Policy and Procedures

MaSire Care Home LLC

"Providing In Home Exceptional Care with Support Services Derived From the Heart in an Environment That Offers Comfort, Privacy and Safety"

1450 Cypress Street
Louisville, Kentucky 40210

Phone Number: (502) 609-0796
Email Address:

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Philosophy

Commit, Recover, Thrive!

Mission Statement

Our mission is to provide a safe, loving & sober environment for individuals
Who are seriously seeking recovery & aspire at a chance for a new
Beginning!!

Free To Grow, Thrive and Recover

Goals

After completion of the housing phases each member will be clean, have
Permanent housing, and a strong foundation of tools to stay clean
Empowering them to become positive role models!!!

Objectives

- Provide safe, loving, sober environment.
- Provide counseling sessions.
- Provide transportation to required meetings such as AA & NA.
- Provide education and access to community resources.
- Provide mentorship through peer support.

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Staff

Director

(responsible for day-to-day)

Paris Shannon (502) 822-9637

Shawn Shannon (502) 619-0796

Peer Support

This is a contractual 1099 position that is re-evaluated on a Monthly basis. The current peer support specialist names and Contact information will be posted on site.

House Lead/Manager

This position is reevaluated on a monthly basis and rewarded to The house member who has shown the most leadership and Responsibility.

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Operating Policies and Procedures

MaSire Care Home LLC House Rules

There is no drugs and alcohol allowed on the premises any violation will result in automatic termination from the house.

No person is allowed on the premises who is under the influence of any drugs or alcohol. This will constitute as automatic termination from the house.

There is no smoking allowed inside the house. Smoking is allowed in the designated area only (backyard).

All cigarette butts must be disposed of in the proper container.

All participants must be in by curfew which is 10:00 pm every day. All participants are on 30 day property restrictions and are only allowed out at approved hours by staff.

Sleeping Area

All participants will be assigned a twin bed and a nightstand. There will be no rearranging once assigned to a bed space. Bed linen and pillow will be provided.

No food, drinks, weapons, or guests allowed in the sleeping area.

All personal clothing needs to be labeled and clean.

No loitering or hanging in the personal area.

Kitchen/Meals

All participants are responsible for their own food. Local food pantries will be used for those without resources to obtain food items. Label all personal food items.

No food allowed in the living area. All meals are to be indulged in the kitchen or dining room.

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All participants are responsible for cleaning up kitchen area after each use. This includes dishes washed, tables and counters wiped, also floors swept and mopped.
No leftover food or dishes should be left out at any time. Refrigerated foods must be labeled and dated. No food can be left in the refrigerator past 5 days.
Wash hands at all times.
Do not store personal clothes in the kitchen area or laundry room.

Bathroom

All participants should clean bathroom area after each use. Make sure toilets are flushed, clean the basin tub and shower, empty trash and sweep the floor.
All personal towels and washcloths should be kept in sleeping areas and put away for personal use.
All personal bed linen and towels need to be washed weekly.

Living Area/Recreational Area

All participants should keep living are clean after personal use.
No food allowed in living area/recreational area.
All guest should be signed in and remain in the living area.
Be sure trash iss empty and the floor is always swept.
Return toys to storage area.
Return remote control to the T.V.
This house is set up in a series of phases for participants to transition and progress. Participants must not have any violent or sexual charges or offenses and must remain drug and alcohol free.
The first 30 days participants are restricted to the property and cannot leave the property unless they are working, in school, or have prior arrangements made with a coordinator.
Participants must always sign in and out of house.

Phase 1: 30-60 day.

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AA, NA or recovery meetings.
Sign a commitment contract for 4 to 6 months.
Curfew is at 10 pm every day.
Participants will identify any barriers from school and work with a case worker.
Attend daily community group- (The community holds each participant accountable for any inappropriate behaviors and will be addressed by recommending consequences).
Everyone must participate in working in one of the following positions:
Laundry-Household laundry
Housekeeping-clean bathrooms, kitchen, downstairs, upstairs, sweep and mop floors, clean toilets, clean sink, clean refrigerator, vacuum, cigarette area, dust and clean basement area.
Security- check outside area every 15 minutes starting at 10 to maintain safety and make sure locks are checked.
Kitchen- clean, prepare, and/or assist in cooking meals.
Dorm Master- assist house coordinator, in charge of curfew, log ins and out, chore sheets and meeting attendance.
Completion of phase 1 consist of attending 90% of group meetings or support groups having a temporary sponsor, and completion of steps 1-3 of AA/NA. If mental health issues are present attendance with a counselor and support group is required 90%. Clients may be required to attend a Intensive Outpatient Program (IOP) with local providers for treatment issues.

Phase 2- 60-90 days

Curfew at 10 pm every day.
Continue with employment.
Continue with 12 steps and meeting attendance, treatment groups, and community meeting attendance.
Permanent sponsor and homegroup.

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Participants will begin to deal with legal, financial, family, and disability issues, ect, with a caseworker.

Phase 3

Assistant staff (positions are awarded based on availability).
Continue to work on transitional issues, permanent housing, legal, financial, family, disability, etc.
Teach phase 1 classes.
Relapse prevention.
Continue 12 step work and meetings.

Admissions

Client will undergo an intake screening, have health insurance, be clean and sober coming from a rehabilitation facility, and seriously seeking recovery.
Clients must be at least 18 years old or older to be considered for housing.
Clients with mental disabilities will be evaluated on a case by case basis to determine fit for housing.

Readmissions from relapse

Client must be clean and sober and complete a 28-30 day program in a rehabilitation facility. Client is to be picked up from the facility and drug tested immediately in the event they are reaccepted into the house.
Beds are on a first come first serve basis and will not be held while client completes the 28-30 day program.
In the event client relapses and encourages another client to take part they will not be allowed back into the house. In the event a client relapses a 3rd time they will not be allowed back into the house.
In the event the client relapses a 2nd time, after they complete a 28-30 day program, they will have a panel interview with all staff. During this interview, the client will make their case as to why they should be

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reaccepted. Staff will deliberate and decide on acceptance as well as determine the probationary period that could range from 2-6 months of sober living outside of the home.

Transfer

Client will undergo an intake screening, have health insurance, be clean and sober coming from a rehabilitation facility and seriously seeking recovery.

Clients with mental disabilities will be evaluated on a case by case basis to determine fit for housing.

Discharge

Upon termination from the house, the client will immediately be dismissed from the property and not permitted on the premises. Personal items that were not collected before exiting will be collected by staff and stored for 3 days. Client is responsible for reaching out to the house lead to arrange collection of property in that time frame to avoid disposal of personal items. The following are grounds for immediate termination:

- Using drugs or drinks alcohol
- Stealing in any form including food
- Destruction of property (Client will be financially responsible for the repair cost).
- Soliciting and/or consuming another client's medication.
- Acts of violence or threats of violence
- Sexual harassment
- Violating house rules 3x.

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VIOLATION OF ANY HOUSE RULES WILL RESULT IN CONSEQUENCES UP TO TERMINATION FROM THE PROGRAM!!

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MaSire Care Home LLC

House Rules

1. No use of alcohol or other drugs.
2. Compliance with random urine tests.
3. Compliance with established curfew. (Everyday 10 pm)
4. Clients must be out of bed by 7 am.
5. Clients are to shower daily for no longer than 20 minutes.
6. Clients may not re-enter their living units until 2:30 pm.
7. Participation in Self-Improvement programs, Outpatient treatment and Community Support Groups. (must attend seven (7) AA/NA meetings per week)
8. Smoking is prohibited inside all living units and front yards. Smoking is only allowed in designated areas (behind residence). Use appropriate container to dispose of cigarette butts. (No smoking before 6 am and after 11:30 pm Sun-Thurs 12:30 Fri.-Sat.)
9. Stealing is prohibited, this includes eating food that does not belong to you, confirmed accusations will result in termination from the program.
10. Clients may not use kitchen after 10 Sun-Thurs and 11 Sat-Sun.
11. Destruction of property will result in termination from the program and all cost of repair extended to you.
12. Clients must be respectful of all staff, other residents and members of the community.
13. Clients must create a job proposal and get approval from staff before employment begin date.
14. If employed, verification of employment is required (ie: clock in/out slips, schedule).
15. Clients are not allowed to work 3rd shift.
16. Groups missed will only be excused with proof of medical emergency. Doctors appointments must be scheduled around group hours. Missed IOP groups must be made up.

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17. Soliciting or consuming other clients medication is prohibited and will result in immediate termination from the program and possible prosecution.
18. Zero tolerance policy for violence, threats of violence or harm and profanity.
19. Zero tolerance policy for sexual harassment toward anyone.
20. You are expected to help keep residence and living area clean, neat and safe. You must adhere to the list of house chores including all scheduled deep cleanings.
21. No one will be permitted to leave until chores and deep clean are completed and checked by house lead or staff.
22. You are prohibited from entering any other living unit outside your own without prior consent from a staff member.
23. Clients are prohibited from hanging out in front of the residence.
24. All visits must be approved by staff at least one (1) day prior to visit.
25. Clients are allowed (1) visit per eek between 3 pm-5 pm and one (1) visit on the weekend between 12 pm-8 pm.
26. Clients can not visit female/male house while on thirty (30) day property restriction.
27. All visitors must sign-in and leave by 8 pm.
28. Visitors are allowed in clients personal space at the discretion of the staff.
29. Clients are allowed one (1) drop-off per week and must be approved by staff.
30. Staff must be present when client receives drop-off.
31. If client is away from property for more than four (4) hours, they must call and check in with staff.
32. In house relationships are prohibited.
33. No fraternizing between staff and clients.
34. You may be asked to move out of your residence at any time as a result of violence, unsafe behavior, alcohol or drug use and violation of any house rules, during such time you will be escorted by a manger to gather your belongings.
35. Upon termination you will not be permitted to remain on the property. Please inform staff upon your intent to depart immediately.

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Confidentiality Agreement and Participant

Client ID (Service Point) ____________________

Confidentiality Agreement

When you come to The MaSire Care Home for support or services, it is important that you feel comfortable speaking with a case manager or other staff. One aspect of this sense of safety is knowing that everything you say and that everything in your file is held confidential.

We are obligated to submit **statistical** information to Jefferson County such as age, gender, ethnicity, referral source, and general categories of assistance required–no individually identifiable information is released without your express, written permission. In addition, you may meet other participants while visiting here or participating in a group or other activities. Those individuals have the same right and expectation of privacy as you do.

We do not speak about an individual participant to any other participant out of our house or to persons outside this agency unless we have your signed release specifying the person we are able to speak with.

There are four exceptions to the confidentiality agreement. We will break confidentiality and make a report to the appropriate agency in the following situations:

1. Information given to use that indicates a child has been abused or is in danger of abuse.
2. Information given to us that indicates a violent crime is about to take place.
3. Information given to us that indicates that you are in danger of doing harm to yourself or others.
4. If the court subpoenas our records.

Participant Rights

1. To view your own file upon request.
2. To be treated with respect and dignity.
3. To participate actively in the development of your case plan.
4. To receive answers to your questions about service delivered from this agency.
5. To file a grievance regarding the house, this agency or its staff and receive a copy of the grievance policy.

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Your signature below indicates that you have read this statement , you understand it, and you agree to it. In addition, your signature indicates that you will hold confidential the names of and information about others you may meet at this agency.

Client Signature

Date

Service Provider Representative

Date

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Confidentiality Agreement and Participant Rights

Service Contract

I, ______________________________, agree to abide by the MaSire Care Home rules and guidelines. I will inform my advocate of any and all changes in my income and I will seek support including safety planning from my advocate if I wish to reunite or contact my abuser. I understand the program rules and have been provided with information regarding the Grievance Process, Confidentiality, Participant Rights, and Termination of Service Policy. I agree to attend appointments as agreed upon with my advocate. If I cannot attend I will contact my advocate and reschedule as soon as possible. My participation while voluntary in this program will be my priority and I agree to follow through with the steps I have set for myself to achieve my goals. I understand I hold the responsibility to provide any receipts to my advocate for resources that may be provided to me. I understand that I can terminate from the MaSire Care Home program at any time, however the agency request that a 30 day notice he provided if possible. I also understand that termination from the program because of non-compliance can occur as detailed in the agency termination policy.

______________________________ Participant Signature

______________________________ Date

______________________________ Advocate Signature

______________________________ Date

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Confidential Health Assessment

Miscarriages? If yes, how many? When?
Abortions? If yes, how many? When?
Menopausal symptoms or treatment? If yes, when?

For Men Only:
Do you now have, or have you had, problems with your prostate, difficult or painful urination, or impotence? If yes, please describe these problems:

For Children (only if your child is the primary client for this therapy):
What immunizations has your child received (you may provide a copy of his or her shot record if that is easier)?
When: Type of immunization: Any problems or side effects:

/ /
/ /
/ /
/ /

Lifestyle/Health Habits:
On average, how many hours of sleep do you get? Do you have problems with sleep?
If yes, what kind of sleep problems do you have?

Do you exercise regularly? If yes, how often and for how long?
In what kinds of exercise or physical activities do you participate?

How is your appetite? Do you have any problems with your appetite?
If yes, what kind of problems are they?

Have you recently gained or lost a significant amount of weight (for most adults, more than 20 pounds in 6 months) If you are smaller than average, a lesser amount may be significant for you? If yes, please describe this weight gain/loss and what you believe is the reason?

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How much coffee, tea, cola, or other substance containing caffeine do you consume each day?

Do you smoke or use chewing tobacco or snuff? If yes, how much?
Are you a former tobacco user who has quit? If yes, when did you quit?
Please indicate which of the following drugs you have used, if any:

Age at First Use
How often you usually use(d) How much You Usually Use(d)

Method(s) of Use How long Since Last Use

Alcohol ______________________

Methamphetamine ______________________

Amphetamines (speed) ______________________

Barbiturates (downers) ______________________

Cocaine (powder) ______________________

Cocaine (crack) ______________________

Hallucinogens (LSD, ect) ______________________

Heroin ______________________

Methadone ______________________

Morphine ______________________

Opium ______________________

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Inhalants ____

Marijuana/Hashish ____

PCP (Angel Dust) ____

Steroids ____

Client/Guardians Name:	Signature:	Date:
Staff Member Name:	Signature:	Date:

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Treatment Plan

Client Name: ____

Date of Intake: ________ Plan Term: 90 days 120 days BEYOND
(PLEASE CIRCLE ONE)

WEEK OF:____________________ DATES: ____________________________

Client's long-term goal for seeking services: _______________________________

____

____

Results client wants to obtain from seeking our services: ____________________

____

____

Support System: ____

Barriers: ____

Treatment Method: Peer Support Specialist Related Programming

WEEKLY GOAL SETTING

Client Will	Outcome

Client Signature: ___________________________________ Date: ________

Authorized Staff Signature:_____________________________ Date: ________

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dx ___

CLIENT LAST NAME ______ First ______ M.I. ___

May I contact you by e-mail? If Yes, print address______________________

Address________________________________ City______________________

State _______ ZIP__________ SSN ______________ *(SSN is required for certain 3rd-party Payers)*

Phones, Cell ______________ Home ______________ Date of Birth __________________

______NOT OK to leave message ________NOT OK to leave message

Gender________ Age_______ EMPLOYER / SCHOOL ________________________

RESPONSIBLE PERSON — If other than client. If client's name is NOT on insurance card you must provide insurance subscriber's full name, SSN, gender, and date of birth.

Last Name____________________ First _______________ M.I. _____ DOB __________

Address______________________ City _______________ State ______ ZIP ________

Relationship to Client ________________ SSN ______________ *(SSN is required for required 3rd-Party Payers)*

Phones, Cell _____________________ Home______________________

____NOT OK to leave message _____ NOT OK to leave message

Gender _______________ Age _________ EMPLOYER / SCHOOL______________________

Insurance __________________________ **ID#** ___________________________________

(unless I make copies of your cards/authorizations)

SPOUSE OR PARTNER'S NAME ____________________________ Years Together _____________

CHILDREN'S NAMES & AGES ____

EMERGENCY CONTACT ____

(You consent for Debras House to contact this person during an emergency)

Phones: Cell ______________________ Home____________________ Work ________________

HOW DID YOU HEAR OF OUR SERVICES? ____

ARE YOU CURRENTLY ENROLLED IN OTHER SERVICES? Tell Me More: _______________________

____

AGREEMENT TO POLICIES

I understand and have been given a copy of the Agreement. I accept and agree to the Financial Agreement, Cancellation / Late / No-Show, 3rd-Party Payer Release and Assignment, Payment Authorization, Contract and Consent, Limits of Confidentiality, Personal Health Information, Release of Information, Authorizations & Referrals, Acceptance of Agreement, and Question or Problems.

____ ____________________

Client or Responsible Party Signature Date

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INTAKE FORM

DATE:	1 st Scheduled Date of Arrival:	Time:
Name:		
Phone#		
Insurance:		
ID#		
PSP		

Reason for seeking services: ____

____

____

Assessments to be administered:

□ Anger □ Suicide □ Depression □ Marital Satisfaction □ SUD (DUI) □ SAP

____ ID and Insurance Card Copied (FaceSheet)

____ Client Assigned to Appropriate folder (labeled w/ First name, Last initial onZy0

____ Electronic folder created in appropriate location

____Registration Packet (FaceSheet, Registration form, Demographics, DSM) uploaded to electronic folder

____Client account created in MyClient Plus

____ Registration Packet (FaceSheet, Registration form, Demographics, DSM) uploaded into MyClient Plus

____Client Activity log completed or created and printed, placed in appropriate binder

____ Emergency Contact index card created and stored accordingly

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NO HARM AGREEMENT

1____________________________, agree NOT to kill myself, attempt to kill myself, or cause any harm to myself or anyone else at any time.

(Initials)__________ I agree to get rid of anything that I could use to kill myself, including but not limited to, guns, other weapons, pills, etc..

(Initials)__________ In the event of an emergency, such that I am in serious danger of hurting or killing myself, I agree to alert staff to dial 911 , or go to the nearest hospital emergency room, for immediate assistance.

(Initials)__________ I further understand that if staff,__________________, determines that I am in serious danger of hurting or killing myself, my right to confidentiality is waived, and ____________________, will make any necessary telephone calls for my own protection.

(Initials)___________ I therefore authorize _________________________to contact the following people, in case of emergency:

(a) ____

NAME PHONE RELATIONSHIP TO ME

(b) ____

NAME PHONE RELATIONSHIP TO ME

(c) ____

NAME PHONE RELATIONSHIP TO ME

___________ I will also call one of the Suicide Hotlines listed below:

- Hopeline 24/7 (National Crisis Hotline): 1-800-784-2433
- Crisis Hotline: 407-425-2624

OR

- Go to the emergency room
- Call 911

___________ I agree that if I have a bad time and feel that I might hurt or kill myself, I will immediately call _________________________ who is my ____

PERSON'S NAME_________________________RELATIONSHIP TO ME ___________________________

I agree that these conditions are part of my counseling contract with my Therapist and are effective immediately and indefinitely.

Printed Name of Client __________________ Signature: __________________ Date: ____________

Printed Name of Auth Staff __________________ Signature: __________________ Date: ____________

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RELEASE OF INFORMATION

Client Name ____________________ SSN ____________________ DOB ____________________

I authorize ____

☐ to release information to the following person/agencyto obtain information from the following person/agency

Name/Agency ___________________________ Relationship to Client ___________________________

Address ____

City ____________________________ State _______________ Zip ____________________

Telephone Number ____________________________ Alternate Number ____________________

PURPOSE and LIMITS

☐ Collaboration ☐ Continuity of Care ☐ Billing ☐ Other ____________________

☐Limits __________ ____

INFORMATION to be EXCHANGED

☐ Agency, physician, or hospital records

☐ Financial records

☐ Re-release of other's medical records

☐ Correspondence

☐ Medical records of therapy sessions

☐ Therapy notes for the therapist

☐ Drug and alcohol history, diagnosis, and treatment*

☐ Psychological evaluations

☐ Other __________ __________

☐ Educational records

☐ Raw test data and testing materials

I understand that my signature authorizes the release of this information only between the above-named persons or agency. I understand that except to the extent that action has already been taken based on my authorization, I may withdraw this authorization at any time by written notice. I understand that this authorization shall remain in effect for one year (365 days) from the date of the signature below, unless I specify an earlier date as indicated. I understand that my therapist may not make signing a release of information a condition for ______________ therapy unless the services are provided for the purpose of creating health information for a third party.

I authorize the release of the indicated sensitive records also (client to initial):

Mental Health Records ____________________(initial)

HIV or AIDS ____________________(initial)

Chemical Dependency ____________________(initial)

DUI Records ____________________(initial)

____ ____

Signature of Client/Parent/Legal Guardian Date Signature of Counselor Date

____

Signature of Witness Date

*This information has been disclosed to you from records whose confidentiality may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR, part 2) prohibits 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 CFR, 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 information to criminally investigate or prosecute any alcohol or drug abuse client.

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CLIENT LAST NAME First M.I.

May I contact you by e-mail? If Yes, print address____________________

Address______________________________ City____________________

State _____ ZIP________ SSN __________ ***(SSN is required for certain 3rd-party Payers)***

Phones, Cell __________ Home __________ Date of Birth __________

______NOT OK to leave message ________NOT OK to leave message

Gender______ Age______ EMPLOYER / SCHOOL ____________________

RESPONSIBLE PERSON — If other than client. If client's name is NOT on insurance card you must provide insurance subscriber's full name, SSN, gender, and date of birth.

Last Name______________ First __________ M.I. _____ DOB ________

Address________________ City __________ State _____ ZIP ________

Relationship to Client __________ SSN __________ ***(SSN is required for required 3rd-Party Payers)***

Phones, Cell ______________ Home______________

____NOT OK to leave message ____ NOT OK to leave message

Gender __________ Age ________ EMPLOYER / SCHOOL______________

Insurance ______________ **ID#** ______________

(unless I make copies of your cards/authorizations)

SPOUSE OR PARTNER'S NAME ______________ Years Together __________

CHILDREN'S NAMES & AGES ______________________________

EMERGENCY CONTACT ______________________________

(You consent for Debras House to contact this person during an emergency)

Phones: Cell ______________ Home______________ Work __________

HOW DID YOU HEAR OF OUR SERVICES? ______________________________

ARE YOU CURRENTLY ENROLLED IN OTHER SERVICES? Tell Me More: ______________

____

AGREEMENT TO POLICIES

I understand and have been given a copy of the Agreement. I accept and agree to the Financial Agreement, Cancellation / Late / No-Show, 3rd-Party Payer Release and Assignment, Payment Authorization, Contract and Consent, Limits of Confidentiality, Personal Health Information, Release of Information, Authorizations & Referrals, Acceptance of Agreement, and Question or Problems.

______________________________ ______________

Client or Responsible Party Signature Date

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Confidential Health Assessment

Today's Date: ______________

Name:___________________________ Birth Date: ________________

Address:_______________________________Phone: (H)________

(C)___________________ SSN: _______________________

Primary Care Physician: ________________ Phone: _______________

List any health problems or concerns you now have:____________________

Type of problem/concern: __________________ How long:________________

Under a doctor's care? (Y/N, name of doctor):

How would you describe your general health at this time? ______________________

____

____

When and where was your most recent physical exam? _________________________

____

Did the results of that exam show that you had any medical problems at that time? ________

____

If yes, what were they? ____

Please list any times you have been hospitalized or had surgery: ____________________

Name and location of hospital, When:	reason you were hospitalized:	Type of surgery/other treatment & outcome:	Present status:
/ /			
/ /			
/ /			

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Section 2

Co-occurring Services

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REQUEST FOR OUTPATIENT SERVICES SIGN-UP SHEET

Date: ______________________________

9 am-10 am ________________________ ________________________
Name Contact Phone

10 am-11 am ________________________ ________________________
Name Contact Phone

11 am-12 pm ________________________ ________________________
Name Contact Phone

12 pm-1 pm ________________________ ________________________
Name Contact Phone

MaSire Care Home

1450 Cypress St. Louisville, KY 40210

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The MaSire Care Home is a general partnership and has no W-2 employees. The MaSire Care Home shall contract with professional providers to serve clients. The contractors are in a 1099 and responsible for filing taxes, acquiring professional liability insurance, and CEU's. Contractors will provide a copy of professional documents to the agency for record keeping.

Peer Support

This position is supervised by Jamila Hadden and reports to her.
ROLE AND RESPONSIBILITIES
The Peer Specialist provides peer support services to clients with substance use related diagnosis and functions as a role model to peers substance use related diagnosis and functions as a role model to peers exhibiting effective use of coping skills while performing: Mastery over their own recovery process Peer Support Specialist are responsible for a wide range of tasks to assist peers including:

1. Assist clients in articulating personal goals for recovery through the use of one on one and group sessions.
2. Support clients in identifying and creating goals and developing recovery plans.
3. Assist clients in setting up and sustaining self-help (mutual support) groups.
4. Utilize SMART Recovery tools to assist clients in creating their own individual wellness and recovery plans.

QUALIFICATIONS AND EDUCATION REQUIREMENTS
Knowledge of the Recovery process and the ability to facilitate recovery using established standardized mental health processes. Knowledge and skill to teach and engage in basic problem solving strategies to support individual clients in self-directed recovery. PREFERRED SKILLS Knowledge and skill sufficient to use community resources necessary for independent living and ability to teach those skills to other individuals.
ADDITIONAL NOTES

- Must Have Reliable Transportation
- Able to pass TB Test and Background Check

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Drug Test Policy

Upon acceptance into the house every resident is required to pass a drug test. This will be administered as soon as they arrive. The drug test for:

*Amphetamines (AMP)
*Cocaine (COC)
*Barbiturates (BAR)
*Phencyclidine (PCP)
*Buprenorphine (BUP)
*Benzodiazepines (BZO)
*Methadone Metabolite (EDDP)
*Ecstasy (MDMA)
*Methamphetamine (MET)
*Morphine (MOR)
*Oxycodone (OXY)
*Propoxyphene (PPX)
*Nortriptyline (PPX)

The MaSire House uses a 12 panel urine test to screen clients for the above mentioned drugs. To determine a positive or negative result the screener will remove the panel and look for the strips that have a color band in the "C" section. If there is a color band in the "C" section as well as the "T" section that indicates a negative result.

The MaSire House will also use a digital display alcohol breathalyzer to screen residents for alcohol. After the client blows into the device, if a result over 0.0% BAC is displayed on the screen that indicates a positive result of alcohol use.

The MaSire House conducts random drug tests that every resident of the house is subject to. These random tests will be both a urine analysis as well as a breathalyzer.

House Rules

- NO USE OF ALCOHOL OR OTHER DRUGS
- Compliance with random urine test
- Compliance with established curfews

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- MANDATORY PARTICIPATION IN SELF-IMPROVEMENT PROGRAMS
- MANDATORY PARTICIPATION IN OUTPATIENT TREATMENT OR COMMUNITY SUPPORT GROUPS
- SMOKING IS PROHIBITED INSIDE ALL LIVING UNITS AND FRONT YARDS (Smoking is only allowed in designated areas, behind residence)
- Stealing is prohibited,this includes eating food that does not belong to you
- Clients must be respectful of all staff, other residents and members of the community
- IF EMPLOYED, VERIFICATION OF EMPLOYMENT IS REQUIRED
- Documentation of a doctor's appointment or proof a medical emergency is required for all missed groups; groups missed will only be excused with documentation.
- Soliciting or consuming other client's medication is prohibited
- You are expected to help keep the residence clear, neat and safe. You must adhere to the list of house chores including all scheduled deep cleanings
- Your bedroom is always expected to be kept neat and clean.
- CLIENTS MUST ENGAGE IN (6) SIX HOURS OF PROGRAM DAILY (30 HRS A WEEK)
- You are prohibited from entering any other living unit outside of your own without prior consent from a staff member
- House members can have guests in their personal space at the discretion of the director. All guests must leave by 8 pm
- ZERO TOLERANCE POLICY FOR VIOLENCE, THREATS OF VIOLENCE OR HARM AND PROFANITY

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- ZERO TOLERANCE POLICY FOR SEXUAL HARASSMENT TOWARD ANYONE
- VIOLATION OF ANY HOUSE RULE MAY RESULT IN TERMINATION FROM THE HOUSE
- You may be asked to move out of your residence at any time as a result of violence, unsafe behavior, alcohol or drug use, during such time you will be escorted by a manager to gather your belongings.

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I, ______________________________, make a commitment to living. I will not harm myself or anyone else in any way. I will not attempt suicide, or any other self-injury.

If I begin to have thoughts of harming myself:

1) I will try to identify specifically what is upsetting me

2) I will review alternatives to self-harm, such as thinking about my friends, family or the future

3) I will do at least one of the following things for 30 minutes to try to make myself feel better:

____

____

____

4) I will seek out a responsible, caring and supportive person if thoughts of self-harm continue.

5) If at any time I do not feel I can control my behavior, I will contact 911 or the nearest emergency room.

Important, supportive people in my life I can contact:

Name Relationship Phone #

____

____

____

____

____

____

____

Printed Name of Client ____________________ Signature: ________________ Date: ________________

Authorized Staff Name ____________________ Signature: ________________ Date: ________________

Printed Name of Therapist ____________________ Signature: ________________ Date: ________________

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MASIRE CARE

MEDICATION LOG

CLIENT:____

PRESCRIPTION(DRUG NAME):______________________________________

AMOUNT (tabs, etc.) in prescription bottle & size:_________________________

Beginning Date:_________________ Completion Date:__________________

DATE	MEDICATION & AMOUNT TAKEN	CLIENT INITIALS	STAFF INITIALS

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SIGN OUT SHEET

NAME	LOCATION	TIME LEFT	TIME RETURNED

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Client Overnight Leave Request

Client: ______________________ Dates to be away: ________________

Staying overnight at/with: ____________________________________

Contact Phone# _______________ Address: ________________________

Goals for leave: ____

How I will be supporting my recovery while away. (Please be specific. Include descriptions of meetings, support people, sponsor and peer contact, accountability plan, etc.)

Staff Commentary:

Client Signature

Date Submitted

Review Date

Approved Date

Declined

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Masire Care MEETING SHEET

DATE	TIME	MEETING	CHAIRPERSON SIGNATURE

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Chore List

Living Room- ____________________

Dining Room- ____________________

Kitchen- ____________________

Bathroom & Hallway- ____________________

Laundry Room- ____________________

Basement- ____________________

Front Yard- ____________________

Back Yard- ____________________

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