County of Santa Cruz

HEALTH SERVICES AGENCY
Behavioral Health Division
Substance Use Department
1400 Emeline Ave. Building K, Santa Cruz, CA 95060
Phone: (831) 454-7519 Fax: (831) 454-4770

ADMISSION AGREEMENT

SERVICES INCLUDE:

County of Santa Cruz Substance Use Disorder Services currently offers two programs.

- Outpatient Treatment Services
- Recovery Support Services

The following services are available for the outpatient treatment level of care. The frequency of services will vary depending on clinical need. Individual and group counseling is limited to 9 hours per week.

- Assessment & referral
- Individual Counseling
- Group Counseling (can specify groups)
- Patient Education
- Family Therapy
- Crisis Intervention Services (as needed)
- Discharge Services
- Care Coordination

The following services are available for our Recovery Support Services program.

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Recovery Monitoring, which includes recovery coaching and monitoring
- Harm Reduction/Relapse Prevention education, which includes interventions designed to teach how to anticipate and cope with the potential for triggers to substance use and increase safety through health coping skills.

SERVICE ADDRESS

1400 Emeline Ave. Bldg. K Santa Cruz CA 95060

PAYMENT PROVISIONS:
Treatment is funded by Medi-Cal. Active Medi-Cal or approved secondary funding source is required to maintain treatment. Loss of funding could result in termination of services and referral to another program.

HARM REDUCTION POLICY:

Our program philosophy is client centered and our mission is to support your treatment goals.

If you are not meeting your self-directed treatment goals of abstinence or harm reduction, our policy is to schedule a treatment session with you to discuss your treatment needs and review your WRAP (wellness recovery action plan). This may include revising your WRAP, increasing treatment support, and/or conducting ASAM reassessment and referral to a higher level of care if clinically indicated.

Using substances will not result in automatic discharge unless your substance use directly impacts other program members and/or is associated with violent behaviors, please refer to the below reasons for termination.

INTERVENTION(S) FOR ATTENDING SERVICES UNDER THE INFLUENCE

If you attend treatment services under the influence of substances, one or more of the following interventions may occur:

- If you attend group treatment services under the influence, you may be asked to leave the group and/or meet with a counselor individually.
- You may be asked to leave the premises.
- If there is a risk of driving under the influence, treatment staff will intervene and organize transportation for you.
- If while under the influence of substances, you pose an immediate threat to the health or safety of yourself, or the public law enforcement will be notified.
- Your provider may complete a ASAM reassessment of your treatment needs and refer to higher LOC if clinically indicated.

THE FOLLOWING MAY RESULT IN VERBAL OR WRITTEN WARNING OR PROGRAM TERMINATION:
Warnings or termination can occur at the discretion of your provider based on their clinical judgement. If termination occurs, a Notice of Adverse Benefit Determination (NOABD) will be issued per DHCS requirements.

- Disruptive behavior
- Abusive language

- Not adhering to program requirements.
- Possession of drugs or alcoholic beverages on the premises; All individuals are prohibited from dealing or using drugs/alcohol on or about the premises.

VIOLATIONS THAT WILL RESULT IN TERMINATION FROM TREATMENT:
I acknowledge that the following violations will result in **immediate termination** from the program and notifying law enforcement.

- Any form of physical violence or destruction of property.
- Threats of violence.
- Bringing any form of weapon on the premise.

By signing, I acknowledge that I have read the above information, was oriented to the program functions and requirements within 72 hours of admission, offered a copy of this form, agree to accept services, and agree to commit to the responsibilities listed above. I understand that I may revoke this consent at any time.

- I have been provided with a copy of this Admission Agreement_______(initial).

____
Client Signature   Date

____
Treatment Staff Signature   Date