. By signing this document. I attest that I agree with and will adhere to each aspect of this document.

____ __________________________

Participant Name Date

____ __________________________

Intake Counselor Date

Massachusetts Impaired Driver (MID) Program Fees:

The following MID program services must be completed, and all program fees paid when due to satisfy the requirements of the program.

Service:	Quantity	Scheduled time per service	Total Cost
Program Intake	1	1.5 hrs.	$175.00
Group Sessions	16	2.0 hrs.	$1,088.00
Exit interview	1	½ hrs.	$80.00
Total program cost			$1,343.00

Please select one of the following payment options:

Option A- $1343.00 paid in full at start of Program.

Option B - $700.00 deposit at start of Program
$643.00 on or before week 8 of program.

Option C - Documented fee waiver by Court.

Only the following payment methods are accepted: Cash, money order, or credit/debit card. NO personal checks allowed.

Other Fees:

Notification for cancelled appointments must be made during regular business hours Monday-Friday 9am to 5pm. Notification of the no show for your appointment/session will be sent to the court/source of referral within 48 hours 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. Make-up groups are scheduled twice per month. Missed groups must be made up within 30 days.

Fee type:	Cost
Breathalyzer (2)	$12.00 ea.
Urine Screen	$30.00 ea.

Program Rules:

Violation of any of the following rules will result in termination from the program. Please initial each statement

- LHI has a drug and alcohol-free policy. The use and/or possession of drugs and alcohol are strictly prohibited on LHI property.
- Program participants will be subject to a minimum of two random breathalyzers administered by the MID Group Facilitator. No one is excused for any reason from taking a random breathalyzer test. Refusing to take the breathalyzer, or leaving the group before the breathalyzer is administered, will result in immediate termination from the program. A positive breathalyzer will result in automatic termination.
- LHI will not tolerate disruptive, harassing, or abusive behavior toward any persons or property associated with LHI.
- Do not bring weapons of any kind into the building.
- Children, family members, and/or friends are not allowed into any appointments or group sessions.
- You must arrive on time for all scheduled services. The front desk staff are not authorized to let anyone into the group room once the MID Facilitator has collected the group from the lobby.
- The use of cell phones or other electronic devices is prohibited while in group sessions.
- Program participants are allowed two unexcused missed sessions. In the event that there are three unexcused missed sessions, that will result in your termination from the program.
- Missed services must be rescheduled within 5 days and completed within 30 days of the missed session.
- All program fees must be paid by or before the 8th group session.
- Program participants must attend and participate in an exit interview at the end of the assigned program.
- Program participants must attend a Victim Impact Forum to complete the program requirements. These forums are offered once every 90 days. The MID facilitator will assign the group to a Victim Impact Forum. Failure to attend the Victim Impact Forum on the assigned date will result in a missed session subject to fees and rescheduling.
- Program participants must attend at least 2 documented self-help (AA, NA) meetings. Original documentation (photocopies will not be accepted) of participation must be submitted to the MID facilitator no later than the 11th group session. Failure to comply will result in non-admittance into the group, which will count as a missed session and may result in termination from the program.

By signing below, I acknowledge that I have read and understand the program fees and rules.

Please initial next to the following statements:

___I understand that failure to comply with the rules will result in my termination from the program.

___I understand that if I am terminated from the program, I am not entitled to a refund of any payments.

___I understand that if I re-enroll in the program after termination I will be entering as a new participant.

____________________	____________________	______________
Print Name	Signature	Date

____________________________ ______________

Lowell House, Inc. Staff Signature Date

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					Times in the 6 months before your DWI arrest	Age last used
	Never Used	One to 10 times	11-25 times	26-50 times	More than 50 times		
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: Never	1-3 times	4-6 times	7-10 times	More than 10 times	Times during the 6 months before and including DWI arrest
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				During the last 6 months
		None	1-2 times	3-4 times	5 or more times	
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					During the last 6 months
		Never	1-6 months	7-12 months	1-3 years	4 or more years	
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				During the last 6 months
		No never	Sometimes	A lot	Most of the time	
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.

	Question	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.

	Question	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.

	Question	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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LOWELL HOUSE, INC

Alcohol Use Questionnaire

On more than one occasion have you intended to drink only two drinks but drank many more or a longer period of time than intended? ☐ Yes ☐ No

On more than one occasion have you tried to cut down or stop drinking by could not?
☐ Yes ☐ No

Have you spent a lot of time drinking, or being sick from or having hangover from drinking?
☐ Yes ☐ No

Do you have persistent thoughts about wanting a drink? ☐ Yes ☐ No

Have you found that drinking or being sick from drinking has often interfered with the care of family or caused job or school related problems? ☐ Yes ☐ No

On more than one occasion have you been in situations hazardous (e.g., driving, fights, using machinery) when drinking? ☐ Yes ☐ No

Have you continued to drink even though it was making you feel depressed or anxious or adding to any other health issues you may have? ☐ Yes ☐ No

Have you experienced memory blackouts when drinking? ☐ Yes ☐ No

Have you found that the number of drinks to reach intoxication increased over time? Or that the effects of alcohol are less over time? ☐ Yes ☐ No

Have you ever found that when the effects of alcohol wear-off you have any of the following happen to you; trouble sleeping, shakiness, restlessness, nausea, sweating, racing heart rate, muscle cramping or seizures? Have you ever taken a drink or other medication other than aspirin to relieve symptoms?
☐ Yes ☐ No

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

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.

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

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

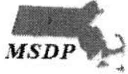
12. Would you like more information about HIV where to get tested / treated?
☐ Yes ☐ No

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.

	Not at all ... *Extremely*
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?	☐*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!

Massachusetts Council on Compulsive Gambling, Inc.
190 High St., Suite 5
Boston, Massachusetts 02110-3031
Telephone: 617-426-4554/TTY 617-426-1855
Helpline: 1-800-426-1234/Fax: 617-426-4555
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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)