Our House of Favor

House rules
And
Management Care plan

House Application

Today's Date: _____ Sobriety Date: _____ Gender _____

Name: _____ DOB: _____

Social Security #: _____ Cell # _____

Insurance Carrier & Medicaid #: _____

Emergency Contact Name & #: _____

Previous Address: _____

Drug(s) Of Choice:

_____

Last Date of Use: _____ Long Period Sober: _____

Marital Status : _____ Number of Children: _____

Highest Level of Education: _____

EMPLOYMENT

Are you currently employed: _____

If Yes, Employer Name & Address:

_____

_____

Do you receive any government assistance(SSI, DISABILITY, FOOD STAMPS)?

_____

If Yes, how much, & day of the month receives

_____

LEGAL INVOLVEMENT:

List history of Felony Arrest/Charges:

_____

_____

ANY SEXUAL OFFENSES THAT CAUSES YOU TO BE REGISTERED?: _____

Any pending charges?: Yes or No

If yes list charges _____

Are you on PROBATION: _____ PAROLE: _____ HIP?: _____

If yes, Name and number of Officer(s): _____

_____

Address: _____

Email Address: _____

How often do you report: _____ Day & time _____

MEDICATIONS:

Are you currently taking any prescribed Medications?: _____

If yes, list of medications _____

_____

Prescribing Physician name, address, phone number:

_____

_____

I hereby declare that the information provided is true and correct. I also understand that any willful dishonesty may render for refusal of this application or immediate discharge from Our House of Favor.

Print Name: _____

Signature: _____ Date _____

OHF Staff Print name: _____

Signature: _____ Date _____

Ethics

All persons working in Our House of Favor (recovery residence owners, operators, staff, and volunteers) are expected to adhere to their respected certifications (i.e. Clinical counselor, peer support) code of ethics as well as the following Code of Ethics.

1. Assess each potential resident's needs, and determine whether the level of support available within the residence is appropriate. Provide assistance to the resident for referral in or outside of the residence.

2. Value diversity and non-discrimination.

3. Provide a safe, homelike environment that meets Our House of Favor Standards.

4. Maintain an alcohol- and illicit-drug-free environment.

5. Honor individuals' rights to choose their recovery paths within the parameters defined by the residence organization.

6. Protect the privacy and personal rights of each resident.

7. Provide consistent and uniformly applied rules.

8. Provide for each resident's health, safety, and welfare.

9. Address each resident fairly in all situations.

10. Encourage residents to sustain relationships with professionals, recovery support service providers, and allies.

11. Take appropriate action to stop intimidation, bullying, sexual harassment and/or otherwise threatening behavior of residents, staff, and visitors within the residence.

12. Take appropriate action to stop retribution, intimidation, or any negative consequences resulting from a grievance or complaint.

13. Provide consistent, fair practices for drug testing that promote the residents' recovery and the health and safety of the recovery environment and protect the privacy of resident information.

14. Provide an environment where each resident's recovery needs are the primary factors in all decision-making.

15. Promote the residence with marketing or advertising supported by accurate, open, and honest claims.

16. Decline taking a primary role in the recovery plans of relatives, close friends, and/or business acquaintances.

17. Sustain transparency in operational and financial decisions.

18. Maintain clear personal and professional boundaries.

19. Operate within the residence's scope of service and professional training and credentials.

20. Maintain an environment that promotes the peace and safety of the surrounding neighborhood and the community.

The Code of Ethics must be read and signed by all those associated with the operation of the recovery residence: recovery residence owners, operators, staff, and volunteers. Individuals subject to this code are obligated to report unethical practices according to the affiliate's reporting rules. In signing the following, I affirm that I have read, understand, and agree to abide by this Code of Ethics.

Resident Name (print): _____ Date: _____

Signature: _____

OHF Staff: _____

No Substance Use & Immediate Discharge Agreement

The Our House of Favor provides safe and sober temporary housing for individuals struggling with substance use disorders and or mental health issues.

Clients here are NOT on a Lease, and they have No rights to this property at any time.

Clients may be asked to vacate the Our House of Favor and leave the property immediately if they are involved in any of the below-listed situations:

1. Using drugs.
2. Consuming alcohol.
3. Exhibiting behavior consistent with the use of drugs or alcohol intoxication.
4. Demonstrating behavior that is not consistent with behavior modification / recovery.
5. Disrupting the therapeutic environment or creating a safety hazard: 6. failure to communicate or respond to phone calls or text messages.
7. Failure to comply with instructions from the owners or managers.
8. Failure to return to the house by curfew.
9. Failure to remain on the property when on restriction.
10. Involved in criminal activity.
11. Negative contact with police, LMDC, department of parole and probation.
12. Refusal to participate in structured programming.

I hereby declare that I agree with and completely understand the Our House of Favor Residents Rules.

Resident Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Enforcement of UDS, Dismissal, Grievance and Medication Policies

As a member of Our House of Favor you have agreed to abide by the House Rules. This agreement covers drug testing, dismissal processes, and grievance policies. By signing this document, you agree that you understand possible consequences and processes for dismissal and are aware of the grievance policy as stated.

Drug Testing Policy

Residents of the Our House of Favor must comply with all drug and alcohol testing requirements, including random testing and tests based on behavior. Refusal to submit to a test will result in immediate dismissal from the house. Testing may occur weekly, randomly, or after overnight passes or extended trips. Initial drug testing is required upon entry, and additional testing may be conducted if suspicion of substance use arises.

Dismissal Process

Our House of Favor is an abstinence-based program, and we have a zero-tolerance policy when it comes to relapse and/or drugs and alcohol being found on property. In the occurrence of a relapse, circumstances determine how each situation is handled by staff.

When asked to leave property due to using or failing a drug screen/breathalyzer, or as a consequence for violating House Rules, staff will take the necessary measures to help the resident get to a safe place that meets their recovery needs as long as he or she is willing.

Dismissed residents may return to the residence if a bed space is available, and the resident meets the following requirements:

- Have one week of continued sobriety confirmed by your sponsor.
- Pass a urinalysis test and a breathalyzer.
- Approval of return by staff and members of the recovery residence.
- Payment of any outstanding fees and readmission fee.

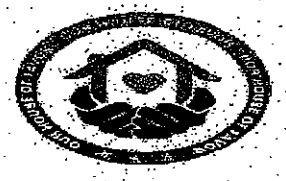
UDS and Room Search

Our House of Favor requires a drug test randomly. Observed urine drug screens may be performed. A refusal of an observed urine drug screen or a refusal to comply with urine drug testing is an automatic discharge. If you provide urine that is not yours, it is an automatic discharge. All urine drug screens performed are sent to the lab (PATIENT CHOICE) for confirmation and paid for by your insurance. Rooms may be subject to random searches at any time

I understand Our House of Favor's Drug Testing / Room Search Policy.

Resident Signature _____ Date_____

Staff Signature _____ Date_____



Residents Rights

- As a resident of Our House of Favor you have rights that the residence staff/mentors will safeguard during your stay. You have a right to:
- An environment that supports your recovery.
- Be free from verbal and physical abuse.
- Be treated with dignity and respect.
- Choose your own, personal recovery goals.
- Participate actively in your recovery.
- Confidential records that are accessible only to designated staff and which can be released to others only with your written permission, except as allowed by state and federal law.
- Be referred to subsequent services upon leaving or transfer from this residence if necessary.
- Retain personal property that does not jeopardize your or others' safety or health.
- Receive and send unopened mail.
- File a complaint to the owner/operator without fear of retaliation and to have the complaint addressed within a reasonable amount of time.
- Be fully informed before changes occur in these rights and responsibilities as well as to changes in policies and procedures should they occur.
- Not to be required to perform services for the residence, which are not included in the usual expectations for all residents.

I have been informed of my rights as listed above.

Print Name: _____

Signed: _____ Date: _____

Resident Confidentiality Agreement

Our House of Favor and its staff will respect the privacy of residents. Any information concerning residents, potential residents, and visitors will be treated with the utmost respect. Staff will regularly review confidentiality requirements to comply with both KRHN/NARR standards and state and federal confidentiality laws.

All data collected on residents will be shared with governing agencies to protect individual identities. This data will only be used to improve the quality of services.

Our House of Favor will ensure the safety of resident records. Personal information will be protected by reasonable security safeguards against loss or theft, as well as unauthorized access, disclosure, copying, use or alteration.

Confidentiality on patient-identifying records may be broken without resident consent only in extenuating circumstances, such as when resident or staff safety is at risk, child or elderly abuse is suspected, or if a court order is received.

Outside of these circumstances, patient-identifying information will never be sold, lent, or given to third parties without resident consent.

Our House of Favor will obtain informed voluntary consent from residents before any information is released to agencies or family members.

Our House of Favor staff and residents also have a responsibility for keeping the confidentiality of others in the program. This includes not confirming or denying another client's participation to outside agencies or persons via telephone, in-person, on social media, or in written requests.

As a resident of Our House of Favor, you consent and agree to the terms marked above. You will be informed of any changes to this agreement at least a week before they come into effect.

Print Name: _____

Signed: _____ Date: _____

be able to participate in mental health services, start on medication today, or continue my current medications uninterrupted.

3. The potential risk of Telemental health services is that there could be a partial or complete failure of the equipment being used which could result in mental health staff's inability to complete the evaluation, mental health services, and/or prescription process.
4. There is no permanent video or voice recording of the Telemental health service's session.
5. All e existing confidentiality protections apply.
6. All existing laws regarding Resident access to mental health information and copies of mental health records apply.
7. Dissemination of Resident identifiable images or information from the Telemental health interaction to researchers or other entities shall not occur without the consent of the Resident.

I, _____, consent to Telemental health services in circumstances in which mental health staff appropriate to my needs is not immediately available at my site. My mental health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all of my questions have been answered.

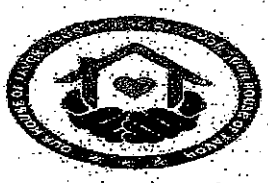
I understand the written information provided above.

Resident Print: _____

Resident Signature: _____ Date: _____

Our House of Favor Staff print name: _____

Signature: _____ Date _____



Medication Agreement

Acceptable and properly prescribed medication, like MAT prescriptions are permitted on the premise of Our House of Favor. Our House of Favor is not a medical facility and in accordance with the State of Kentucky regulations will not administer any medication to residents of Our House of Favor. All residents are responsible for the proper storage and self- administration of their own medication(s).

While Residents will be responsible for self-administration they agree to the below stipulations in order to remain in compliance with Our House of Favor's medication policy. By initialing each stipulation and signing at the bottom of the agreement the resident is acknowledging that they have read and understood the medication policy and agree to comply with all the terms in order to remain as a resident of Our House of Favor:

Resident Initials:

___ All prescription medications are to be in their original containers as obtained from the pharmacy with the prescribing medical professional identified on the container
___ Dates of the medication are to be current and prescription is not to be expired
___ All medications are to be accurately and correctly listed on intake form
___ Medication(s) are to be taken only as prescribed
___ Residents are responsible for the proper storage of their medication and must demonstrate that medications are kept in an appropriately locked container stored away from any visible surfaces
___ Medication is to be locked away at all times excluding when it is time for self-administration, it is expected the resident immediately return medication to locked container following self-administration
___ Resident agrees to notify staff of any new or refill prescriptions within 48 hours in order to maintain accuracy of resident file
___ Medication is not to be shared or misused/abused in any way
___ All medications are subject to random search and the resident agrees to comply with any necessary searches (i.e providing access to containers, etc.)

By signing below I, _____ acknowledge that I have read and agree with the aforementioned terms of the Our House of Favor medication policy. And I understand that any violation of the above terms is cause for removal from the property.

Resident Signature: _____ Date: _____

Consent for Release of Information

I, _____, born on _____

SSN_____, authorize Our House of Favor to disclose to

the following information (circle one): (any and all the info related to treatment) or (other)_____.

The purpose of this disclosure is for (circle one): (collaboration of care) or (other)_____.

This authorization expires in 1 yr or whenever Our House of Favor is no

longer providing me with services.

I understand that my records are protected under the Federal regulations 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.

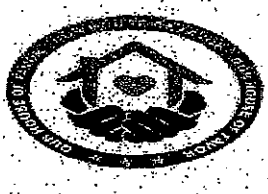
Signature of patient_____ Date_____

Signature of staff_____ Date_____

ATTENTION RECIPIENT:

Notice Prohibiting Redisclosure

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.



FINANCIAL AGREEMENT

Resident Name : _____

Admission Date: _____ SSN# _____

_____I agree and consent to Our house of Favor billing Medicaid for my weekly programming.

_____ Our house of Favor program fees shall not exceed those extended by Medicaid (i.e. copay, deductible)

_____I understand I am responsible for any fees incurred outside of my weekly programming

_____I understand that I must maintain my eligibility for Medicaid in order to continue receiving services.

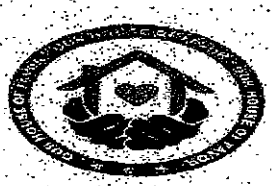
_____I understand I am responsible for all my copays and deductibles (when applicable). I understand that program fees are non-refundable.

PROMISE TO PAY ACCOUNT For and in consideration of services to be rendered I with sincerity promise to pay Our house of Favor. all of its fees for services rendered to me from admission to discharge. I understand that the total of such charges will be billed to my insurance and are due and payable according to this FINANCIAL AGREEMENT.

In acceptance of this FINANCIAL AGREEMENT with Our house of Favor, I agree that to qualify for the Our house of Favor program I must adhere to the rules and regulations as listed above and make my scheduled payments when due. I further understand that failure to make payments when due, may result in my discharge from Our house of Favor. program. Any unpaid account balances at the time of discharge are subject to collection costs and lawyer fees if and when applicable

Resident Signature & Date: _____

Authorized Staff Signature & Date: _____



TRANSPORTATION AGREEMENT

I, _____,understand that due to lack of my own personal transportation, I may request transportation from time to time from _____ (Community Support Associate) an employee of Our house of Favor. I hereby indemnify **Our house of Favor** and their staff from all damage or injury caused to me or others when I willingly accept transportation to or from any location or event, whether **Our house of Favor** is related or not.

Resident Signature Date: _____

Staff Signature Date: _____

Photo and Video Release Form

I, _____ hereby grant permission to Our House of Favor to use my likeness in photographs and/or videos taken during program event/activity. I understand that these photographs and/or videos may be used for the following purposes:

- Promotional materials
- Social media posts
- Website content
- Newsletters
- Other marketing materials

I acknowledge that I will not receive any compensation for the use of my likeness in the photographs and/or videos.

I release Our House of Favor from any and all claims, demands, or causes of action that I may have now or in the future for the use of my likeness in the photographs and/or videos.

Circle One: AGREE or DISAGREE

Participant's Name: _____

Participant's Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Grievance Policy

1. All clients have the right and are encouraged to communicate his or her grievance to Our House of Favor staff members or company representatives. There will be no consequences or retaliation for the resident filing a grievance.

2. All residents have a right to file a formal written grievance. The resident may request a form from any staff member or House Manager. (Grievance Forms are in the office). The resident should fill out the form and return it to any staff member or the House Manager.

3. Written grievances shall be forwarded to Saybah Glay.

4. In the instance where the decision maker is the subject of a grievance, decision making authority shall be delegated to Saybah Glay,Owner.

5. Time frame for expedient resolution is two business days upon receipt of the complaint/grievance.

6. The resident will be sent a written notice of the grievance outcome and steps for appealing the outcome.

7. Throughout this process, the resident has the right to contact, make a complaint and/or appeal the grievance outcome to the Kentucky Recovery Housing Network by calling (502) 782-8478.

Medication Policy

All prescribed and over the counter medication are given to the House Manager. Medications are locked in a cabinet. All packages are to remain sealed and the house manager opens.

Print Name: _____

Signed: _____ Date: _____

Telehealth Consent

What are Telemental health services and when are they used?
Telemental health services are used when mental health staff cannot be physically present with you to evaluate your mental health needs and, if appropriate, prescribe medications. Mental health staff may be present at another location and available to serve you through newly available technology. Instead of talking to someone on the phone at another location, Telemental health services use a video camera and computer to send both voice and personal images (pictures) between you and mental health staff so not only can you talk to each other, but you can also see each other. This allows mental health staff to make a better evaluation of your needs.

How do Telemental health services work?
You will be in a private room either by yourself, with a friend, family member, or staff person. The room will have a computer with a video camera. The mental health staff will also be in a private room but at another location with the same type of equipment. When the session is ready to begin, clinic staff will start the computer and camera so that you and mental health staff can see each other and talk together. When the session is over, clinic staff will shut off the equipment.

How is it different from a regular session with mental health staff?
Other than you and mental health staff not being in a room together, there is very little difference in the session. Mental health staff will ask and document clinical information that you share with him/her, send any prescriptions that are ordered to the pharmacy for you to pick up if medications are prescribed, document the service that is provided, and ensure that documentation is included in your clinical record for future reference.

What happens if I choose not to consent to Telemental health services?
If you choose not to consent to Telemental health services, we will be unable to provide you with convenient and readily available services and your services will be rescheduled for a later date and/or a different site.

I understand that:
1. I have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right to future care, treatment, or risking the loss or withdrawal of the program benefits to which I would otherwise be entitled.
2. The potential benefit of Telemental health services is that I will be able to talk with mental health staff today from this local setting for an evaluation of my needs. When appropriate, I will

HIPAA Authorization for the Use or Disclosure of Health Information

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

I hereby authorize to release my medical records to Our House of Favor for the purpose of continuity of care and continuing treatment. I understand that this authorization to release records will remain effective until I revoke it in writing and with the understanding that the recipient shall use the information in compliance with acceptable laws.

I consent for Our House of Favor to release my personal healthcare information (PHI) to requesting third party organizations, including, but not limited to: the social security administration (SSA)and other government entities, medical offices, mental health offices and attorneys. I understand that PHI is considered every page of my electronic health record file, including, but not limited to intake forms, progress notes, treatment plans, itemized bills, assessments, file uploads, and discharge paperwork.

Right of Revocation: I understand that I have the right to revoke this authorization at any time by sending written notice to Our House of Favor. I understand that a revocation is not valid to the extent that Our House of Favor has acted in reliance on such authorization. This authorization does not expire until I submit a written request. A hard or digital copy of this release shall have the same force and effect as the original.

Informed Consent: By signing this form, you agree to receive behavioral health services provided by Our House of Favor, and its contractors. We know that starting treatment is a big decision and you may have many questions. We will do our best to answer any questions or concerns. This form explains information about Our House of Favor policy, State and Federal Laws and your rights with regards to treatment. All Our House of Favor employees and contractors have met the highest level of education, certification and licensing requirements set forth by Kentucky state law. Counseling practices, philosophy, plan limitations and risks will be discussed with you during your intake.

TREATMENT PROCESS AND DOCUMENTATION. It is the healthcare professional's responsibility to keep accurate records including Evaluations, Treatment Plans and Progress Notes. By signing this document, you are consenting to the Treatment Plan that your provider creates and agree to any goals, objectives and therapy techniques that may be used in your therapy process.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Confidential information

discussed in session is not discussed with anyone without your written permission except for 1. Diagnosis and dates of service shared with your insurance company to process your claims 2. Information you tell Our House of Favor about physical, sexual or elder abuse; then, by Kentucky State Law, we must report this to the Kentucky Department of Children and Family Services 3. Where you sign a release of information to have specific information shared 4. If you tell Our House of Favor that you are in danger of harming yourself or others.

Telehealth Consent:
I agree to participate in a telemedicine evaluation and/or ongoing treatment performed by a provider who assumes sole responsibility and liability for treatment.

By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a provider and other persons involved in my medical or mental health care.

HIPAA and Privacy Policies: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes our policies related to the use and disclosure of your healthcare information. Your health information may be used for the purposes of providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT: We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

HEALTHCARE OPERATIONS: We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and Our House of Favor licensing activities. There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Kentucky State Law, we are obligated to report this to the Department of Children and Family Services. If you provide information that informs us that you are in danger of harming yourself or others, we must report this also; Clinical records, psychotherapy notes and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have a right to restrict any disclosure of personal health information.

Patient Rights: You may consent in writing to release your records to others. You

have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization. You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. If you feel that information contained in your medical record is incorrect incomplete, you may ask us to add information to amend the record. We will make a decision on your request within 60 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request. You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request. If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Acceptance of Terms: I agree to these terms and will abide by these guidelines. I have read, understood, and agree to the terms above.

ACCEPTED AND AGREED TO:

Patient Name:

Date of birth:

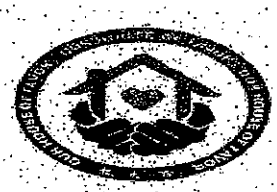
Signature:

Date:

ACCEPTED ON BEHALF OF:
Our House of Favor

House Rules

- No Use Of Alcohol Or Other Drugs
- Compliance With Random Urine Test & Room Searches
- Compliance With Established Curfews: Sun-Thur@ 11pm & Fri-Sat@ 12am
- Mandatory Participation In Self-Improving Recovery Programs
- Mandatory Participation In Iop
- Smoking Is Prohibited Inside All Living Units
- Smoking Is Only Allowed In Designated Areas
- Stealing Is Not Tolerated. This Includes Eating Food That Does Not Belong To You. Confirmed Accusations Will Result Termination From The Program.
- Destruction Of Property That Belongs To Our House Of Favor Will Result In Termination And All Costs Of Repair Extended To You.
- All Residents Must Be Respectful Of All Staff And Other Members Of The Community
- Verification Of Employment Is Required
- Documentation Is Required From Physicians For All Missed Groups. Groups Will Only Be Rescheduled With Documents Of A Doctor's Appointment Or Proof Of A Medical Emergency. Groups And Iop Are Only Excusable With A Doctor's Statement
- Soliciting Or Consuming Other Residents' Medication Is Prohibited And Will Result In Termination From The Program And Possible Prosecution
- Our House Of Favor Maintains A Zero Tolerance Policy For Physical Violence, Threats Of Violence, And Harm Or Profanity Towards Residents Or Staff
- Our House Of Favor Maintains A Zero Tolerance Policy For Sexual Harassment Toward Anyone Within The Community
- You Are Expected To Help To Keep The House Clean, Neat, And Safe. You Must Adhere To The List Of House Chores Posted Weekly
- Your Bedroom Is Expected To Be Kept Neat And Clean At All Times With Designated Blanket On Top And Your Living May Be Searched At Any Time.
- Residents Must Be Proactive During Daily Working Hours. No Tv Or Music Unrelated To Recovery During Program Hours On Days That We Are Not Out Of The House From 10 – 2.
- You May Be Asked To Move Out Of Your Residence At Any Time As A Result Of Violence, Unsafe Behavior, Alcohol, Or Drug Use Or The Needed Change Due To Circumstances Related To The Housing Needs Of Our Company.
- You Are Prohibited From Entering Any Other Living Unit Outside Of Your Own



Without Prior Consent From Staff Member

- No Borrowing Or Bartering Food Stamps Or Money
- You Will Attend Mandatory Bible Study Once A Week
- Weekly Church Attendance Of Your Choice Is Required
- All Court Dates And Medical Appointments Must Be Shared 72 Hours Prior To The Appointment
- There Is A $25 Per Week Rent Due Every Week
- All Residents Will Be Responsible For Gas To Go
- To Court Date And Medical Appointments Outside Of The Louisville Area

I hereby declare that I agree with and completely understand the Our House od Favor

Residents Rules.

Print Name: _____

Signature: _____ Date _____

OHF Staff print name: _____

Signature: _____ Date _____

RELAPSE PREVENTION PLAN

RELAPSE PREVENTION PLAN

Preventing relapse requires a commitment to recovery. It also requires a plan of action. Relapse is not an event, but a process. Before the physical act of relapse, a person experiences changes in feelings, thoughts, and behaviors. Cravings also play a role in relapse. By developing and following a written plan, you can halt the relapse process.

What is your drug of choice? _____

Write down the reason(s) you have decided to stop using/drinking: _____
_____
_____
_____

What are some *feelings* that might lead to relapse? (Examples: Anger, boredom, happiness, not caring about recovery.)

1. _____
2. _____
3. _____
4. _____
5. _____

For each feeling listed above, write down a healthy way of coping with that feeling:

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____

What are some *thoughts* that might lead to relapse? (Examples: Thinking about the good times or thinking you are cured.) Be as specific as possible.

1. _____
2. _____
3. _____
4. _____
5. _____

What are some *behaviors* that might lead to relapse? (Examples: Not attending meetings, not calling your sponsor, eating too much junk food, being in an unhealthy relationship.) Be as specific as possible.

1. _____
2. _____
3. _____
4. _____
5. _____

Who are the *people* you are most likely to use with?

1. _____
2. _____
3. _____
4. _____
5. _____

Write down the names of five people you can call when tempted to use:

1. _____
2. _____
3. _____
4. _____
5. _____

Where are the *places* you are mostly likely to use?

1. _____
2. _____
3. _____
4. _____
5. _____

What other *situations* or *events* are triggers for you?

1. _____
2. _____
3. _____
4. _____
5. _____

Cravings: Remember that cravings will pass. However, there are different techniques to help with intense cravings. You can talk about it with your sponsor or with a friend in recovery. Or you can distract yourself by journaling, watching a comedy, listening to loud music, running, doing a crossword puzzle, cleaning house, working on a project, etc.

Write down 10 ways to cope with cravings.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

How many 12-step meetings will you attend each week? _____

Fill in meeting names, when they meet, and the places they meet (for one week).

Meeting	Day/Time	Location

How will you get to meetings? _____

_____

How often will you call your sponsor? _____

How often will you meet with your sponsor? _____

List five consequences of a relapse. (Examples: Failing a drug screen, calling in to work, missing an appointment, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

List five benefits of working a recovery program:

1. _____
2. _____
3. _____
4. _____
5. _____

Write down five short-term goals (1-12 months) that you can only achieve through sobriety.

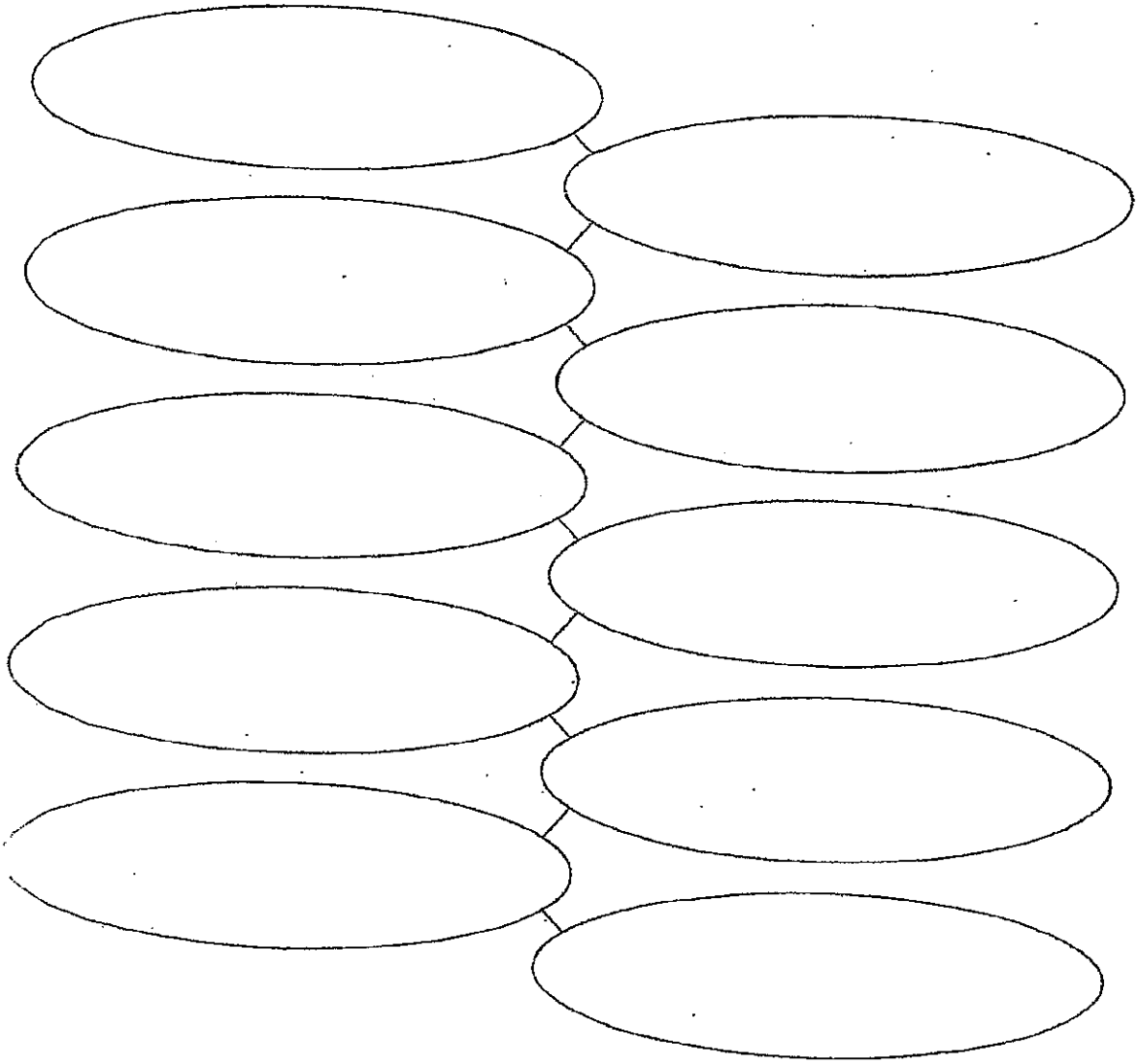
1. _____
2. _____
3. _____
4. _____
5. _____

Write down five long-term goals (1-3 years) that you can only achieve through sobriety.

1. _____
2. _____
3. _____
4. _____
5. _____

Relapse Chain Worksheet

Instructions: The last link in the relapse chain represents your use of alcohol, tobacco, or other drugs. Each preceding link represents a specific relapse warning sign. Identify as many warning signs as you can. Then state how much time elapsed between the earliest warning sign and the first time you used a substance again. Also, state how you felt about using substances again, and how your family (or other significant people in your life) felt.



Time elapsed from early warning signs to actual use: _____

How I felt about using again: _____

How my family or significant others felt: _____

Lapse and Relapse Worksheet

Instructions: Answer the following questions to help you figure out what led to your first drink, cigarette, or other drug use after having quit.

1. Describe the main reason you took the first drink, cigarette, or other drug.

2. Describe your inner thoughts and feelings that triggered your need or desire for the first drink, cigarette, or other drug.

3. Describe any external circumstances that triggered your need or desire for the first drink, cigarette, or other drug.

4. Describe the first decision you made that started the lapse or relapse process.

Relapse Warning Signs Worksheet

Instructions: In the left column, list the attitudes, thoughts, and behaviors that are warning signs of potential relapse. In the right column, write strategies for coping with each of these situations.

Relapse warning signs	Coping strategies

PRESCREENING / ELIGIABILITY

Our House Of Favor Prescreen

ETA:
Name:
Age:
Dob:
SSN:
Insurance:
Phone:
Gender:
Co-occurring mental health:
Prior Treatment:
Recovery Residence History:
Substance of Abuse:
I.V. use:
Medication:
Recovery Time:
History of self harm?
Recent suicidal and or homicidal ideation?
Relationship Status?
Children?
Work experience/plan?
Tb?
Fee discussion?
History of violence?
Sex offender?
Was it verified through the National Sex offender Registry?
Warrants?
Legal issues?
Legally mandated? Legal Charge?
Vehicle?
Valid license?
Drug screen discussion?

MEETING AND CHORES

OHOF Chore Assignments and Signing Sheets

Chores	Names	Monday	Tuesday	Wednesday.	Thursday	Friday	Saturday	Sunday
KITCHEN								
LIVINGROOM								
BATHROOM								
TRASH								

Chores	Names	Monday	Tuesday	Wednesday.	Thursday	Friday	Saturday	Sunday
KITCHEN								
LIVINGROOM								
BATHROOM								
TRASH								

Our House Of Favor Meeting Sheet

Date	Time	Meeting	Chairperson

DISCHARGE PLAN

Our House Of Favor Exit Strategy

Client:_____ **Date:**_____

Entry date:_____ **Exit Date:**_____

Participation: ☐None ☐Low ☐ Moderate ☐ High

Reason For Transition:

☐ Transitioned As Planned
☐ Rule Violations
☐ Incarceration
☐ Against Staff Advice
☐ Early Transition
☐ Other:_____

Summary Of Progress:

_____

Ongoing Recovery Plan:

_____

Collateral Resource Contact Information:

_____

Forwarding Address:

_____

Client Signature:_____ **Date:**_____

Staff Signature:_____ **Date:**_____

STRUCTURE OF ORGANIZATION

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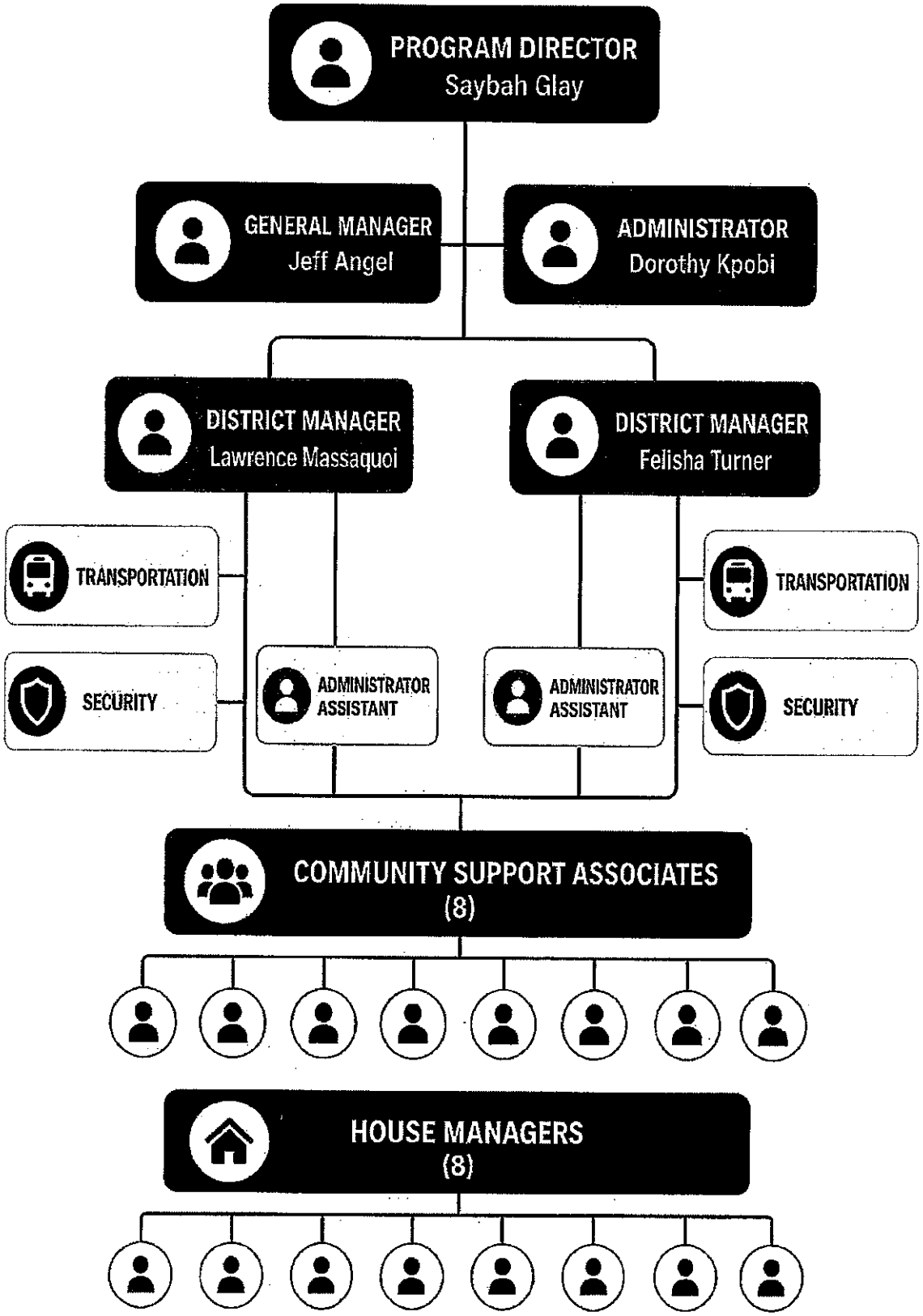
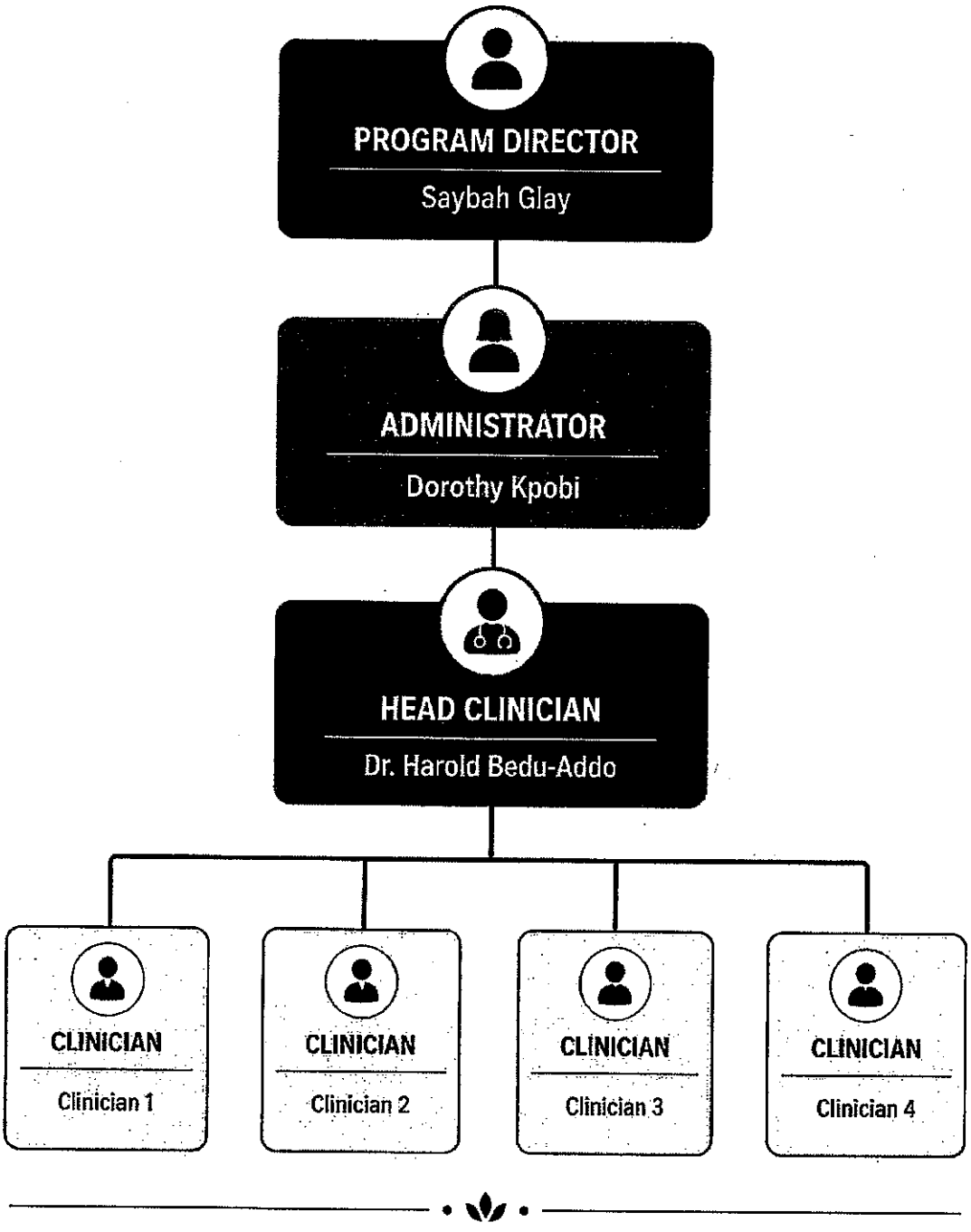
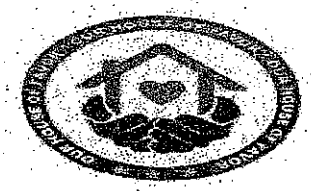


STRUCTURE OF ORGANIZATION



General Manager (GM) Responsibilities



Job Title: General Manager
Reports to: Owner

Summary:
The General Manager is responsible for overseeing the day-to-day operations of the program, ensuring the delivery of high-quality services to adult clients. This role involves strategic planning, staff management, budget oversight, program development, and compliance with regulatory standards. The General Manager will work collaboratively with clinical staff, and community partners to enhance program effectiveness and client outcomes.

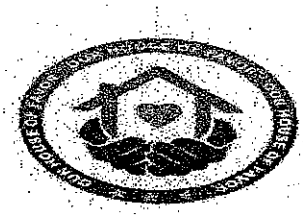
Key Responsibilities:

- Operational Management:
  - Oversee the daily operations of the IOP, ensuring programs run smoothly and efficiently.
  - Develop and implement operational policies and procedures to enhance service delivery.
  - Manage scheduling, staffing, and resource allocation to meet program needs.
  - Collaborate with the district manager in training new staff.

- Clinical Oversight:
  - Collaborate with clinical staff to ensure adherence to evidence-based practices and therapeutic protocols.
  - Monitor client care outcomes and implement quality improvement initiatives.
  - Ensure that all services are delivered in compliance with regulatory and accreditation standards.

- Staff Management:
  - Conduct performance evaluations and provide ongoing professional development opportunities.
  - Foster a positive and collaborative work environment that promotes staff well-being and retention.

- Program Development and Evaluation:
  - Identify opportunities for program growth and enhancement based on community needs and emerging trends in mental health and substance use.
  - Conduct regular assessments and evaluations of program effectiveness, client satisfaction, and staff performance.
  - Report program outcomes to the owner and make recommendations for improvements.



- Community Engagement:
  - Build and maintain relationships with community organizations, and referral sources to promote the IOP and its services.
  - Participate in community outreach and education efforts to raise awareness about mental health and substance use and available resources.

- Compliance and Risk Management:
  - Ensure compliance with all local, state, and federal regulations regarding mental health services.
  - Develop and implement risk management strategies to ensure client and staff safety.
  - Maintain accurate and confidential client records in accordance with HIPAA and other relevant regulations.

- Qualifications:

  - High School Diploma or GED.
  - Excellent leadership, communication, and interpersonal skills.
  - Commitment to promoting diversity, equity, and inclusion within the workplace and the community.

DISTRICT MANAGER
(DM)
RESPONSIBILITIES

Responsibilities of a District Manager

District Manager (DM): The purpose of this position is to oversee day to day operations where there are 30 or more clients and to address issues or concerns of staff and clients. This includes:

- Going to the houses once a week to inspect paperwork as well as the cleanliness and safety of the house.
- Having a conversation with 2-3 clients on how the house is running. This should be done away from the House Manager, Community Support Associate (CSA) and any other clients. The purpose is to give the client the opportunity to speak freely without fear of judgment or retaliation. Anything said between the DM and the client should remain between them as long as it does not cause harm to other clients or to us as a business. (ex. Inappropriate sexual conduct, or threats of suicide).

Other responsibilities are as follows:

- To delegate responsibilities which involve each household.
- Meet with staff at least twice a month.
- Make sure that urinalysis is conducted twice a month.
- To keep the client base active (keep beds full). You must have the ability to make contact and build relationships to ensure clients are continually coming into the program.
- Be confident and well versed in problem resolution and critical thinking.
- Capable of assessing and reviewing notes to ensure that they are done correctly.

Routine weekly house inspection.

The DM has a responsibility to ensure everything under his/her supervision is being observed from paperwork to house management. This is a salary position and you are expected to always be on call. Please expect to work at least a minimum of 50 Hrs a week. IF you are not to commit to being on call then you should have an assistant that is aware of your situation to provide coverage for yourself and make your supervisor aware. If you have any questions or concerns about anything listed here, please feel free to call Mr. Angel. If you are not able to meet these obligations, then you could be demoted or terminated. Your signature certifies that you agree and accept these responsibilities.

Signed:_____ Date:_____

COMMUNITY SUPPORT ASSOCIATE
(CSA)

RESPONSIBILITIES

Our House Of Favor

CSA RESPONSIBILITIES

NEW CLIENTS

1. When the client first comes through the door make sure the client turns in all medications and placed behind a locked door and a locked file cabinet. (Behind two locked doors)

2. Make sure the client washes all their clothes before taking any clothes to their room.

3. The client's property must be searched before they move their property into their room.

4. The client must have an intake completed within the first 24 hours of being in Our House of Favor.

INTAKE

1. Create a file with the client's name on the tab of the folder.
2. Make a copy of the client's insurance card and identification card. If the client does not have a copy of their identification card then take a picture of the client and print it.
3. Fill out the personal information form and send it to HR.
4. The release of information form in the packet is to be used for their emergency contact and must be filled out. (Their contact can not be anyone in the program.) If the client is on Probation then we have to have a Release of Information in order for us to give the client services.
5. Read all the forms to the clients and make sure they fully understand. This process should not be rushed and is important.
6. Top 3 Forms on each client's file should be,
    A. Copy of identification card and insurance card.
    B. Release of Information form (make sure at the top of the form to label the R.O.I. emergency contact.)
    C. Personal Information Form
7. Administer a drug screen for the client then complete a drug screen form and place the form in their file. Whenever a client's test has positive results then we administer another drug screen. If the client still is testing positive, then the client must have to complete a detox in order to be accepted in Our House of Favor. (We will allow Majiuana but must be monitored.)

8. Then after the intake is complete the front page with all the clients info should be sent to Ms. Saybah, Jeff, Lawrence,Felisha, Ms. Dorothy, and Ms. Gifty and this should be C.C in all together.

EXIT STRATEGY

1. As soon as you know the client is leaving the program, the client must turn in all bedding and any other Our House of Favor. property. (Sheets, Pillows, Covers ect...)
2. Fill out an exit strategy form with the client and place it in the client's folder.
3. Do not put the folder back in the file cabinet, instead place the folder in the designated area for past clients and bring to the office the following day to be properly stored for confidentiality and audit purposes.
4. When the client is by the door, give the client their medication and explain they can not enter the sober living house after their medication is given back to them.
5. Make sure the client's bedding is washed and their room is ready for a new client to move in.
6.Then Email the exit strategy to Ms. Saybah, Jeff, Lawrence, Ms. Dorothy, and Ms. Gifty and all should be C.C. together.

One on One's

1. Work on building a relationship with your client. Get to know your client.
Our House of Favor Management closely monitors and makes sure all notes are accurate and being completed daily. If CSA's do not do a one on one with a client not only are you doing a disservice to the client but you are fraudulently billing under your name and could lose your credentials for this as well as give Our House of Favor a bad reputation.

2. How did you assist your client today?

   A. Assist them in primary doctor appointments ,dental appointments, vision appointments.
   B. Do they need a cell phone? It's detrimental if they have a cell phone, especially if we have a group via Telehealth.
   C. Do they need bus passes? (LRCC and Federated Transportation) This will assist the client with transportation.
   D. Another source of transportation is Medicab, have them call 72 hours prior to their appointments.
   E. Is the client on maintenance medication? New lease has their own shuttle and will provide rides back and forth to their appointments.
   F. Make sure to check their daily goal and weekly goal and see if you can be of any

assistance.

G. Have we signed them up for section 8? Have we signed them up for Housing Urban Development? The list will be long, so let's suggest they sign up early. H. The clients are now free from 11-2, Goodwill has great resources and will assist in most areas. Suggest the client making it to the office on Broadway and sign up for some programs.

I. Remember it's our responsibility to pass the message, do frequent status checks if the client has a sponsor, home group, doing any service work. Share your experience, strength and hope to encourage and give them a hope shot to prove the life you live is attainable.

J. This is a great time to check and see if your client is attending their 5 Mandatory meetings a week.

K. Do they struggle with time management? Help them create an agenda. Do they struggle with their food stamps not lasting? Help them shop and show them how to create meals to last. Do they struggle with finances? Work with them on a budget. Explain the difference between wants and needs.

L. Does your client have a resume? Help them create a resume for jobs.

3. These clients are your responsibility. It's our job as CSA's to provide the information and then it's their choice if they choose to apply it.

Weekly Check List

1. Conduct a thorough room search of the client's room. **Check EVERYTHING.** This is not a room check to make sure the room is clean. This means checking every single thing in the room.
2. Random Drug screens will be assigned to the houses by management in the group chat. If for some reason we do not have forms, we still screen the clients and take pictures to fill out forms when you have some. Then file their drug screen form in their folder.
3. Make sure your filing cabinet has every form needed to complete your job successfully. Make sure all intakes are completed correctly and updated. We have scenarios when clients enter the program and do not have an Identification card or insurance card but obtain them later. Please make sure you make a copy of those and keep files updated.
4. Make sure all your discharge summaries are completed for the clients that have left.

Incident Reports

1. Let the rules govern the house.
2. Anytime a client has to go to the hospital or an emergency situation, we must document that and file in their folder.
3. We must make sure to file incident reports for relapse and detox situations.
4. Explain to the client he/she will be on two weeks property restrictions when returning from

detox.
5. If the detox beds are full and the client has to wait on a bed to open then he/she is on property restriction and not to leave the house.
6. If the incident report is part of our zero tolerance policies then report to management immediately.

Daily Duties

1. Check the rooms and chores. Make sure every client signed the chore sheet. 2. Administer medications.
2. Make sure every client is out of the house at the designated times.
3. Make it to work on time.
4. It is also your job to help keep the beds full. While at meetings or anytime possible please give them Jeff, Lawrence, and the Our House of Favor Office number for a pre-screen to be completed.

HOUSE MANAGER
(HM)
RESPONSIBILITIES

Our House Of Favor

House Manager RESPONSIBILITIES

NEW CLIENTS

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3. The client's property must be searched before they move their property into their room.

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House Of Favor,

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2. Make a copy of the client's insurance card and identification card. If the client does not have a copy of their identification card then take a picture of the client and print it.
3. Fill out the personal information form (Front Sheet) and send it to HR.
4. The release of information form in the packet is to be used for their emergency contact and must be filled out. (Their contact can not be anyone in the program.) If the client is on probation the client has to have an R.O.I to provide services to the client.
5. Read all the forms to the clients and make sure they fully understand. This process should not be rushed and is important.
6. Top 3 Forms on each client's file should be,
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    C. Personal Information Form (Front Sheet)
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screen. If the client still is testing positive, then the client must have to complete a detox in order to be accepted in Our House Of Favor. (We will allow Marijuna but it must be monitored)

8. After the intake is completed it should then be sent in to the following and CC together Saybah Glay, Jeff Angel, Lawrence Massaquoi, Felisha Turner, Gifty Nepay, Ms. Dorothy. If you don't have the emails, please acquire them.

EXIT STRATEGY

1. As soon as you know the client is leaving the program, the client must turn in all bedding and any other property. (Sheets, Pillows, Covers ect...)
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Do not put the folder back in the file cabinet, instead place the folder in the designated area for past clients and bring it to the office the following day.
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5. Make sure the client's bedding is washed and their room is ready for a new client to move in.
6. Email the exit strategy to the following people. Saybah Glay, Jeff Angel, Lawrence Massaquoi, Felisha Turner, Gifty Nepay, Ms. Dorothy. If you don't have the emails, please acquire them. And should be CC together.

Weekly Check List

1. Conduct a thorough room search of the client's room. **Check EVERYTHING.** This is not a room check to make sure the room is clean. This means checking every single thing in the room.
2. Random Drug screens will be assigned to the houses by management in the group chat. If for some reason we do not have forms, we still screen the clients and take pictures to fill out forms when you have some. Then file their drug screen form in their folder.
3. Make sure your filing cabinet has every form needed to complete your job successfully. Make sure all intakes are completed correctly and updated. We have scenarios when clients enter the program and do not have an Identification card or insurance card but obtain them later. Please make sure you make a copy of those and keep files updated.
4. Make Sure a client roster of your location to the following 6 management and administration on Monday's and Friday's. Saybah Glay, Jeff Angel, Lawrence Massaquoi, Felisha Turner, Gifty Nepay, Ms. Dorothy. If you don't have the emails, please acquire them.

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2. Administer medications.
3. Make it to work on time.
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