GEORGE HAWKINS
MEMORIAL TREATMENT CENTER
10320 North Airport Road
Clinton, Oklahoma 73601
1-800-247-4612 ext. 32370
Local: 580-331-2370
Fax: 405-422-8282

To Whom It May Concern:

In this packet, you will find our Client Residential Admission Packet. Please complete the forms and return to the Admission's Office at the contact information above. In order to be placed on our waiting list, you will need to have all requested documents turned in before we place a *Received* date stamp on your application. The waiting list is based on a first come, first serve basis meaning the sooner we receive all the required documents, the sooner you are placed on our waiting list.

PLEASE NOTE THE FOLLOWING: You must have the following completed within 30 days to comply with program eligibility:

- → Physical Examination with any necessary medications filled for a 60-day period. Must have a doctor's order for any daily over-the-counter medications such as Aleve, Ibuprofen, etc.
- → Laboratory Results including: 1) Tuberculosis Test/ PPD Skin Test 2) Hepatitis Profile*

Lab tests must read negative in order to qualify for admission. Positive test results are handled as special circumstances. The client should contact both their physician for immediate treatment, and the Treatment Center for notification. *No tests older than thirty (30) days will be accepted.

The George Hawkins Memorial Treatment Center is a non-medical center designed to facilitate the rehabilitation of the chemically dependent individual in a structured, therapeutic environment. Our combined services include, but are not limited to, individual/group therapy, alcohol/substance abuse education, relapse prevention, spiritual/cultural activities, and 24-hour supervision.

Our minimum admission criteria: 1) Prospective client must be discharged or released for at least thirty (30) days from restricted environments such as prison, half-way houses, and mental/physical hospitalization; however, we will accept an immediate transfer from a county jail facility if judicial arrangements are made. 2) A statement must accompany the application stating that the client is stable and compliant with medications. 3) Must be at least 18 years of age or older. 4) Must have a valid **C**ertification **D**egree of **I**ndian **B**lood. 5) Must provide immunization record.

Referrals from other agencies: In the event of a referral, the referring agency must: 1) Include a discharge summary/treatment plan. 2) Be responsible for transportation to/from our facility. 3) An alcohol and drug assessment is highly encouraged and results released to this Treatment Center.

All potential clients are responsible for contacting George Hawkins Memorial Treatment Center on a weekly basis to maintain eligibility for admission. If you fail to make contact in 30 days, you will be removed from the waiting list and will need to reapply for admission.

Irene Lime
Admissions Coordinator

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What to Bring

Please note these policies:

Deliveries or Forgotten Items
No outside items will be accepted after admittance into the Treatment Center. You will need to bring everything you need for your 60-day staff at the

Phone Calls and Money Needed:
Clients have access to phone calls in Residential Treatment; however, phone privileges are not given until after the first two (2) full weeks of Residential Treatment.

George Hawkins Memorial Treatment Center provided all basic necessities, if client is unable to bring themselves. The only money needed will be for any special necessities the Treatment Center does not carry. The client can send the money with their case manager to request the items, and a receipt will be provided.

George Hawkins Memorial Treatment Center is a tobacco, e-cig, and vapor-free facility.

Please bring these items, and only these items:

- Twin sized linens
- Pillow, pillow case
- Twin sized bedding
- 2 towels/washcloths
- Alarm clock/no radio
- Personal hygiene (60-day supply)
- Toothbrush/Toothpaste
- Shampoo/Conditioner
- Body wash
- Deodorant
- Shaver/lotion/Q-tips
- Contact solution
- Shower shoes/house shoes
- Coat/jacket for season
- Laundry basket/bag
- Postage/Stationary

You must have all up to date non-narcotic prescription medication in the original bottle with legible prescription label in your name. You must bring enough medication for your 60-day stay.

Unacceptable items:

- No tank tops, halter tops, short shorts, miniskirts, etc.
- No associated gang apparel/colors or garments displaying alcoholic/drug paraphernalia
- Pants that sit below the waist are unacceptable. No sagging
- No personal food or drinks allowed. Meals and snacks will be provided daily
- No weapons of any kind. This includes pocket knives and scissors
- No marijuana products – medical card or not
- No cell phones, tablets. or personal computers. If you do not have anyone to leave these items with, we do have a locked safe that we can keep your electronics in during your 60-day stay.

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ADMISSION CRITERIA

NOTICE: Prior to any individual being admitted to George Hawkins Memorial Treatment Center, all clients are subject to a criminal background check looking for sexual crimes only. We are a co-ed facility and our number one priority is to ensure the safety of our clients and staff.

1. 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. The client must be physically and 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, cohabitating couples or close blood relatives including cousins will not be accepted concurrently.

3. Client must be willing to abide by program rules and regulations as well as consent to treatment. Failure to do so can result in dismissal from the program.

4. The Treatment Program must receive a client file from the previous social service or legal agency that includes discharge plans or a summary prior to the client being admitted. If the client is court ordered, court documents are required before admission.

5. Priority will be given to Native Americans who are enrolled tribal members to the Cheyenne and Arapaho Tribes.

6. Client or prior referring agency is responsible for transportation to and from our facility.

7. Each client will be required to have a full physical no more than thirty (30) days prior to admittance. A client with a mental health history must include a psychiatric report.

8. Client must be willing and able to participate in his/her treatment program.

I have read and thoroughly understand that the above criteria for admittance to George Hawkins Memorial Treatment Center. I am aware that in not abiding by the rules and regulations of this Treatment Center, is cause for prompt dismissal from the Treatment Program.

______________________________________ ________________

Signature of Applicant Date

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CLIENT INFORMATION

TODAYS DATE	TRIBE AGENCY	GENDER
FIRST NAME	M.I.	LAST NAME
ADDRESS	CITY|STATE|ZIP	
DATE OF BIRTH	SOCIAL SECURITY NO.	
PRIMARY CONTACT NUMBER		
SECONDARY CONTACT NUMBER		
REFERRED BY (PLEASE INCLUDE CONTACT INFO)		

ALCOHOL/DRUG SUMMARY

LAST SUBSTANCE USED	LAST AMOUNT USED	PRIOR SUBSTANCES
HOW OFTEN HAS THERE BEEN DRUG USE?	PRIOR OVERDOSE?	
LAST SOBER DATE	PRIOT TREATMENT/INFO	
PROGLEMS ENCOUNTERED FROM DRUG/ALCHOL USE?		
HEALTH PROBLEMS?		
MOTIVATION FOR TREATMENT?		
HAVE YOU USED IHS CONTRACT HEALTH SERVICE?	SSERVICE UNIT:	

COURT INFORMATION (IF COURT ORDERED)

COURT TYPE: (PLEASE CIRCLE)	FEDERAL	STATE	COUNTY	CITY	TRIBAL
CHARGE(S):					
COURT JUDGE	COURT COUNTY	DUI/ DWI?	UPCOMING COURT DATE		
YOUR ATTORNEY	ATTORNEY'S CONTACT NO.				

A CONSENT/RELEASE OR INFORMATION MUST BE SIGNED BY YOUR ATTORNEY, JUDGE, PROBATION OFFICER BEFORE ANY INFORMATION REGARDING CLIENT IS SENT OUT. A BLANK RELEASED IS ATTACHED IN THIS APPLICATION PACK, OR CAN BE EMAILED BY CALLNG (580)331-2370. COPIES OF COURT PAPERS MUST BE TURNED IN AT TIME OF INTAKE.

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HEALTH EXAMINATION REPORT

FULL NAME	DATE OF BIRTH
ADDRESS | CITY, STATE, ZIP	SS#:

PLEASE HAVE THE FOLLOWING COMPLETED BY A PHYSICIAN OR THEIR DESIGNEE

	YES	NO			YES	NO			YES	NO
Diabetes				Tuberculosis				Asthma		
Operations				Heart Troubles				Sinus Trouble		
Fractures				Fainting Spells				Skin Disease		
Head Injury				Epilepsy				Hernia		
Back Injury				Mental Disease				Chronic Back Pain		
Other Injuries				Jaundice				Rheumatism		

Relevant Medical History for Residential Treatment

Physical Readings:

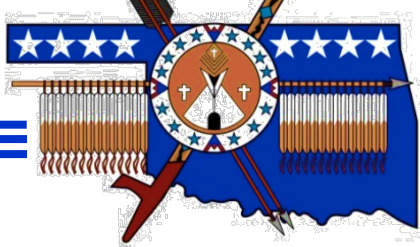
HEIGHT	WEIGHT	BLOOD PRESSURE	TEMP
PULSE	RESPIRATION	LUNGS	ABDOMEN

EXTREMITIES	OTHER SIGNIFICANT FINDINGS
EARS	EYES
TEETH	NOSE/THROAT
SKIN	HEART
SCARS	PREGNANT?
ACTIVE CASE OF TUBERCULOSIS?	ACTIVE CASE OF HEPATITIS
ALLERGIES	LIMITATIONS
WORK SAFE FOR KITCHEN DUTY? IF NO PLEASE EXPLAIN:	

PLEASE ATTACH THE TB/PPD SKIN TEST REPORT AND HEPATITIS PROFILE REPORTS

AS A PHYSICIAN, I CERTIFY THE ABOVE INFORMATION IS TRUE AND CURRENT

SIGNATURE OF PHYSICIAN	DATE
PRINTED NAME OF PHYSICIAN	CONTACT NO:



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RELEASE OF INFORMATION

I, ____, ____,
Client/Applicant's First, Middle, and Last Name *Date of Birth (MMDDYYY)*

hereby voluntarily authorize GEORGE HAWKINS MEMORIAL TREATMENT CENTER to release or exchange client information to:

The information is to be released by:	And is to:
NAME OF FACILITY George Hawkins Memorial Treatment Center	**NAME OF PERSON/ORGANIZATION/FACILITY**
ADDRESS 10320 N. Airport Road	**ADDRESS**
CITY/STATE/ZIP Clinton, OK 73601	**CITY/STATE/ZIP**

The purpose or need for the disclosure is:
☐Further Medical Care ☐Attorney ☐School ☐Personal Use ☐Insurance ☐Disability ☐ Legal
☐ Other (Specify)____

Specific Information to be released:

____

____

____

Purpose of release:

____

____

THIS MUST BE SIGNED AND A COPY MIST BE INCLUDED WITH ANY CORRESPONDENCE.
Including information that will be mailed/sent/faxed to ICW/DHS, etc.

I understand that the records requested may be protected under C.F.R.42 Part2. Governing Alcohol and Drug Abuse Patient Records and State Confidentially Laws and Regulations cannot be released without my consent unless otherwise provided for by the regulation. Any refusal to sign a release of information will in no way affect my ability to receive services nor will it cause me to be refused services. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as follows.

____ ____________________
Signature of Client or Applicant Date

This box is for NOTARY use only – I.D. is REQUIRED for notarization.

State of: ___________________________________

County of: _________________________________ NOTARY

Subscribed and sworn to before me on this _________ day of _______________, 20 ______. SEAL

NOTICE OF RECIPIENTS OF ALCOHOL AND DRUG ABUSE RECORDS

Each disclosed sheet of information shall contain the following statement stamped in RED: "This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2) The federal rules prohibit you from making any further disclosure of this information unless further disclosure expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. This authorization for release of information may be considered as an original in instances of fax transmittal with notary signature (see below).