OVERVIEW OF THE LARC PROGRAM

The Living and Recovering Community (LARC) is an intensive residential treatment program that offers comprehensive substance use disorder stabilization and medical case management services with housing search advocacy for up to 90 days. Services are provided within a treatment planning model that is individualized to meet the unique needs of each client. LARC offers a safe and structured space in which participants can focus on establishing or re-establishing rituals of recovery and wellness that enhance the quality of life.

Located at the edge of Franklin Park on the 11th Floor North of the Lemuel Shattuck Hospital, LARC offers 24 comfortable private and semi-private rooms, 4 spacious bathrooms, a large group room, a kitchen and dining area, a coin operated laundry facility and is handicap accessible.

POPULATIONS SERVED

LARC serves men and women living with HIV/AIDS and substance use disorder where a history of addiction and relapse episodes have jeopardized their ability to access or maintain stable residency in either treatment or housing programs. LARC also concentrates on medication adherence education in order to provide knowledge and assistance in understanding the connection between medication adherence and living a healthy and productive life. The program also integrates persons involved in medication assisted treatments (methadone, suboxone, etc.) into the treatment setting.

ADMISSION ELIGIBILITY DOCUMENTATION

The following must be provided for a referral to proceed:

☐ A fully completed application
☐ A written diagnosis of substance use disorder meeting the DSM IV-R or V criteria
☐ A written HIV certification, using application form or diagnosis on medical letterhead with physician signature and updated lab work.
☐ Referral to substance use treatment in residential setting signed by licensed professional
☐ A copy of detox completion or letter from doctor stating medical stability and ability to participate in the program
☐ A photo ID provided by a state or federal agency
☐ Verification of financial resources (Social Security printout and Food Stamp printout)
☐ Assessment of recent instability associated with substance use disorder
☐ If on methadone, completion of the attached paperwork and last dose letter
☐ Non-infectious TB status
Authorization for Release of Protected or Privileged Health Information

CONFIDENTIAL

Client Name: __________________________ Client Date of Birth: __ / __ / __ Alternate Name: __________________________

Telephone: (____) __________ Client Address: ____________________________

Street ______ Apt. # ______ City ______ State ______ Zip Code

I, __________________________, do hereby authorize Victory Programs, Inc.

to disclose my protected health information (PHI) to and/or to obtain my protected health information (PHI) from

the following Entity: Victory Programs Inc, LARC Program – 170 Morton Street, Jamaica Plain, MA 02130

(P) 617-522-2936 (F) 617-522-1345

The purpose of this disclosure is: Coordinate intake to program

(Purpose of disclosure, as specific as possible)

Information to be released: Bio/psych social assessment, HIV diagnosis/counts, income verification, MAT

information other pertinent information relating to intake process and procedures.

(Please specify the information you would like to be release

Timeframe of the information to be released: ☒ All Records or Date(s) of Service __________________________________________

I understand and agree with my signature:

• The information specified above will be released to and/or obtained from the Entity designated above.
• That my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations
• That records of any services I receive funded by U.S. Department of Housing and Urban Development (HUD) Housing Opportunities for Persons with AIDS (HOPWA) are protected under the federal regulations governing the confidentiality of records of persons receiving HOPWA services 24 C.F.R. 574.440
• The Authorization is valid for 1 year unless I indicate a different time or reason for expiration here: __________________________
• Once the information is released, Victory Programs cannot guarantee that the Recipient will not re-disclose the information to another party who may not be required to comply with state and or federal laws governing the use and disclosure of PHI and, in such case, the PHI described above may be re-disclosed and would no longer be protected by such laws governing privacy of health information.
• I may revoke this Authorization at any time except to the extent that Victory Program has taken action in reliance on this Authorization. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at the address above.
• I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Victory Programs, except when my refusal may limit Victory Programs’ ability to provide safe and effective care. If this exception applies, my refusal to sign an authorization may result in my not obtaining treatment from Victory Programs.

I have carefully read and understand the terms of this Authorization. I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily, authorize the disclosure of the above protected health information (“PHI”) to the designated person/entity as specified above. I give my permission to share my PHI, which may include protected or privileged information, in written and/or other stored format.

Signature: __________________________ Date: __ / __ / ______

HIV/AIDS Diagnosis and/or Treatment
I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about my HIV/AIDS diagnosis or HIV/AIDS treatment.

Signature: __________________________ Date: __ / __ / ______
### General Information

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Gender:</td>
<td>Social Security:</td>
</tr>
<tr>
<td>Applicant's Current Location:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applicant's Current Housing Situation:</td>
<td>Homeless</td>
<td>Housed</td>
</tr>
<tr>
<td>If Housed List Street Address:</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>Client Telephone:</td>
<td>Language Spoken:</td>
<td>Pregnant:</td>
</tr>
<tr>
<td>Mother's First Name:</td>
<td>First time in treatment:</td>
<td></td>
</tr>
</tbody>
</table>

### Referring Provider Information

<table>
<thead>
<tr>
<th>Agency Name:</th>
<th>Referrer's Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Number:</td>
<td>Fax Number:</td>
</tr>
<tr>
<td>Contact Email:</td>
<td>Reason for Referral:</td>
</tr>
</tbody>
</table>

### Addiction and Recovery Status

<table>
<thead>
<tr>
<th>Drug of choice 1:</th>
<th>Drug of choice 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of most recent relapse:</td>
<td>Date of last use:</td>
</tr>
<tr>
<td>Drug(s) last used:</td>
<td></td>
</tr>
<tr>
<td>Did Applicant complete detox?</td>
<td>Yes</td>
</tr>
<tr>
<td>Date Completed:</td>
<td></td>
</tr>
</tbody>
</table>

### Medical Information and Status

<table>
<thead>
<tr>
<th>PCP Name:</th>
<th>PCP Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Status:</td>
<td>HIV Asymptomatic</td>
</tr>
<tr>
<td>Currently on HIV Meds?</td>
<td>Yes</td>
</tr>
<tr>
<td>Have you ever tested positive for TB?</td>
<td>Yes</td>
</tr>
<tr>
<td>Diagnosed with</td>
<td>Hepatitis B</td>
</tr>
<tr>
<td>Seizure Disorder?</td>
<td>Yes</td>
</tr>
<tr>
<td>Any Neurological Conditions?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Please list any allergies, including food:
## MEDICAL CASE MANAGEMENT INFORMATION

<table>
<thead>
<tr>
<th>Does applicant have a current MCM?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

If yes, name and agency:  
Phone:

Immediate case management needs:  
Needs PCP  Need Psych  Need Dental  Other:

List any scheduled appointments:

## MENTAL HEALTH INFORMATION

<table>
<thead>
<tr>
<th>Psychiatrist Name:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

Current Diagnosis:  
Date of Diagnosis:

Hospitalization for MH Issues:  
YES  NO  
When:

Suicide Attempts?  
YES  NO  
If yes, explain:

History of trauma?  
YES  NO  
PTSD Diagnosis?  
YES  NO

## FINANCIAL INFORMATION

<table>
<thead>
<tr>
<th>What income do you have?</th>
<th>None</th>
<th>SSI</th>
<th>SSDI</th>
<th>DTA</th>
<th>Food Stamps</th>
<th>Other</th>
</tr>
</thead>
</table>

SSI/SSDI Amount:  
Food Stamp Amount:

DTA Office and DTA Worker Name:

## LEGAL HISTORY

<table>
<thead>
<tr>
<th>Ever been arrested?</th>
<th>Yes</th>
<th>No</th>
<th>Date of Last Arrest:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you convicted?</td>
<td>Yes</td>
<td>No</td>
<td>Date of Last Conviction:</td>
</tr>
<tr>
<td>Any open cases/warrants?</td>
<td>Yes</td>
<td>No</td>
<td>Where?</td>
</tr>
<tr>
<td>Any current restraining orders?</td>
<td>Yes</td>
<td>No</td>
<td>If yes, what court:</td>
</tr>
<tr>
<td>Any domestic violence arrests?</td>
<td>Yes</td>
<td>No</td>
<td>If yes, last arrest date:</td>
</tr>
</tbody>
</table>

## SOCIAL SUPPORTS

<table>
<thead>
<tr>
<th>Emergency contact:</th>
<th>Phone:</th>
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Children?  
YES  NO  
If yes, how many and ages?

Counselor Preference (circle one)  
MALE  FEMALE  EITHER/NO PREFERENCE
PHYSICIAN’S CERTIFICATION OF HIV/AIDS STATUS

Name of Client: _______________________________ Date of Birth: ______________
PCP Name: _______________________________ PCP Phone: ______________

Authorization for Release of Information

I, _______________________________, authorize my physician, _______________________________, to disclose to LARC the information requested on this form to assist in my admission to and participation in the LARC program. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse 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 and that in any event this consent expires one years from its executions or upon the withdrawal of my application or my discharge from the LARC Program.

______________________________
Client Signature

______________________________
Signature of Witness

PHYSICIAN’S CERTIFICATION

I, _______________________________, am currently providing medical care for _______________________________ at the following clinic/hospital, _______________________________. As such, I certify that he/she can benefit from substance use disorder treatment and:

☐ CDC defined AIDS
☐ Is HIV symptomatic
☐ Is HIV asymptomatic

LAB INFORMATION The following blood counts, indicated below

<table>
<thead>
<tr>
<th>CD 4 COUNT</th>
<th>VIRAL LOAD</th>
<th>DATE OF LAB WORK</th>
</tr>
</thead>
</table>

______________________________
Signature of Medical Provider

______________________________
Date
This form must be completed by a licensed professional.

Referral for Substance Use Disorder Treatment in a Residential Setting

Name of client: ___________________________ Date of Birth: ________________

Referring Clinician: ______________________ Phone: ______________________

Clinician ________________________________

Licensure Type: ___________________________

_______________________________(print client name) would benefit from substance use disorder treatment in a residential setting.

_______________________________

Signature of Licensed Provider Date
1. If a client is on medication, he or she must have an adequate supply of medication (30-day supply upon admission) with them and valid prescriptions that will insure that he or she will not have any interruptions in medication until appointments can be made at the LARC program.
2. All medications must be in bottles with appropriate labels. Any sign of tampering or misuse of the medications may result is non-admission to the program.
3. All medications are to be turned in upon admission to the program.

☐ The medication list has been attached to the application

OR please Provide List of all Current and ACTIVE Medications

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
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Medical Provider's name and Phone: ________________________

Provider's Signature: ________________________
OVER THE COUNTER MEDICATION
INFORMATION FOR APPLICANT

Client Name: __________________________

Today's Date: __________________________

Please check all over the counter medications that the client is able to take or indicate any other over the counter medications not listed. The medication doses are not to exceed the manufacturer's daily recommended dosages:

The following over-the-counter medications are permissible to use as indicated per manufacturer's recommendations on a PRN basis only and will not conflict with the client's current medication regimen.

☐ Acetaminophen
☐ Ibuprofen
☐ Naproxen
☐ Asprin
☐ Tums/Rolaids
☐ Other: __________________________

Notify LARC Staff of Medication Client cannot take or indicate below.

________________________________________________________________________

Provider's Name: __________________________

Provider's Phone: __________________________

Provider's Signature: __________________________
Methadone Provider's Referral Form

Client Name

Methadone Provider Agency

Mailing Address

Date Client Entered Methadone Tx Program

Date of Birth

Staff Contact

City, State and Zip

Phone

Client's Consent to the Release of Information

I, ________________________________, authorize the following agency (home clinic), ________________________________, to disclose to the Living and Recovering Community (LARC) and the Community Substance Abuse Centers (CSAC), the information requested on this form to assist in my admission to and participation in the LARC program. I understand that my records are protected under the Federal Regulations governing Confidential of Alcohol and Drug Abuse 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 it has been taken in reliance on it, and that in any event this consent expires one year from its execution or upon withdrawal of my application or my discharge from the LARC program.

________________________________________  ________________________________
Signature of Client                         Date

Methadone Provider’s Information
Briefly describe applicants dosing history: ________________________________________

Briefly describe applicant’s methadone treatment goal: ____________________________

☐ Please attach documentation of applicants last 6 toxicology screens
Methadone Aftercare Agreement - Home Clinic

Client Name: ___________________________ DOB: ___________________________

Home Methadone Clinic: ___________________________

Home Clinic Staff Contact: ___________________________

Home Clinic Phone: ___________________________ Fax: ___________________________

This is an agreement between the Living and Recovering Community (LARC) of Victory Programs, the applicant (client), his or her home methadone clinic (listed above), and the Community Substance Abuse Centers (CSAC).

While engaging in treatment at LARC, the client will be courtesy dosed at the Community Substance Abuse Center (CSAC) of Jamaica Plain, MA. This clinic is located at Lemuel Shattuck Hospital. Upon discharge from LARC, the CSAC program immediately ceases courtesy dosing for this client and he or she is required to return to the home clinic for continued treatment.

AGREEMENT

This is an agreement that client, ___________________________, will resume services at his home clinic immediately upon cessation of services at the LARC program. The home clinic will be notified when the client is discharged from LARC by staff of the program and/or the CSAC program. Further arrangements to coordinate care can be made by contacting LARC.

Client Signature: ___________________________ Date: ____________

Home Clinic Staff: ___________________________ Date: ____________

LARC Staff: ___________________________ Date: ____________
WHAT A CLIENT NEEDS TO BRING

☐ 30-Day Supply of Medication
☐ Casual day time clothes/shoes, pajamas and a robe, Comforter and your own pillow
☐ Toiletry items, shampoo, toothpaste, towels, washrag etc.
☐ A padlock with 2 keys (one for client and one for staff)
☐ Insurance card/picture ID
☐ Money to purchase small items
☐ Small radios and alarm clock
☐ Cell Phone (policies will be explained during intake)

*It is suggested that valuables not be brought into the program

Coin operated laundry facilities are available on floor. Clients need to bring their own laundry detergent and it is required to wash their clothing upon admission.

DRESS CODE AT LARC

Clients are not allowed to wear clothing that is sexually provocative or explicit. All shorts must be of appropriate length and undergarments must be worn at all times. Pajamas are not permitted to be worn to groups, on the floor after morning wake up routine or outside during fresh air breaks. Any clothing with references to drugs, alcohol, tobacco or gambling are not permitted. Shirts and shoes should be worn at all times for sanitary reasons.

ADMISSION PROCESS

1. Referral and application paperwork is completed, preferably emailed to Intake Coordinator
2. Once information is received, intake coordinator will setup phone screening or face to face interview
3. If accepted, admission date is scheduled as soon as possible

Please review all of the above checklists to ensure you have completed the information required in full. If you are having problems with a particular document or gathering a piece of information, we can help.

Jessica Williams - INTAKE COORDINATOR 617-522-2936 X 401 or Dial 6
RECEPTION - 617-522-2936 and Dial 9 | FAX: 617.522.1345