AIDS Housing Technical Assistance

Bobby White Housing Services

Cedar Family Home

Health, Wellness and Education Initiative

HPRP – "50 Families"

Joelyn's Family Home

The Living and Recovering Community (LARC)

New Victories

Portis Family Home

ReVision Family Home

ReVision Urban Farm

Ruah House

Shepherd House

Victory House

Victory Housing on Warren Street

Victory Transitional House

Women's Hope

Women's Hope Transitional House

LARC Program
Lemuel Shattuck Hospital
170 Morton St. 11 North
Jamaica Plain MA 02130

Tel: 617.522-2936
Fax: 617.522-1345
Web: www.vpi.org

Updated 11.2011

ADDICTION STABILIZATION OPPORTUNITIES FOR PERSONS LIVING WITH HIV

Overview of Program:

The **Living and Recovery Community** (LARC) is an intensive residential program which offers comprehensive substance abuse stabilization and case management/housing search services for up to 90 days. Such services are provided within a treatment-planning model that is individualized to meet the unique needs of each client. In this way, LARC offers a safe and structured space in which program participants can focus on establishing or re-establishing rituals of recovery and wellness that enhance quality of life.

Populations Served:

LARC serves men and women living with HIV/AIDS and alcoholism and/or drug addiction whose histories of addiction relapse have jeopardized their ability to access and/or maintain stable residency in either treatment or housing programs. LARC fully integrates persons involved in methadone treatment into the stabilization program.

Stabilization Services:

- Individual Addiction/Relapse Prevention Counseling
- Group Counseling (over 30 groups weekly)
- Comprehensive Case Management
- Housing Search Counseling and Advocacy
- Stress Reduction Trainings
- Life Skills Building, Medication Management and Stress Reduction Techniques

Program Eligibility Criteria:

- 18 years of age or older
- History of alcoholism and/or drug addiction with recent instability/relapse
- HIV infection
- Medical clearance for inpatient substance abuse treatment (detoxification from all illegal and/or unprescribed substances)
- Medical, psychiatric and neurologic stability with the ability to engage in the program
- Non-infectious tuberculosis status

Location:

LARC is located on the 11th floor (north) of the Lemuel Shattuck Hospital in Jamaica Plain. The hospital building itself is situated on the edge of Franklin Park within walking distance of the Forest Hills Orange Line T Station.

Facilities:

The LARC program has 20 comfortable private and semi-private beds, 4 spacious bathrooms, an ample kitchen and dining area, a large solarium/group room, and several staff office spaces. In addition, LARC has laundry facilities which include clothes washers and dryers. The LARC program is handicapped accessible.

FOR MORE INFORMATION, PLEASE CALL THE LARC PROGRAM 617-522-2936

Thanks for your interest in LARC. The following information is designed to guide you through the application, intake and admission process

ADMISSION DOCUMENTATION

To be eligible for admission, an applicant **must provide** documentation of the following:

1. A history of alcoholism and/or drug addiction
2. Medically, Psychiatrically and Neurologically able to participate in an intense treatment program
3. HIV infection, including CD4 count and Viral Load Number (within last 4 months)
4. Medical clearance for inpatient treatment (detoxed from all illegal and unprescribed substances)
5. Recent instability in her/his addiction recovery (relapse or risk of relapse)
6. Verification of Financial Resources and Expenses

In order for the application to proceed, all release formsneed to be signed allowing the clinical staff of Victory Programs Living and Recovering Community (LARC) to communicate with their primary care physician, mental health provider(s), methadone provider, and any other relevant care providers.

ADMISSION PROCESS

Phone Screening

An initial phone screen is conducted to insure that the applicant meets the eligibility criteria.

Document Completion

The identified provider coordinates the completion and return of required forms and the submission of appropriate documentation, including:

- Program Application Form.
- Physician's Referral Form.
- Applicant's Consent to the Release of Information Form(s)
- Financial Resources and Expenses Verification Documentation
- Methadone Provider's Referral Form (if applicable)

Face to Face Interview

The applicant comes to LARC for an interview with program staff. This interview includes:

- The initial intake assessment
- Signing of necessary releases to continue the intake process
- Signing of the Client Agreement to Program Participation and the Client Agreement to Rights and Responsibilities

Program Acceptance

- Once the applicant has been accepted for admission to LARC, s/he will be notified by phone.

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Client's Consent to the Release of Information

I, ____, authorize the staff of the referring program ____,

and the staff of The Living And Recovering Community (LARC) to exchange any information regarding my addiction, health care, and case management needs and resources that may be useful in facilitating my application and possible admission to the LARC program. I understand that my records are protected under the federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Pts. 160 & 164, 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, and that in the event this consent expires one year from its execution or upon the withdrawal of my application or my discharge from the LARC program.

_____________________________ _______________________
Signature of Client Date

_____________________________ _______________________
Signature of Witness Date

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Referring Provider's Form

GENERAL INFORMATION

Applicant's name: ____

Current address:____

Telephone #: ____

Age: ________ Date of birth: _________ Gender: _________ Pregnant (Y/N) _____

SS#: ________________________________ Language(s) spoken: _______________

Has the applicant participated in the LARC program before? ________ When? _____

REFERRING PROVIDER INFORMATION

Name of referring provider: _____________________________________

Relationship to applicant: ______________________________________

Agency: ____

Address:____

Phone: ___________________________________ Fax:_______________________

Provider's signature and date:___________________________________

Reasons for LARC Referral: ______________________________________

____

____

____

____

ADDICTION AND RECOVERY STATUS

Description of applicant's most recent addiction relapse: ______________________

____

Description of applicant's current recovery status:_____________________________

____

Description of current alcohol/ drug usage (if applicable): ______________________

____

Description of applicant's detoxification needs: ______________________________

Is the applicant involved in methadone treatment? Yes___ No: ___ Dosage: ______

Methadone provider agency name and #: _________________________________

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MEDICAL INFORMATION AND STATUS

Name of primary care physician: ____

Physician's phone number: ____

Other involved health care agencies (CMA, VNA,…)?: ________________________

Date of HIV diagnosis: ____

Opportunistic infections and dates: ____

____

Does applicant have any neurological involvement related to HIV? Please describe:

____

____

Current medications: ____

____

____

____

Current medical status: ____

____

HOUSING INFORMATION AND STATUS

What is the applicant current housing situation?_________________________________

____

Is applicant's current housing situation safe? __________________________________

____

What are the applicant's housing needs? _______________________________________

____

Amount of monthly rental payment (if applicable): ____________________________

MENTAL HEALTH INFORMATION AND STATUS

Is applicant currently seeing mental health care provider? Yes____ No____

How frequently? __________________________ Date of last visit:_________________

Mental health care provider's name: ____

Mental health provider's phone #:____

Psychiatric history (include diagnosis and type of treatment):

____

____

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CASE MANAGEMENT INFORMATION

What are the applicant's immediate case management needs?

____

____

What workers/ agencies are providing case management support to the applicant at present?

____

____

LEGAL ISSUES

Does the applicant have legal cases pending, and if so, what is the current status of these legal issues?

____

____

FINANCIAL INFORMATION

Applicant's total current monthly household income: ________________________________

Current sources of income (include employment, benefits, food stamps, other sources):

____

Medicaid number and type: ____

Recipient identification number (if applicable): ______________________________

Other Insurance (CMA, NHP, HCHP)? ____________________________________

SUPPORT STATUS

Married: ____ Unmarried: _____ Divorced: _____ Widowed: _____ Couple: _____

Name of significant other (if applicable): ______________________________

Does applicant have children, and if so, how many?_________________________

Describe applicant's "family" and/or system of support: ______________________

____

Describe presence of addiction in applicant's family? _________________________

____

____

____

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NOTE: ALL INFORMATION ON THIS PAGE MUST BE COMPLETED AND SIGNED FOR THE APPLICATION TO BE PROCESSED

Request for Physician's Certification of HIV/AIDS Status

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____________________ Name of Client

____________________ Client's Date of Birth

____________________ Name of Primary Care Physician

____________________ Physician's Phone Number

Authorization for Release of Information

I, ____________________, authorize my physician,____________________, to disclose to LARC the information requested on this form to assist in my admission to and participation in the LARC program. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and drug Abuse Patient Records, 42 CFR Part 2, 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, and that in any event this consent expires one year from its executions or upon the withdrawal of my application or my discharge from the LARC program.

____________________ Signature Client

____________________ Signature of Witness

PHYSICIAN'S CERTIFICATION

I, ____________________ (please print name), am currently providing medical care for ____________________ at the following clinic/hospital, ____________________. As such, I certify that he/she;

- ☐ a diagnosis of AIDS
- ☐ is HIV symptomatic
- ☐ is HIV asymptomatic

LAB INFORMATION

The following blood counts, indicated below, have been taken within the last four months;

CD 4 Count	Viral Load	Date of Lab Work

____________________ *Signature of Medical Provider*

____________________ *Date*

victory programs
OPENING DOORS TO HOPE, HEALTH AND HOUSING

NOTE: ALL INFORMATION ON THIS PAGE <u>MUST BE COMPLETED AND SIGNED</u> FOR THE APPLICATION TO BE PROCESSED

MEDICATION INFORMATION and ADDITIONAL MEDICAL INFORMATION

The applicant, ______________________________, is currently on the following medication regimen. Please complete the below list accurately or attach a copy of the applicant's current medication list. For this application to be processed further, an applicant must have a **<u>30 day supply of medication</u>** should he/she be admitted to the program.

HIV/AIDS Medication:

Medication Name	Dosage	Frequency

Other Medications:

Medication Name	Dosage	Frequency

☐ Tuberculosis Assessment is attached to this application

☐ Additional TB information is attached to this application

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United Way
United Way of Massachusetts Bay

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OVER THE COUNTER MEDICATION PERMISSION

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Client Name: ______________________________

Today's Date: ______________________________

The following over-the counter medications are permissible to use as indicated per manufacturer's recommendations on a PRN basis only and will not conflict with the client's current medication regimen. The medication doses are not to exceed the manufacturer's daily recommended dosages:

- ☐ Acetaminophen
- ☐ Ibuprofen
- ☐ Naproxen
- ☐ Aspirin
- ☐ Tums/Rolaids
- ☐ Other: ___________________________

Provider's Name: ____

Provider's Phone: ____

Provider's Signature: ____

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Methadone Applicants Only

NOTE: FOR METHADONE CLIENTS ALL INFORMATION ON THIS PAGE <u>MUST BE COMPLETED AND SIGNED</u> FOR THE APPLICATION TO BE PROCESSED

Methadone Provider's Referral Form

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______________________________ Name of Client

______________________________ Client's Date of Birth

______________________________ Methadone Provider Agency

______________________________ Staff Contact

______________________________ Mailing Address

______________________________ City, State and Zip Code

______________________________ Date of Client's Entry into Methadone Program

______________________________ Telephone Number

Client's Consent to the Release of Information

I, ______________________________, authorize the above agency, ______________________________, to disclose to LARC the information requested on this form to assist in my admission to and participation in the LARC program. I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2 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 it has been taken in reliance on it, and that in any event this consent expires one years from it's execution or upon withdrawal of my application or my discharge from the LARC program.

______________________________ Signature of Client

______________________________ Date

Methadone Provider's Information

Briefly describe the applicant's dosage history: ______________________________

____

____

Briefly describe the client's methadone treatment goal (i.e., detox or maintenance)

____

____

Documentation of most recent six urine toxicology screens:

Date	Results

Methadone Provider Staff Signature______________________________

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Methadone Applicants Only

NOTE: FOR METHADONE CLIENTS ALL INFORMATION ON THIS PAGE <u>MUST BE COMPLETED AND SIGNED</u> FOR THE APPLICATION TO BE PROCESSED

Methadone Aftercare Agreement

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Client Name: ________________________________ Date of Birth: _______________

Home Methadone Clinic: ____

Home Methadone Clinic Fax Number*:* _______________________________________

Home Methadone Contact Person: ____

Home Clinic Phone Number: ____

This is an agreement between the Living and Recovering Community (LARC) of Victory Programs, the client listed above, and his or her home methadone clinic listed above. While at LARC, the client is courtesy dosed at the Methadone Assessment and Treatment (MAT) of Roxbury Comprehensive Community Health Center, located at the Lemuel Shattuck Hospital in Jamaica Plain, the same building in which LARC is located. Upon discharge from LARC the MAT Program ceases courtesy dosing for the LARC client, and the client must return to his or her home clinic for continued dosing.

This is an agreement that, ____,
(client name)

will resume services at his or her home clinic, _______________________________,
(home clinic name)

after discharge from the LARC Program. The home clinic will be notified when the client is discharged from LARC by staff of the LARC program and/or the MAT Program. Further arrangements to coordinate care can be made by contacting LARC.

Client Signature: ____ Date: ________

Home Clinic Staff Signature: __________________________________ Date: ________

LARC Staff Signature: _______________________________________ Date: ________

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WHAT A CLIENT NEEDS TO BRING

Clients who are admitted to LARC should bring the following items:

- ☐ Casual day time clothes, pajamas and a robe
- ☐ It is suggested that valuables not be brought into the program
- ☐ Toiletry items, shampoo, toothpaste, etc.
- ☐ Towels, washrags, etc.
- ☐ Small alarm clock
- ☐ Comfortable shoes
- ☐ Comforter and your own pillow
- ☐ Insurance card/picture ID
- ☐ Money to purchase small items
- ☐ Small radios (televisions are not permitted)
- ☐ Cell Phone (policies will be explained during intake)

Laundry facilities are available on the floor, but you need to bring your own laundry detergent as each new admission is required to wash his or her clothing upon admission.

DRESS CODE

As this is a coed program, clients are not expected to wear clothing that is sexually provocative or explicit. All shorts must be of appropriate length and undergarments must be worn at all times. Pajamas are not permitted to be worn to groups, on the floor after morning wake up routine or outside during fresh air breaks. Any clothing with references to drugs, alcohol, tobacco or gambling are not permitted. Shirts and shoes should be worn at all times for sanitary reasons.

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Community Servings: Home Delivered Meals Program
Certification Form

Applicant/Client Section: I hereby authorize my physician, nurse practitioner or physician assistant to release information regarding my medical condition to Community Servings for the purpose of verifying my eligibility:

______________________	______________________	______________
Client Name	Signature	Date

Healthcare Provider Section:

Community Servings provides home delivered meals to clients at a critical stage of a life-threatening illness. On behalf of the applicant/client noted above, please complete this form with all relevant information. Once completed, **please fax: 1) completed certification form, 2) laboratory results, and 3) medication list to Community Servings, Client Services at 617-522-7770.** The certification form and laboratory results help us assess client eligibility, and the medication list helps our Registered Dietitian assess appropriate diet. Thank you for your help in serving our clients!

Applicant/Client: Height: ________ft. _______in. Weight: _______________

A. PRIMARY DIAGNOSIS: Check all that apply.

- ❑ HIV+
- ❑ AIDS (CDC defined) Year of diagnosis: ______
- ❑ Cancer specify type: ___________________
- ❑ Renal Disease
- ❑ Diabetes: I or II (circle one)
- ❑ Lung Disease
- ❑ Cardiac Disease
- ❑ Multiple Sclerosis
- ❑ Other – Please specify: _______________________________

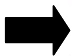
B. MEDICAL CONDITIONS RELATED TO ILLNESS: Patient exhibited the following conditions in the past 30 days:

- ❑ End of life care – Please describe: _______________________________________
- ❑ Severe diarrhea, nausea, or vomiting (circle ones applicable)
- ❑ Oral or esophageal lesions preventing adequate nutritional intake
- ❑ Peripheral neuropathy significantly limiting standing and/or ambulation
- ❑ Anemia or other condition causing severe fatigue or shortness of breath
- ❑ Wasting (unintentional weight loss of more than 5% usual body weight)
- ❑ An opportunistic infection, neoplasm, or dementia (circle ones applicable) Describe: ____________
- ❑ Chemotherapy or radiation therapy (circle ones applicable) Frequency of treatment: ____________
- ❑ Mental Illness – Please describe: _______________________________________
- ❑ Other – Please describe: _______________________________________

C. MOBILITY: Factors that would impact a client's ability to maintain a healthy diet & independent lifestyle.

- ❑ Bed bound
- ❑ Can't stand for more than 15 minutes at one time.
- ❑ Can't walk more than 50 feet at one time.
- ❑ Can't carry a weight of more than 15 lbs.
- ❑ No cooking facilities
- ❑ Other_______________________________________

My signature certifies the medical information provide above.



______________________	______________________	__________
Physician/NP/PA Signature	Clinic or Hospital Affiliation	Date

______________________	______________________
Print or Stamp Name	Telephone Number

Community Servings - 18 Marbury Terrace- Jamaica Plain, MA 02130- Tel. 617-522-7777 - Fax 617-522-7770 Revised: August 2009

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FINAL CHECKLIST FOR PROVIDERS/REFERRAL SOURCES

Please fax this packet back to 617-522-1345 Attn: Don Drake, PD

Please be sure that all paperwork is fully completed, especially the following items as they may cause a delay in the intake process:

[ ] The HIV Certification is completed by the applicant's medical provider along with the most recent CD4 count and Viral Load Count

[ ] The applicant/client is discharged with 30 days of medication. If you would like to call in the medication, LARC uses the following pharmacy:

ALLCARE PHARMACY – 508-754-8878 for prescribers

Note: On Friday admissions, medications may not be delivered until late Monday afternoon so please take this into account when planning weekend medication coverage for the client.

[ ] Is the over the counter medication permission sheet reviewed and completed by the client's prescriber. Not completing this may limit the client's ability to use over the counter medications.

[ ] If the client is using methadone assisted treatment, are al forms completed per instructions?

[ ] Clients at LARC participate in the Community Servings Meal Program. Please be sure that **page 13**, the Home Delivered Meals Program sheet for Community Servings is completed and signed **by the medical provider. Arrows indicate where signature is needed.**

[ ] Client is aware of what items he/she are required to bring to the program. Please notify the program ahead of time if the client does not have access to some of the items.

[ ] Cell phones are permitted but can be used in the privacy of the room only.

If you need anything or have any questions, please do not hesitate to contact us at 617-522-2936. Thank you.