Hope & Recovery Center
210 Starting Point Dr. Ponca City, Oklahoma 74601
PHONE (580)749-7322 FAX (580) 304-7901

Dear Potential Client,

We would like to thank you for inquiring about admissions to our 60-day residential treatment program. The application must be completed in full, with all required forms as soon as possible. Your application will not be accepted until all forms are complete. Once your application has been received in full, our admission staff will contact you to complete a interview. You will be notified as soon as possible of admission, being placed on a waiting list if needed, or referred to another treatment facility more appropriate for your needs. Application needs to be completed within 30 days, or it will not be considered, and you will have to reapply.

Admission Criteria:

1) **The client should be mobile. The facility meets the standard for handicap use, and the client must be able to follow the basic physical demands of our treatment program. Client must be physically & mentally capable of carrying out the basic detail duties that are rotated among clients each week.**
2) **The client must be eighteen (18) years of age or older. Married, engaged, or cohabitating couples will not be accepted concurrently.**
3) **Client must be willing and able to participate in his/her treatment program.**
4) **Each client will be required to have a full physical prior to admittance.**
5) **If you are court ordered to attend treatment you will need to provide documentation from the court. If you have an active warrant, we will still review your application.**

If you have any questions, please contact our admissions office at (580) 749-7322.

Thank you,

Admissions Team

CHECKLIST

ON THIS PAGE YOU WILL FIND ALL THE REQUIRED DOCUMENTS THAT WE NEED IN ORDER FOR YOUR APPLICATION TO BE COMPLETE. YOU MAY TURN IN EVERYTHING AT ONCE, OR SEPARATELY, AND WE WILL KEEP EVERYTHING IN A FILE FOR YOU. OUR FACILITY IS A FIRST COME FIRST SERVE BASIS, BUT YOU MUST HAVE EVERYTHING ON THE CHECKLIST TO BE CONSIDERED FOR ADMISSION.

___CLIENT INFORMATION/LEGAL INFORMATION (Page 4)
___SUBSTANCE USE HISTORY (Page 5)
___Certificate Degree of Indian Blood (Copy of CDIB)
___Driver's License/State ID or Social Security Card
___MEDICAL EXAMINATION REPORT
(Completed by a physician/clinic ONLY) (PAGE 6)
___HEPATITIS PROFILA A, B, & C READINGS IN LAB FORMAT
___Tuberculosis (TB)/PPD TEST* Results
___UPDATED LIST OF CURRENT MEDICATIONS
(That has currently been prescribed by your physician)
___OTC Medication Routine Order Form:
Completed by the physician/clinic (PAGE 7 & 8)
___COPY OF INSURANCE CARDS (IF APPLICABLE)
___AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (ROI-Page 9)
___COMPLETED White Eagle Health Center Application:
The client will need a chart set up before accepted into the treatment program.

Please send application to:

- FAX documents: **580-304-7901**
- SCAN and EMAIL DOCUMENTS: francis.primeaux@ihs.gov
- BRING DOCUMENTS TO HOPE & RECOVERY CENTER DURING BUSINESS HOURS M-F, 8:00 AM – 4:30 PM
  LOCATED AT: 210 STARTING POINT DR, PONCA CITY, OK 74601
- MAIL DOCUMENTS TO: HOPE AND RECOVERY ADMISSIONS
  200 WHITE EAGLE DR.
  PONCA CITY, OK 74601

***LAB TESTS:** **(TB/PPD, HEP)**

Must read negative, to qualify for admission. Positive test results are handled as special circumstances.

***ASSESSMENT PRIOR:**

After submitting the application with all necessary documents, you will receive a call to schedule an interview with our admission staff prior to being admitted. THIS IS A REQUIREMENT FOR ALL POTENTIAL CLIENTS.

***STAY IN CONTACT:**

IF YOU CHANGE YOUR PHONE # OR ADDRESS LET US KNOW ASAP.

***REFERRALS:**

IF REFERRED BY A FACILITY, WE WILL NEED DISCHARGE PAPERWORK/SUMMARY

***PLEASE KEEP PAGES 10 & 11:**

THIS IS THE INFORMATION FOR YOU IF ACCEPTED.

Application for Inpatient Treatment

CLIENT INFORMATION

FIRST NAME: _____ MI: _____ LAST NAME: _____

DOB: _____ AGE: _____ GENDER: _____ TRIBE(S): _____

MAILING ADDRESS: _____ CITY, STATE, & ZIP: _____

PHONE #: _____ EMAIL: _____

HAS APPLICANT PARTICIPATED IN RESIDENTIAL TREATMENT PROGRAM BEFORE? YES NO
IF YES, PLEASE PROVIDE DATE AND LOCATION OF PRIOR TREATMENT:

_____
LOCATION OF TREATMENT & DATE

LEGAL INFORMATION

ARE YOU COURT ORDERED TO ATTEND TREATMENT? _____ YES _____ NO

IF YES, PLEASE PROVIDE DOCUMENTATION

HAVE YOU EVER BEEN ARRESTED OR CHARGED WITH A CRIME INVOLVING DOMESTIC VIOLENCE AND/OR ASSAULT? _____ YES _____ NO

PLEASE LIST YOUR ATTORNEY OR PROBATION OFFICERS NAME (IF APPLICABLE):

_____

PHONE #: _____

SUBSTANCE USE HISTORY

SUBSTANCE Circle specific substance(s) or print name	DATE LAST USED	AMOUNT USED
Alcohol: beer, wine, coolers, liquor, homebrew, Lysol, hairspray, mouthwash, aftershave, sanitizer, etc.		
Cannabis: marijuana, medical marijuana, pot, hash oil, etc.		
Cocaine: crack, coke, powder, etc.		
Amphetamine: crystal meth, speed, diet pills, etc.		
Inhalants: Lacquer, glue, paint thinner, gasoline, aerosol sprays, etc.		
Club Drugs: Ecstasy (MDMA), GHB, Rohypnol, Ketamine, etc.		
Hallucinogens: (LSD, mushrooms, PCP, etc.)		
Illicit Street Opiates: (heroin, morphine, etc.)		
Prescription Opioids: Codeine (T-2s/T-3s), Oxycontin, Percocet, Darvon, Morphine, Demerol, etc.		
Prescription Depressants: Diazepam (Valium), Lorazepam (Ativan), Halcion, Librium, Xanax, Barbiturates, etc.		
Prescription Stimulants: Ritalin Dexedrine, Adderall		
Over the Counter Drugs: Codeine (T-1s), Gravol, Cough Syrup		
Smoking Tobacco		
Smokeless Tobacco		
Other:		

MEDICAL EXAMINATION REPORT

FIRST NAME: _____ LAST NAME: _____
DATE OF BIRTH: _____ AGE: _____

This form is to be completed by a physician or nurse only.

Please note we will need labs for hepatitis a, b, & c, along with TB/PPD skin test results.

MEDICAL	NORMAL	ABNORMAL
Appearance		
Eyes/Ears/Throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Skin		

MUSCULOSKELETAL	NORMAL	ABNORMAL
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

ALLERGIES? ___ YES ___ NO

DOES THIS APPLICANT SMOKE? ___ YES ___ NO

DIABETIC? ___ YES ___ NO

HIGH BLOOD PRESSURE? ___ YES ___ NO

HEIGHT: _____ WEIGHT: _____

BLOOD PRESSURE READING: _____ / _____

IS THIS APPLICANT ABLE TO PARTICIPATE IN DAILY WALKING, LIGHT EXERCISE, & BASIC CHORES? ___YES ___NO

PRESCRIBED MEDICATION	PRESCRIBED DOSAGE	MEDICATION USED FOR

_____ _____
PRINTED NAME OF EXAMINER NAME OF MEDICAL FACILITY

_____ _____ _____
SIGNATURE OF EXAMINER DATE CONTACT NUMBER

OTC Medication Routine Order Form

There must be an authorization by a physician or physician assistant or nurse practitioner in the adult's file for use of any medications. This would include over the counter medications. This form is designed as a convenient means to satisfy the physician order requirement in situations where the physician feels comfortable authoring RMA or equivalent orders for some common and safe over-the-counter medications. RMA orders are never allowed for medications used to alter behavior for adults with developmental disabilities.

Patient Name: _____DOB: _____

Known Allergies: NO _____ YES ____ If yes, please specify: _____

Initial of Approved **Standing Orders**

_____**TYLENOL:** 325 mg, 1-2 tablets every 4-6 hours as needed for pain or temp. (101 F or greater).
CHANGES: _____

_____**IBUPROFEN**: 200 mg, 1-2 tablets every 4-6 hours as needed for pain or temp. (101 F or greater).
CHANGES: _____

_____**PEPTO BISMOL:** Chew 1-2 tables every ½ hour as needed for diarrhea and/or nausea. Not to exceed 8 doses in 24 hours.
CHANGES: _____

_____**MYLANTA OR MAALOX:** 30CC times daily as needed for heartburn.
CHANGES: _____

_____**TUMS:** 1-3 tablets every 8 hours as needed for muscle cramps or heartburn.
CHANGES: _____

_____**MILK OF MAGNESIA (MOM):** 30cc daily for 3 days with no bowel movement. May repeat 2 times and if no results, call Doctor.
CHANGES: _____

_____**COUGH SYRUP:** 1-4 tsp. every 4 hours as needed for cough. Not to exceed 24 tsp. in 24 hours.
CHANGES: _____

_____**CEPASTAT LOZENGES:** Suck 1 tablet every 2-3 hours as needed for sore throat.
CHANGES: _____

_____**BENADRYL:** Used only for bee stings, rashes, or bug bites creating an itch. When used to alter behavior and individual prescription is necessary.
CHANGES: _____

_____**BACITRACIN OINTMENT OR NEOSPORIN:** Apply as needed up to 2 times in a 24-hour period to cuts and scratches after cleansing with soap and water.
CHANGES: _____

_____**HYDROGEN PEROXIDE:** Clean wounds with this prior to applying antibiotic ointment.

CHANGES: _____

_____**HYDROCORTISONE** 0.5% CREAM: Apply as needed up to 3 times in 24 hours to itchy skin or rash.

CHANGES: _____

_____**BENZOLPEROXIDE** UP TO 0.5%: Wash or apply solution to face at bedtime as need for acne.

CHANGES: _____

_____**MULTIPLE VITAMIN:** 1 daily (Do not give with Iron without a Doctor's Order)

CHANGES: _____

_____**FIRST AID:** As needed per American Red Cross standards

CHANGES: _____

_____**MELATONIN:** 1-5 mg – 30 minutes before bedtime.

CHANGES: _____

_____**OTHER:** _____

_____**OTHER:** _____

_____**OTHER:** _____

_____**OTHER:** _____

_____**OTHER:** _____

_____**OTHER:** _____

COMMENTS:

_____

_____

_____

_____

_____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

Physician's Name: _____

Physician's Phone Number: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Form Approved: OMB No. 0917-0030
Expiration Date: December 31, 2026
See OMB Statement on Reverse.

Complete all sections, date, and sign

I. AUTHORIZATION

I, _____ , hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

II. THE INFORMATION IS TO BE DISCLOSED BY:	III. AND IS TO BE PROVIDED TO:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

IV. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐ Treatment, Payment or Other Healthcare Operations ☐ Attorney ☐ School ☐ Other *(Specify)* _____
☐ Personal Use ☐ Disability ☐ Research ☐ Health Information Exchange *(IHS/Other)* _____

V. THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____
☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Substance Use Disorder Treatment/Referral ☐ HIV/AIDS-related Treatment ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Sexually Transmitted Diseases ☐ Psychotherapy Notes ONLY *(by checking this box, I am waiving any psychotherapist-patient privilege)*

VI. AUTHORIZATION

I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

(Specify new date (mm/dd/yyyy) or expiration event)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SPECIFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS: I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Insurance Exchange.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE *(mm/dd/yyyy)*
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE *(mm/dd/yyyy)*

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	
ADDRESS	
CITY/STATE	
DATE OF BIRTH *(mm/dd/yyyy)*	RECORD NUMBER

PSC Publishing Services (301) 443-6740 EF

ADDITIONAL INFORMATION

Smoking

- Smoking is allowed in designated areas outside of the facility.
- Clients are to provide their own cigarettes and vape.
- Staff and Clients may not provide cigarettes and vape to other clients.

Phone Call

- Phone calls are between 4:30 pm- 9:00 pm. All clients will be allowed one 15-minute phone call daily (Sunday to Saturday)
- All calls will be approved by case manager, counselor, and other authorized staff.

Mail

- Mail is allowed to be sent out daily.
- Must have own postage stamps.
- No mail will be accepted from Department of Corrections or jails.
- Mail will be screened by staff and dispersed to client after.
- No mail will be given to client that could be hazardous or inappropriate.

Electronic mail

No electronic devices are permitted in the Hope and Recovery facility. **No cell phones, tablets, laptops, etc.** are allowable in the facility at any time.

ADMISSION ITEMS

Items Needed:

- Blankets, sheets, comforters, pillows fitted for a twin-size bed.
- Towels and washcloths.
- Hygiene products (shampoo, bodywash etc.)
- 5-7 days of clothes. Be sure to have weather permitting clothes (jacket/coat)
- Proper gym clothing for working out (shoes, sweatpants, etc.)
- Paper, stamps, envelopes.
- Cigarettes, gum, and patches.
- Medication with at least 30-day supply.
- Court, DHS/ICW papers if applicable.
- All money will be locked in a lock box. No large amounts will be allowed.
- Books are allowable.

Do Not Bring

- Any substances (drugs, alcohol)
- Any electronic devices (radio, cellphone, etc.)
- Weapons (knives, guns, etc.)
- No clothing promoting substance use.
- No alcohol-based substances (mouthwash, fingernail polish remover, etc.)

Dress Code:

Women:

- No sleeveless shirts, strapless tank tops, etc.
- No low-cut shirts
- No miniskirts, short shorts, jeans with rips above the mid-thigh.
- Appropriate clothing for gym (no tight leggings).

Men:

- No tank-tops
- No shirt or shorts/jeans ripped or tears in inappropriate places.
- Appropriate clothing for gym.

***Any item deemed unacceptable will be taken away until after discharge. Anything that is left behind will be disposed of after one (1) week from leaving the facility.**