

TANANA CHIEFS CONFERENCE HEALTH SERVICES

Behavioral Health Services

Chief Peter John Tribal Building

122 First Ave, Suite 600

Fairbanks, AK 99701

(907) 452-8251 Fax: 459-3810

Toll Free in Alaska 1-800-478-6822

January 16, 2015

Greetings

I am sending this letter to inform you about the Old Minto Family Recovery Camp which is located in the old village site of Minto on the Tanana River, 30 miles downriver from Nenana and 40 miles west of Fairbanks by air.

OMFRC is a 35 day ASAM Level III.3 Residential Treatment Program. This year the first cohort begins on 6/18/2014. New cohorts begin approximately every 35 days. OMFRC is typically closed from late April to early June for spring break up.

To access information about OMFRC including the application, the following link will provide pertinent information and requirements for entry into the program including recent assessment, physical exam, dental exam, PPD, and criminal background check. We also require Release of Information to be filled out by consumer in order to have this process be productive and information disclosed confidential. Information can be found at:

<http://www.tananachiefs.org/health-service/oldmintofamilyrecoverycampnew/>.

If a consumer is referred by OCS or Tribal Court they must have a signed case plan included with their other required documents. Moreover, collateral information should be included as it allows us to better serve the consumer.

If you have any questions feel free to call me at (907) 452-8251 ext. 3225 or you can e-mail me at greg.alexander@tananachiefs.org.

Sincerely,

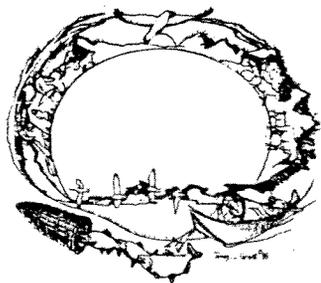
Gregory C. Alexander, CDC I
Administrative Supervisor OMFRC

Our Vision

Healthy People Across Generations

Our Mission

TCC Health Services, in partnership with those we serve, promotes and enhances spiritual, physical, mental and emotional wellness through education, prevention and the delivery of quality services.



TANANA CHIEFS CONFERENCE

Behavioral Health Services
Chief Peter John Tribal Building
122 First Avenue Suite 600
Fairbanks, Alaska 99701
(907) 459 3800 Fax: (907) 459-3835
Toll Free in Alaska: 1-800-478-6822

To whom it may concern

Thank you for your interest in the Tanana Chiefs Conference (TCC) Old Minto Family Recovery Camp (OMFRC) office located on the 4th floor of the Chief Peter John Tribal Building (CPJTJTB). The first step to determine if you are eligible for services is to complete the attached application and submit it in person at TCC 4th floor, mail it to **TCC OMFRC 122 First Avenue Fairbanks, Alaska 99701**, or Fax it to **(907) 459-3835**. When you send a fax call and let us know you are sending a fax and call again to make sure we received everything faxed. If there are any adults wishing to attend camp with you they must also complete an application.

Once our office receives your application a Behavioral Health Consultant will contact you to do a screening. **It is very important that you provide a phone number where you can be reached to do this screening and continue the process to enter into OMFRC.** After the screening process is done you will be added to the waitlist to receive an assessment if you already do not have one. It is your responsibility to turn in an outside assessment. Once your assessment is received the Clinical Supervisor will review your assessment to determine if OMFRC will be an appropriate placement for you. If not we will assist you in finding an appropriate treatment for you.

After your assessment has been approved for services at OMFRC we will need the following as soon as possible.

- ❖ **Criminal History** is required for all persons over the age of 18 who will be attending the program. OMFRC requires the criminal history to be acquired from the Alaska State Troopers Office and there is a \$20 dollar fee for each request. **Note: any individual or family member convicted of a sexual offense or with extensive history of violence will not be admitted into OMFRC and will be referred to alternative programs.**
- ❖ **Physical Exam** (Note: a physical is required for all members of the family attending the program). You can get the form on the website, faxed or mailed to you. It needs to be done and signed by a health provider. (It cannot be done by a community Health Aid).
- ❖ **Dental Exam** (Note each family member attending the program is required to see a dentist within 3 months of admission).
- ❖ **Results of a current PPD tuberculosis skin test** within the last six months for all members of the family attending the program. For any positive results a doctor's medical clearance will be required prior to entering the program.

It is important to understand that if you or family members have medical or dental conditions that need treatment, admission to OMFRC will be delayed until medical clearance is received. This is due to the high cost, weather and available transportation to and from camp.

The information you provide is necessary for us to determine placement, recommended treatment and provide a safe environment for our consumers and their families. If you have questions or need assistance with the application, please call our office at 1-800-478-6822 or 452-8251 ext 3097.

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**TANANA CHIEFS CONFERENCE
OLD MINTO FAMILY RECOVERY CAMP
CHECK LIST**

YOU ARE ALLOWED ONE PHONE CALL AT THE END OF THE 2ND WEEK.
CELL PHONES (even to listen to music) AND LAPTOPS ARE NOT ALLOWED AT THE CAMP!

WE DO NOT ALLOW DIRECT PHONE CALLS TO THE CAMP—WE WILL TAKE MESSAGES (providing we have a Release of Information) AND FORWARD THEM TO THE COUSELORS AT THE CAMP.

WHAT THE CLIENT MUST BRING

- Sleeping bags, bedding, pillows, towels** for all family members.
- Clothes and shoes** appropriate for the weather and travel.
- Personal Hygiene Products:** Tooth brush, toothpaste, shampoo/conditioner, feminine products, soap, shaving items, non-alcoholic mouth wash, q-tips, etc.
- Diapers, wipes, baby food** for infants (TO LAST 40 DAYS*)
- Medication only**-(TO LAST 40 DAYS*)
- Alarm clock**-battery powered, **flashlight**.
- Stamps and envelopes**- Please have your own supply. We do not provide these items AND due to confidentiality we will not call family and friends to pick up envelopes.
- Native food:** dry meat, dry fish, berries, etc., — optional.
- You are welcome to bring your own supplies for:** beading, knitting, carving, and sewing.
- WE DO NOT ALLOW SODA AND JUNK FOOD AT CAMP** (i.e., candy, chips, etc.).

▶ **We do not allow VICTOR (unemployment) calls during treatment.** ◀

*In case of bad weather—PLEASE bring a 40 day supply of medication, baby food, diapers, etc.

In the event that you need personal item at camp, you can write to your family/friends and let them know they can drop packages or mail off at the Chief Peter John Tribal Building.
Items will be sent to the camp on the next available trip.

REMEMBER—there is limited space available at OMFRC.

OMFRC STAFF will not shop for clients during their time off.

Thank you

**TANANA CHIEFS CONFERENCE
OLD MINTO FAMILY RECOVERY CAMP
CHECK LIST**

ITEMS NEEDED PRIOR TO ENTERING OMFRC—in order of priority.

1. OMFRC Application
2. Substance Abuse (Drug/Alcohol) Assessment or a Comprehensive Assessment—Screening will determine which assessment is needed. Assessments must be dated within the past 6 months.
3. Current Criminal History from Alaska State Troopers office (for adults 18 years and older.)—you will need two forms of ID (one with picture) and \$20.00 cash to get an official copy.

Items 1, 2 and 3 are needed as soon as possible to determine eligibility.

4. Current Physical Exam—within the past 3 months
5. Current TB Test —within the past 6 months.
6. Current Dental Exam—within the past 3 months.

Steps 4, 5 and 6 are required for ALL family members who plan to attend.

*If you reside outside the Fairbanks area: we will need your travel arrangements to and from Fairbanks and Housing information.

Keep in touch with the Case Manager/Counselor at least once a week!

We need to know that you are interested and motivated so that we can confirm bed space for the desired session. If you do not contact us, we will assume you are not interested.
Lack of participation could result in losing your bed space.

PLEASE TAKE CARE OF ALL YOUR COURT, PERSONAL, LEGAL, FINANCIAL, AND FAMILY OBLIGATIONS BEFORE YOU GO TO OLD MINTO FAMILY RECOVERY CAMP.

We will provide:

- ◊ Round trip transportation from Fairbanks to and from camp
- ◊ all meals
- ◊ laundry soap
- ◊ work gloves
- ◊ insect repellent
- ◊ tools for working
- ◊ Coleman lamps/candles
- ◊ wood/woodstoves

The Old Minto Family Recovery Camp is in a traditional camp setting, therefore has limited electricity and no running water. Wood stoves are used to heat the cabins and Coleman lamps are used for lights.

Please do not bring any unnecessary items, as you will be traveling to the camp by a small plane in the winter or by a boat in the summer. **There are no stores in Old Minto. **

Please let your family and friends know to send your mail to the office at:

Tanana Chiefs Conference
OMFRC
"Client name"
122 First Avenue, Suite 600
Fairbanks, AK 99701

Who recommended you for treatment? (agency, address, contact person & phone number)

Agency Name: _____

Contact Person: _____

Address: _____

Phone: _____

Are you currently involved with the legal system? No Yes, describe how and why:

Are you **mandated/required or recommended to participate by:** (check all that apply)

Court FASAP Probation/Parole Tribal Court OCS Employer Family

Other _____

Have you ever been convicted of a violent or sexual crime?

No

Yes → How many times? _____

→ What was/were the crime/s? _____
-(include to what degree)

Are you currently receiving services from any other agency? No Yes (please list agencies)

First Agency

Name: _____

Address: _____

Contact person: _____

Phone Number: _____

Second Agency

Name: _____

Address: _____

Contact person: _____

Phone Number: _____

If you need more space please add an additional page

Have you ever been to residential treatment before? No Yes →

Was it: OMFRFC _____ Other _____

Why do you want to be in this program (what do you hope to get out of it)?

<input type="checkbox"/> # Times _____
<input type="checkbox"/> Dates: _____
<input type="checkbox"/> Did you complete? _____

What is your drug of choice (what you most typically drink or use) and when last used:

(please note that alcohol is a drug)

1 st Choice		2 nd Choice		3 rd Choice	
Drug	Last used	Drug	Last used	Drug	Last used

Are you an injection drug user? Yes No

Do you have travel arrangements to get to and from treatment? Yes _____ No _____

Are you currently involved in a committed relationship?

- No
 Yes → Married
 Living together

→ Will your partner be attending the program also?

- Yes - Name _____
 No

How many children do you have? _____

Please list the names, gender, birth date, and your relationship to the children ***who will attend*** the program with you (if you need extra space, please write on the back).

Name	Gender	Birth date/age	Relationship (e.g. Natural, adopted, or foster child)
	M F		
	M F		
	M F		
	M F		
	M F		
	M F		

Do you or any of the family members which may attend have any special needs or considerations we will need to know about to accommodate you?

	Who is experiencing the problem	Please describe
Medical		
Disability		
Legal		
Work		
Social		

What is the highest grade of education you have completed? _____

What is your primary language?

English → → → →

How well do you ***read and write*** English (circle one)
 Very well Good Fair Difficult

Other _____ →

Do you require an interpreter for English? _____
 How well do you ***read and write*** English (circle one)
 Very well Good Fair Difficult

We look forward to meeting you. You will be notified once your application has been reviewed. If you have questions, please feel free to contact us for assistance. Thank you.

Applicant Printed Name _____

Date _____

Signature _____

Tanana Chiefs Conference, Behavioral Health

OLD MINTO FAMILY RECOVERY CAMP

Medical History & Physical Screening

Name _____ DOB: _____ Date _____

Old Minto Family Recovery Camp is an Alcohol and Drug treatment program operated by Tanana Chiefs Conference in Fairbanks, Alaska. The program setting is isolated, rural, and accessible only by small plane and boat. Treatment is expected to take five weeks. A condition of admission is that clients be able to fully participate in all activities, which include hauling water, cutting and lifting wood, subsistence activities, etc. All clients are required to obtain a health screening to ensure that there are no medical conditions or severe withdrawal potential that would interfere with treatment and leave the client at risk for complications.

TO BE FILLED OUT BY A HEALTH CARE PROVIDER

Please check if the client has ever had any of the following and explain "Yes" answers on the lines below:

- Yes No Yes No
Major Illnesses
Allergies (food, drug, other)
Abnormal blood pressure
Asthma
Liver disease
Diabetes
Back Injury
Major injuries/surgeries
Tired all the time
Swollen feet or ankles
Head Injury
Severe Headache or Migraines
Heart problems in self or family
Unusual Swelling in limbs
Skin problems
Constipation or diarrhea
Any problem with urination
Hernia
Severe fatigue after little activity
Unusual thirst or hunger
Hepatitis (A, B, or C)
Appetite/ability to eat changes
Blurred vision or difficulty seeing
Buzzing or ringing in ears
Seizures
Frequent colds or coughs
Recent changes in weight
Problems with sleep or rest
Bleeding gums or teeth problems
Shortness of breath with exercise
Venereal Disease
Cancer
Kidney problems
Aching joints or muscles
Blood in stool or urine
Other:

Please explain any 'Yes' responses:

(Please use back of page if needed)

Please check current immunizations:

- Flu Shot Hepatitis B Shot Pneumonia Tetanus Shot Other

Does the client have family members or a close relationship with anyone who has active:

Tuberculosis No Yes Mental Illness No Yes If yes, please explain:

Has the client been screened for Tuberculosis? No Yes Last test date: Results:

If not screened within last six months, give PPD. If there is a previous history of PPD conversion, is the client symptom free? _____

Please list hospitalizations or operations or Emergency room visits within the past three years: _____

Is the client currently under a doctor's care? __No __Yes, Why? _____
Doctors name, address and phone number required

Name: _____ Phone: _____

Address: _____

Date of last physical exam: _____ Doctor: _____

Date of last dental visit: _____ Dentist: _____

Date of last vision exam: _____ Optician: _____

Is the client currently taking any prescription medications? __No __Yes → Please list below:

NOTE: Opiate based medications are not allowed at camp. Please indicate if any of the above are opiate based and if there is an alternative that can be prescribed for a 35 day residential treatment stay.

Medication	Dosage	For what Condition	45-day Supply?	
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is any of the above medication mind-altering? Explain: _____

Is the client currently taking any over-the-counter products? __No __Yes → Please list product and what for: _____

Does the client currently have any special dietary requirements? __No __Yes → If yes describe below: _____

High Risk and Priority Assessments

Has the client ever been tested for HIV? __No __Yes. Would client like to be tested for HIV? __No __Yes

Has the client ever been tested for Hepatitis (A, B, or C)? __No __Yes. Would client like to be tested? __No __Yes

Is client an injection drug user? → No __Yes Drug? _____ Last Used _____ With Whom? _____

FEMALES ONLY - Date of last period _____ Is client pregnant? __ No __ Yes __ Don't Know __ Think so
 ___ Any unusual vaginal discharge _____ Regular periods: Y N
 ___ Excessive menstrual bleeding: _____ Last PAP: _____
 Do you use Birth Control Y N Type of Birth Control used: _____ Last Pregnancy _____
 On Hormone Therapy Y N

Is client currently having thoughts of: Suicide __ No __ Yes Homicide __ No __ Yes
 Does the client have a history of attempted suicide or violent behavior toward self or others? Explain: _____

 Please rate clients risk for harm to: self? High Medium Low
 Please rate clients risk for harm to: others? High Medium Low

Is the client currently experiencing signs and symptoms of withdrawal – please check the following:
 None Nausea & Vomiting Tremor Sweats Tactile Disturbances Anxiety
 Agitation Auditory Disturbances Headache Orientation Visual Disturbances
 History of withdrawal problems: _____

NOTE: As an optional part of treatment, clients may take vitamin supplements for physical detoxification, including high doses of B vitamins. Would use of vitamins conflict with any of the client's medical conditions or medications?
 __ No __ Yes

Please comments on any concerns regarding client's ability to fully participate in all treatment activities.

Based on findings of Medical Evaluation, client: Is recommended for Old Minto Family Recovery Camp.
 Is not recommended for Old Minto Family Recovery Camp.

Signature of Physician, Nurse Practitioner or Physician Assistant _____ Contact Number _____ Date _____

Stamp or printed name of Provider _____

**Tanana Chiefs Conference, Behavioral Health
OLD MINTO FAMILY RECOVERY CAMP**

FILLED OUT BY A HEALTH CARE PROVIDER

TB TESTING VERIFICATION

PATIENT NAME: _____

DOB: _____

CHART: _____

The above named patient has had a tuberculin test/evaluation

Date test given: _____

Date test read: _____

Results: _____

Signature of Health Provider: _____ Date: _____

Printed name of provider _____

Tanana Chiefs Conference, Behavioral Health
OLD MINTO FAMILY RECOVERY CAMP

DENTAL EXAM SCREENING

FILLED OUT BY A DENTAL PROVIDER

Requested Service:

Please evaluate patient's Dental Health. Advise if patient is cleared to participate in treatment at the Old Minto Family Recovery Camp for 40 days without requiring emergency treatment.

Name _____ DOB: _____ Date _____

Patient was prescribed the following medication: _____ Non-narcotic
_____ Narcotic

(Please note: If the patient requires Narcotics for pain relief, they may not be able to enter treatment at Old Minto during this session).

Summary of Evaluation:

- It is unlikely that this patient will require emergency dental treatment.
- This patient is not cleared for OMFRC because emergency treatment will be required soon.

Dental Provider's signature

Date

Stamp or printed name of Dental Provider

**PLEASE ASK CLIENT IF THEY NEED RELEASE
OF INFORMATION (ROI) FOR THE
FOLLOWING AGENCIES:**

1. Anchorage Alcohol and Safety Action Program (AASAP)
2. Fairbanks Alcohol and Safety Action Program (FASAP)
3. _____ Alcohol and Safety Action Program
4. Lawyer
5. Office of Children Services(OCS)
6. Probation Officer
7. Tribal Court



**TANANA CHIEFS CONFERENCE BEHAVIORAL HEALTH
AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

Ph (907) 451-6682 ext 3630 Fax (907) 459-3814

Printed Name of Client: HRN:	Previous Names, If Applicable:
Date of Birth:	Daytime Telephone Number:
INFORMATION TO BE RELEASED FROM:	SEND INFORMATION TO:
Provider Name/Organization:	Name of Person/Facility/Organization:
Address:	Address:
Contact Number:	Contact Number:
Fax Number:	Fax Number:

The following specific confidential information:

Client Initial

1. _____
2. _____
3. _____

The purpose or need for this disclosure is:

- Further Medical Care Legal
 Personal Use/Request of Individual Benefits/Insurance Other (Specify) _____

The information may be transmitted via (consumer initial each approved means)

_____ fax _____ verbal _____ electronically _____ hard copy

I understand that:

- My health information is protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Consumer Records (42 CFR Part 2; and/or HIPAA, 45 CFR) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. If I am receiving Part 2 services, TCC may condition my treatment on whether I elect to sign an authorization for payment. If I am not receiving Part 2 services, I understand my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for services.
- I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. Submit written revocation to TCC Health Information Management 1717 West Cowles Street, Fairbanks, AK 99701. If not so revoked, this consent automatically expires on: (specify) _____
- For substance abuse treatment records that are covered by 42 CFR Part 2, Federal law prohibit the recipient of these records from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse participant. For all other medical records covered only by HIPAA information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by HIPAA rules.

I further acknowledge that the information to be release has been explained to me and certify that this consent is being given of my own free will.

_____ Signature of Clients	_____ Printed Name of Clients	_____ Date
_____ Signature of Parent/Guardian (if required)	_____ Printed Name of Parent/Guardian	_____ Date
_____ Signature of Staff/Witness		_____ Date

For TCC's Use:

- Date Received: _____
 Fees explained if needed: _____
 Verification of Identity and Authority _____
 Identification: _____
 Information sent by: _____