

SILVER AND GOLD I DO NOT HAVE,
BUT WHAT I DO HAVE I GIVE TO YOU.
ACTS 3:6



Dear Applicant,

Souls Harbor is a transitional community for men in recovery. We offer accountability, resource referrals, workforce development and structure. There is a shared housing cost of \$50/week, half of which is returned upon successful completion of the Souls Harbor NWA program.

We require all residents at Souls Harbor to comply with the following rules:

Clean drug/alcohol screenings: Positive UA and/or breathalyze test will result in dismissal.

- o If you are prescribed any medications that may test positive on our drug screens, we ask that you request alternative medication from your doctor.

Completion of at least 4 hours Sweat Equity each week

- o Sweat Equity consists of jobs around the grounds and facility.

Attendance of 90 recovery meetings for the first 90 days.

- o Following 90 days, residents are required to attend 3 meetings per week. Obtain a sponsor and meet regularly.

Attend mandatory Community Meetings on **Monday 5:30pm – 6pm**. Attend Group Therapy **Monday and Thursday evenings from 6:00-8:00pm**.

Gain full-time employment or attend school and part-time employment.

Abide by 10:00pm curfew Sunday – Thursday and 12am (midnight) curfew on Fridays - Saturdays

This is only a brief description of Souls Harbor's rules and requirements. A detailed Resident Handbook is provided upon approval.

Following approval, we will run a background check. We do not accept sexual or violent offenders. Once accepted to Souls Harbor, you will hold an in-person interview with the Executive Director.

Please complete the forms in this packet and submit to a staff member as soon as possible. You can submit via mail to the address below or scan and send to info@soulsharbornwa.org.

1206 N. 2nd Street Rogers, AR 72756

In this packet you will find the HARK intake form. The intake form and VI-SPADT Survey must be completed to apply to Souls Harbor NWA. The VI-SPADT must be completed face to face and can be completed by a Souls Harbor NWA staff member or through a Hark community liaison. A liaison can be obtained at www.harknwa.com

Thank you,
Nick Jones
Executive Director
Souls Harbor of NWA

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Contact Information

Name _____ Date _____

Address _____

Phone _____ Email _____

All residents of Souls Harbor have completed in-patient treatment for drugs and/or alcohol from a licensed facility. This treatment does not include detox or outpatient participation.

1. What is your sobriety date? _____

2. Have you completed in-patient treatment within the last 12 months?

_____ Yes

_____ No

If you answered Yes to the previous question, please provide the following information:

3. Facility Information

Name of Treatment Facility: _____

Location of Treatment Facility (City and State): _____

Date of graduation/completion:

If possible, please attach a copy of your completion document from treatment

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eDISCLOSURE AND AUTHORIZATION

In connection with my application for employment (including contract for services or volunteer services) or tenancy with (), I authorize the use of requested Consumer Reports. These consumer reports (investigative consumer reports in California) may include the following types of information: names and dates of previous employers, salary, work experience, education, accidents, licensure, credit (except California), etc. I further understand that such reports may contain public record information such as, but not limited to: my driving record, workers' compensation claims, judgments, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies which maintain such records.

In addition, investigative consumer reports as defined by the federal Fair Credit Reporting Act, gathered from personal interviews with former employers and other past or current associates of mine to gather information regarding my work performance, character, general reputation and personal characteristics may be obtained.

I AUTHORIZE, WITHOUT RESERVATION, ANY PARTY OR AGENCY CONTACTED BY THE CONSUMER REPORTING AGENCY TO FURNISH THE ABOVE-MENTIONED INFORMATION.

I have the right to make a request to the consumer reporting agency: CourtHouse Concepts, 4250 N Venetian Ln., Fayetteville, AR 72703; telephone 877-750-3660. CourtHouse Concepts, upon proper identification, to request the nature and substance of all information in its files on me at the time of my request, including the sources of information and the agency, on our behalf, will provide a complete and accurate disclosure of the nature and scope of the investigation covered by the investigative consumer report(s); and the recipients of any reports on me which the agency has previously furnished within the two year period for employment requests, and one year for other purposes preceding my request (California three years). I hereby consent to your obtaining the above information from the agency. You may view their privacy policy at their website: www.courthouseconcepts.com.

I hereby authorize procurement of consumer report(s) and investigative consumer report(s). If hired (or contracted), this authorization shall remain on file and shall serve as ongoing authorization for you to procure consumer reports at any time during my employment (or contract) period.

I acknowledge that I have been provided a copy of consumer's rights under the Fair Credit Reporting Act.

Name/First, Middle, Last

Social Security No.

Other Names Used

Date of Birth

Driver's License / State

Residential Address:

Applicant's Signature

Date

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hark



Authorization to Use or Disclose Protected Health Information (PHI)

Section 1. Who is the Individual?

Last Name:	First Name:	Middle Initial
Provider Completing Assessment:	Date of Birth:	Social Security Number:

I hereby authorize the use or disclosure of protected health information about the individual named above. I am: ☐ the individual named above (complete Section 8 below to sign this form)

☐ a personal representative because the patient is a minor, incapacitated, or deceased (complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following person(s) or entity may use or disclose the information:

All providers within the Fayetteville/Northwest Arkansas (NWA) Continuum of Care who utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and/or Service Prioritization Decision Assistance Tool (SPDAT)

Section 3. Who Will Be Receiving Information About the Individual?

The information may be disclosed to:

All providers within the Fayetteville/NWA Continuum of Care who utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and/or Service Prioritization Decision Assistance Tool (SPDAT)

Section 4. What Information About the Individual Will Be Disclosed?

The information to be disclosed may include records on drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), or tests for HIV information.

The information to be disclosed, including behavioral health and/or substance abuse services, includes the following:

A. History of Housing and Homelessness Risks

All information contained within the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment, including:

All information contained within the Service Prioritization Decision Assistance Tool (SPDAT), including:



B. Socialization and Daily Functioning

C. Wellness

- A. Self-Care and Daily Living Skills
- B. Meaningful Daily Activity
- C. Social Relationships and Networks
- D. Mental Health and Wellness
- E. Physical Health and Wellness
- F. Substance Use
- G. Medication
- H. Personal Administration and Money Management
- I. Personal Responsibility and Motivation
- J. Risk of Personal Harm/Harm to Others
- K. Interaction with Emergency Services
- L. Involvement in High Risk and/or Exploitive Situations
- M. Legal
- N. History of Homelessness and Housing
- O. Managing Tenancy

Section 5. What is the Purpose of the Disclosure?

To improve access and service alignment by assessing various health and social needs, and then to match those assessed with the most appropriate housing interventions available. The VI-SPDAT and SPDAT are tools to help guide those assessed to the appropriate services, assist with the case planning process and track changes over time — for those clients that are referred to a case management team as a result of their SPDAT score.

Section 6. What is the Expiration Date or Event?

This authorization will expire 1 year from the date this document was signed in Section 8 or Section 9 below.

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to The Northwest Arkansas CoC, at PO Box 3643, Fayetteville, AR 72702. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.

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- If you refuse the authorization or revoke the authorization, you will continue to receive all the medical care and benefits for which you are eligible. You do not need to sign this form to obtain enrollment, eligibility, payment, or treatment for services and these cannot be a conditioned on signing this authorization.
- The unauthorized disclosure of mental health information violates the provisions of the Health Insurance Portability and Accountability Act of 1996 omnibus rule (HIPAA omnibus rule). The client or representative may only make disclosures pursuant to a valid authorization. The Act provides for civil damages and criminal penalties for violations.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to The Northwest Arkansas CoC, at PO Box 3643, Fayetteville, AR 72701.
- If you have any questions about anything on this form, or how to fill it out, we can help. Please call Havenwood at 479-273- 1060.

Section 8. Signature of the Individual

Signature _____ Date (required) _____

Section 9. Signature of Personal Representative (if applicable)

Signature _____ Date (required) _____

Please describe your relationship to the individual and/or your legal authority to act on behalf of the individual in making decisions related to healthcare. You may be asked to provide us with the relevant legal document giving you this authority.

Relationship to the individual (required): _____

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NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.