Lifeline Connections

hope. help. Healing.

Men's Low-intensity Residential Program

1211 Girard St., Bellingham, WA 98225
Admissions Phone (360) 397-8246 ext. 30500
Admissions Fax (360) 397-8455

Admission criteria for this treatment facility has been established to meet state and federal funding guidelines, to accommodate cohabited living areas, and ensure best practices for health and safety of treatment participants.

MUST BE A RESIDENT OF WASHINGTON STATE

The admission criteria for Recovery House are outlined as follows:

1. All applicants must be 18 years or older individuals who identify as male.
2. All applicants will need to meet the diagnostic criteria for severe Substance Use Disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, and meets the admission criteria for ASAM Level 3.1.
3. All applicants' assessments must meet ASAM 3.1 level of care. Applicants whose assessment recommendation is outside the scope of ASAM 3.1 may be referred to another licensed treatment facility following ASAM treatment guidelines.
4. All applicants' income is at $17, 050.00 or below 30% Area Median Income.
5. All applicants must be capable of participating in program activities and independently self-perform activities of daily living (ADLs). Staff are not able to assist residents with ADLs such as feeding, showering, toileting, taking medication, moving, cleaning, etc. Staff will review reasonable accommodation requests on a case-by-case basis.
6. All applicants must receive medical and behavioral health clearance from a community or tribal healthcare provider and/or mental health professional prior to entry. All applications may be denied admissions if medical or mental health conditions are not able to be treated at 3.1 level of care. All applicants may be denied admissions if their medical condition or mental health condition interfere with ability to program at 3.1 level of care.
7. Recovery House cannot accept applicants who are registered sex offenders. Lifeline Connections staff will use the Dru Sjodin National Sex Offender public website https://www.nsopw.gov/en/ to screen for sex offenders.
8. Any applicant will not qualify for services if they have self-reported or documented any convictions, unresolved, or pending charges in the following categories outlined: arson in the past 5 years, assault 1-3 in the past 2 years, assault 4 approved by clinical director only, crime involving use of a weapon in the past 5 years. Applicants engaged and in compliance with Drug Court and or Mental Health Court can have unresolved charges and may qualify for services. Applicants with unresolved or pending charges longer the outlined time parameters above must be approved by clinical director and or Lifeline Connections representative.

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Men's Low-intensity Residential Referral Form

1211 Girard St., Bellingham, WA 98225
Admissions Phone (360) 397-8246 ext. 30500

Lifeline Connections Admissions Fax (360) 397-8455

Legal Name of Individual: _____ _____ _____
DOB (mm/dd/yy): _____
Referent information:

CHECK LIST OF ITEMS TO SUBMIT FOR REFERENT

- ☐ SUD assessment 3.1
- ☐ Lifeline Connections Referral Form
- ☐ Men's Low-Intensity Referral Form
- ☐ Release of Information (ROI)
- ☐ Provided documents to support 30% AMI (last months tax return or statement of no income)
- ☐ Medical Clearance Screening Tool
- ☐ Mental Health Clearance Screening Tool

NOTE: All patients must show proof of extremely low income prior to admit and day of admit

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Men's Low-intensity Residential Referral Form
Medical Clearance Screening Tool

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Lifeline Connections Admissions Fax (360) 397-8455

Legal Name of Individual: _____ _____ _____
DOB (mm/dd/yy): _____
Referent information:

Able to attend to ADLs: ☐ Yes ☐ No
Biomedical conditions will not interfere with treatment: ☐ Yes ☐ No
All medications are current if applicable: ☐ Yes ☐ No
Patient cognitively able to self-administer medications: ☐ Yes ☐ No
COMMENTS:
Provider Signature and Date of Clearance for residential treatment:

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Men's Low-intensity Residential Referral Form
Behavioral Health Clearance Screening Tool

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Lifeline Connections Admissions Fax (360) 397-8455

Legal Name of Individual: _____
DOB (mm/dd/yy): _____
Referent information:

Patient is able to program at 3.1 level of care: ☐ Yes ☐ No
Patient is stable on his mental health medications if applicable: ☐ Yes ☐ No
Patient is currently not actively suicidal or homicidal: ☐ Yes ☐ No
Patient is able to program and live with other men in a dorm setting: ☐ Yes ☐ No
Patient cognitively able to self-administer medications: ☐ Yes ☐ No
All medications are current if applicable: ☐ Yes ☐ No
COMMENTS:
Mental Health/SUDP Signature and Date of Clearance for residential treatment:

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SELF-CERTIFICATION OF ANNUAL INCOME

Property Name: Lifeline Connections Men's Low-intensity Residential

ZERO INCOME CERTIFICATION:

I hereby certify that I do not individually receive income from any of the following sources:

a. Wages from employment (including commissions, tips, bonuses, fees, etc.).
b. Income from operation of a business.
c. Rental income from real or personal property.
d. Interest or dividends from assets.
e. Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits. f. Unemployment or disability payments.
g. Public assistance payments.
h. Periodic allowances such as alimony, child support, or gifts received from persons not living in my household.
i. Sales from self-employed resources (Avon, Mary Kay, eBay, etc.). j. Any other source not named above.

NO INCOME OR MEANS TO PAY FOR SERVICES DECLARATION I, the undersigned, hereby declare under penalty (print name) of perjury that I do not have any means to pay for mental health and/or substance abuse treatment services. I hereby affirm that I am not currently employed, do not have any health care insurance that covers these services, and I do not have any other means to pay for services, including no family members who can provide assistance.

Signature of patient and date:

Name of Patient:

DEMOGRAPHICS

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaskan native ☐Asian ☐Native Hawaiian or other Pacific Islander ☐Choose not to disclose

Ethnic Categories: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Choose not to disclose

Disability Status: Are you disabled according to the fair housing act ☐ Yes ☐No ☐Choose not to disclose

DOCUMENTATION OF 30%AMI = $17,050.00 annually

☐Patient provided tax statements

☐Patient provided last month's pay stubs

Staff completing form:

NAME: _____ **DATE:**_____