stepping stone of san diego

TREATMENT SERVICES SCREENING PACKET

Thank you for your interest in Stepping Stone of San Diego's treatment program. Below you will find the admission procedures that must be followed in order to enter our program.

1. Complete a screening packet (enclosed) and bring with you in person to our orientation meeting which is held each Tuesday starting at 9:00 am at Stepping Out Outpatient Services located at 3928 Illinois Street, San Diego, CA 92104.
2. Screening packet are only accepted in person. Please do not mail in or email or fax in.
3. In addition to the screening packet, a current TB (tuberculosis) skin test must be submitted with screening packet. TB test cannot be older than 60 days. If your TB test is positive a chest exam will be required.
4. Individuals seeking treatment who are HIV positive will need to provide a third party verification of diagnosis from your physician at time of admission.
5. Upon submission of completed screening packet and TB test individual will be screened by one of our counselors to determine if Stepping Stone or Stepping Out will be able to serve your needs.
6. If for any reason you would like to speak with an intake specialist prior or after this orientation meeting, please call us at to 619-584-4010 ext. 118 and ask to speak with Damon Robinson.

If Stepping Stone's programs are not the appropriate levels of treatment, you will be given referrals to the appropriate facilities.

We realize that finding services can be frustrating and difficult at times. Stepping Stone Residential Treatment may not have immediate bed availability. We understand that due to cultural considerations you may want to wait until there is an available opening. If you would like to wait for bed availability, please let us know this. When there are no openings for admissions, you will be asked to attend all of Tuesday and Friday groups as well as 3 outside meetings until an opening is available.

If you want to get into services as soon as possible, please let us know and we will work to find a treatment center that has beds available.

In order to remain on the referral tracking log you must remain in contact with us! If after 30 days we do not hear from you, your name will be removed from our referral tracking log.

The screening group provides support and an overview of programming. Staff will answer any questions you may have at that time. Stepping Stone is committed to welcoming and assisting people who come to our doors.

Stepping Stone of San Diego, Inc. | Serving the LGBT Community for over 40 years • Federal Tax ID No. 95-3080619. Stepping Stone is a 501(c)(3) nonprofit organization funded by donor contributions and in part by other funding sources. This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health Services (HHS) under contract H89HA00001, HIV Emergency Relief Project Grants for a contracted amount with the County of San Diego. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, the U.S. Government of the county of San Diego.

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TREATMENT SERVICES WELCOMING POLICY

Stepping Stone welcomes all individuals for services related to alcohol and drug addiction, and those in need of life-threatening recovery from co-occurring conditions. It is our mission to primarily serve the Gay, Lesbian, Bi-Sexual and Transgender community as well as all individuals seeking recovery. However, we recognize that our clients often have other medical and psychiatric conditions that interact with and impact their addiction. We are committed to providing the most holistic and comprehensive recovery and treatment services for clients. In order to help clients achieve the best stabilization in all areas, we recognize the importance of integrating attention to these other medical and psychiatric issues throughout the treatment process at Stepping Stone. It is part of our program to provide referrals and support for linkages to services related to these other co-occurring conditions and to incorporate those services into the client's treatment plan and recovery process.

It is recognized that when a person enters Stepping Stone, he/she is reaching out for help and deserves a welcoming response. We take responsibility for assisting each person to make sure that he/she is connected to a relationship that integrates attention to his/her multiple needs while in addiction treatment. In addition, we are committed to making sure that the appropriate resources and referrals are made available whether the individual will be admitted to our treatment facility or not. The life of each person is precious, and we have an important part in welcoming him/her into sober, healthy living, including recovery from co-existing medical and psychiatric conditions.

If you have an experience that is different from what is described above, please feel free to contact the Case Manager, Sandra Koellmann, ASW at 619-584-4010 x 119 or at sandra@steppingstonesd.org. We appreciate and value your input.

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COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

TREATMENT SERVICES SCREENING INFORMATION

Date: _____

Name: _____**DOB:**_____

Phone #: _____ **Alternate Phone #:** _____

Best time to call? _____ **Email Address:** _____

Current Address: _____

_____

Total Monthly Income: _____

Source(s) of Income:

_____ **Employed** **Where** _____
_____ **Unemployment** **How long** _____
_____ **SSI**
_____ **SSDI**
_____ **SDI**
_____ **Family Support**
_____ **Other** _____

Valid form of identification (must have both upon intake):
Social Security Card: YES NO **Valid ID card or driver's license: YES NO**

Please circle if you have Medi-Cal or private insurance

Private Medical Insurance:)
Name of Carrier:_____ **Policy or Group #:**_____
Name of insurance policy holder, social security # and DOB:_____

What substances are you having difficulty with?

Are you an IV user? _____ yes _____ no For how long? _____

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LEGAL STATUS QUESTIONNAIRE

1. **Are you presently on parole or probation? (circle) YES NO**

2. **Have you been arrested in the past 30 days and if so, what for?**

3. **Please explain any incarceration since age of 18?**

HEALTH STATUS QUESTIONAIRE

Do you have any physical health issues such as diabetes, asthma, thyroid, high blood pressure or heart disease we should know about or that hamper or impede you in your daily activities?
(This information should not affect your status on suitability to residential, but will help us in the screening process to meet your needs)

Do you have any allergies to food or medication? (please list all)
(This information should not affect your status on suitability to residential, but will help us in the screening process to meet your needs)

Do you have any chronic illness such as HIV? __Yes _____ No

If yes, indicate diagnose: _____ Date of diagnosis _____

I understand that the only service animals Stepping Stone accepts into their residential services are animals for the seeing or hearing or physically impaired. Do to the nature of the services provided all other service animals must be excluded. _____(Initials)
Do you know any family members or people you have been in relationship with that are receiving services from Stepping Stone? _____

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MENTAL HEALTH INFORMATION

Name: _____ **Date:** _____

Date of most recent hospitalization for psychological problems: _____

Reason for hospitalization: _____

_____

Please list any psychiatric diagnosis that you may have received.

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

Agency or name of Psychiatrist/Therapist: _____

Phone Number: _____ **Email:** _____

PRIOR PSYCHIATRIC TREATMENT HISTORY:

Type: Outpatient, Inpatient, Hospital, Therapy	Agency: UCSD, Scripps, Kaiser, Sharp, etc.	Date Started and Ended	Outcome

_____ **# of suicide attempts** _____ **# of hospitalization for suicide attempts**

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Current Medication List

Please list all Medications currently prescribed:
(Examples – Benzodiazepine aka Benzo's, Wellbutrin, Tramadol, Vicodin, Suboxone, Valium etc.)

Name of controlled medication	Prescribed dosage	Reason/Symptom it treats

Are you currently receiving medically assisted treatment? _____ yes _____ no

Name of Facility: _____

Name of Physician: _____

If you receive a new medication prior to intake you MUST INFORM staff. We may need to consult with the prescribing physician about your status of entry into treatment. Any non-disclosure may result in delay of intake.

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Alcohol & Drug History

Client Name:_____Date:_____

Drug (Circle if Ever Used)	Drug Name	Age First Used	Age Regular Use Began	Frequency 30 Days Prior to Treatment	Usual Route (Oral, Smoke, Inhalation, I.V.)	Date Last Used	Average Amount Used at One Setting	Problem Rank*
Alcohol								
Amphetamine								
Cocaine								
Heroin								
Marijuana/Hash								
Other Opiates								
Sedatives								
Hallucinogens								
Inhalants								
Club Drugs								
PCP/Angel Dust								
Non-Prescribed Methadone								
Over The Counter								
Other								

*Rank is numerical with 1 being most troubling substance.

Staff Signature:_____Date:_____

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Limits on Client/Therapist/Treatment Team Confidentiality

Although confidentiality and privileged communication remain rights of all clients of mental health practitioners according to the law, there are conditions that the therapist/staff counselor is required to disclose confidential information to the appropriate persons.

- You have disclosed, or your therapist believes, that you are a danger to yourself.
- You have disclosed, or your therapist believes, that you are a danger to others.
- You have disclosed child neglect, sexual abuse, physical abuse, and/or emotional abuse in the home.
- You have disclosed knowledge of child neglect, sexual abuse, physical abuse, and/or emotional abuse in the home.
- You or someone else's child has witnessed domestic violence.
- You are a person over 65 and your therapist believes you are the victim of physical abuse and/or serious neglect.
- You disclose elder abuse either in your own home or in the community at large.
- You are unable to care for yourself and would be considered gravely disabled.
- You waive your rights of privilege or give consent to limited disclosure by your therapist.

Group – Staff group facilitators will maintain confidentiality with the exception of the above circumstances, but cannot guarantee your confidentiality by other group members. It is requested that group members maintain confidentiality with each other in order to provide safety. ***Any breach of confidentiality may be grounds for discharging from the program.***

Treatment Team – Confidentiality within the Treatment Team is maintained with the exception of the above circumstances. It is understood by the undersigned that confidentiality extends to the treatment team and that the treatment team consist of staff, interns, and clinical staff.

I _____ have read and understand the above information and consent

(Print Name)

the parameters of confidentiality in my treatment.

_____ _____

Signature of Client **Date**

_____ _____

Signature of Staff **Date**

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SCREENING NOTES

CLIENT NAME: _____

AOD COUNSELOR/PEI STAFF: _____

DATE	NOTES

Completed screening packet _____ TB Test attached _____ Letter of Diagnose_____