Good Road Recovery Center
1308 Elbowoods Lane
Bismarck, ND 58503 ● 701-751-8260

Overview

The 16-bed (8 male and 8 female) facility is owned by the Three Affiliated Tribes (MHA Nation) and is the only tribally-owned facility in the state. We are at 24/7 care facility and we are licensed by the State of North Dakota and can operate and maintain the following ASAM program(s):

- Level 1 – Adult – Outpatient Services
- Level 2.1 – Adult – Intensive Outpatient Treatment
- Level 2.5 – Adult – Partial Hospitalization/Day Treatment
- Level 3.1 – Adult – Clinically Managed Low-Intensity Residential Care

Admission requirements for GRRC includes Biopsychosocial drug and alcohol evaluation along with physician-approved eligibility to participate in treatment. After applying, our treatment team will agree and establish admission date to our different program levels. Thursdays are the set date for admissions. Each client of GRRC will be insured (Sherry Baker, CPC will ensure verification and assist in enrollment if not). GRRC clients will be assigned LAC, Case manager, Nurse, and recovery coach in order to accomplish long-term recovery goals as requested by client. Our primary treatment program will last approximately 6-8 months. Following primary treatment (including aftercare), designated case manager and recovery coach will assist client in finding housing, sorting finances, repair interpersonal relationships, obtaining training or education, and any other aspects needed in order to live a healthy, productive life in recovery. This aspect of our model will last between 3-10 additional months. Total active case length: 8-18 months depending on individual client needs, motivation, etc.

Contacts for services:

- For treatment intake
  - Gillian Plenty Chief - Intake/Aftercare Coordinator
    - gplentychief@goodroadrecovery.com
    - (701) 421-2078 (cell)
    - (7010 751-8260 ext. 128

  - Anita Charging, LSW – Intake/Aftercare Coordinator
    - acharging@goodroadrecovery.com
    - (701) 421-2339 (cell)
    - (701) 751-8260 ext. 127

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Admissions/Intake Form

Name of Client: (Last, First, Middle Initial)	Social Security Number:		Date of Birth:
Nicknames/Other Names Used			
Street Address:	City:	State:	Zip Code:
Permanent address if different than above:	City:	State:	Zip Code:
If Homeless (Where are you staying):			
Phone Number:	Message Number:		
Race: __Native American __Asian/Pacific Islander __Native Hawaiian __Caucasian __African American			
Ethnicity: __Hispanic __Non-Hispanic	Primary Language:		
Tribal Affiliation:	Segment:		
Tribal Enrollment Number: (*Please Attach a Copy of CIB or Enrollment Card*)			
Gender/Sex: __Male __Female	Gender Identity: __Gender Variant __Intersex __Man __Woman __Transgender __Questioning __Decline to Answer		
Sexual Orientation: __Asexual __Bisexual __Gay __Lesbian __Heterosexual (Straight) __Questioning __Decline to Answer			
Relationship Status: __Single __Married __Domestic Partnership __Divorced __Separated __Widowed			
Military Status: __N/A __Active __Veteran __Disabled __Other:____________________			
Highest Level of Education: __ G.E.D. __ High School (Highest Level Completed: ____________) __ Some College __ College Graduate College and Degree:____________________ ____________________			
Employed: __ Yes __No	SSI/SSDI: __ Yes __ No		TANF: __ Yes __No

<table>
<tr><td colspan="2">Other Source of Income:</td><td colspan="2">Monthly Income:</td></tr>
<tr><td>Medical Insurance __Yes __No
Please submit a copy of your insurance card</td><td colspan="2">Insurance Company:</td><td>Policy Number:</td></tr>
<tr><td colspan="2">Do you have any legal issues: __ Yes __No
__Tribal __State __County
Location:</td><td colspan="2">Are you currently on Probation/Parole: __ Yes __No
If yes, who is your corrections officer:
Contact Information:</td></tr>
<tr><td colspan="4">If yes, what are your current legal issues:</td></tr>
<tr><td colspan="2">Probation/Parole Status:</td><td colspan="2">Number of arrests within the last 6 months:</td></tr>
<tr><td colspan="4">What were the arrest charges for?</td></tr>
<tr><td colspan="2">What were you court ordered to do/complete?</td><td colspan="2">When is your upcoming court date?</td></tr>
<tr><td colspan="2">Do you have transportation? __Yes __No</td><td colspan="2">If yes, what are your means of transportation?</td></tr>
<tr><td colspan="4">Children: __Yes __No (If yes, name and ages of children):</td></tr>
<tr><td colspan="2">Pregnant: __Yes __No</td><td colspan="2">If yes, expected due date:</td></tr>
</table>

Primary Care Provider(s):	Address:	Phone Number:
(Please sign release of information for provider)		
Specialty Care Provider(s): *(Please sign release of information for provider)*	Address:	Phone Number:

Have you ever needed Mental Health Services? (Including but not limited to behavioral health, psychiatric)

__ Yes __No If so, when: ____

Name of Provider(s): ____

Address: ____

Phone number: ____

(Please sign release of information for provider)

Are you currently taking any medications? __ Yes __No *(If yes please complete the medication form)*	Are you supposed to be currently taking any medications? __ Yes __No *(If yes please complete the medication form)*

Referral Source:

Reason for Intake:

Last Use of Any Type of Substances:

Alcohol Usage (or History):

Drug Usage (or History):
IV Drug Usage (or History):
History of Medical Conditions (HIV/AIDS, Hepatitis, STI, STD, TB, Diabetes):
Smoking Status: __Never __Daily __Some Days __Former Smoker __Vape User __Chew/Snuff __ Half Pack Daily __Full Pack Daily Average usage of Vape/Chew/Snuff:____________________
Have you ever attending any support groups (i.e. AA/NA/Domestic Violence/Parenting Classes)?
Are there any Cultural needs or practices that you wish to continue/share?

Legal Guardian/Custodian name if needed:	Address:	Phone Number:

Relationship:______________________		
Emergency Contact Information: Relationship:______________________	Address:	Phone Number:
Have all Release of Information's been completed and signed? Staff Initials: ____		

CLIENT CONSENT:

Signature of Client:	Date:
Signature of Guardian or Custodian (if needed and Relationship):	Date:
Signature of Witness (if needed):	Date:
Signature of Good Road Recovery Center Personnel:	Date:

AUTHORIZATION TO DISCLOSE INFORMATION

1308 Elbowoods Lane
Bismarck, ND 58503 ● 701-751-8260 ● 701-751-2274 Fax

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. The Good Road Recovery Center will not condition treatment on your agreement to authorize disclosure of your health information. The Good Road Recovery Center may require that you authorize disclosure of your information if needed to make a determination about your eligibility for services.

Name of Client: (Last, First, Middle Initial)	Social Security Number:		Date of Birth:
Street Address:	City:	State:	Zip Code:

I Hereby Authorize:

Name of Person/Agency:			
Street Address:	City:	State:	Zip Code:

To Release Information To:

Name of Person/Agency to Receive Information:			***at Good Road Recovery Center***
Street Address: ***1308 Elbowoods Lane***	City: ***Bismarck***	State: ***ND***	Zip Code: ***58503***

Description of Information to be Released:

The purpose of the information disclosed in this form will be used to determine eligibility and level of services needed.
Items in this form are communicable via written, verbal, electronic, fax and can used to communication between both agencies as needed.
(Each item to be disclosed should be marked)

_____ Substance Use Evaluation (with ASAM scores & Dimensions)
_____ Psychosocial Evaluation
_____ Current Treatment Update and/or Plan
_____ Participation Record in Treatment
_____ Psychotherapy/ Therapy Notes
_____ Educational Information
_____ Nursing/Medical Information
_____ Court/Legal Records
_____ Medical Records:
Only information related to (specify) ____________________________
Only the period of events from to ______________________________
Entire Record ____
_____ Other ____

_____ Psychiatric and/or Psychological Evaluation
_____ Treatment Plan or Summary
_____ Aftercare Plan or Summary
_____ Progress Notes in Treatment
_____ Discharge/Transfer Summary
_____ Demographical Information
_____ Recommendations
_____ Medication Management Information

I understand I have the right to see this information at any time. I understand that I can revoke this consent in writing to both the person giving and the person receiving the information. Any information already released may be used as stated on the consent.
I understand the requested or provided information is needed to determine eligibility for housing and/or social services.
This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date indicated here: ____

____ CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICITION RECORDS.
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.
___Client declined a copy of the signed Authorization. ___ Client was given a copy of the signed Authorization. Date: ______________

CLIENT CONSENT:

Signature of Client:	Date:
Signature of Parent/Guardian or Custodian (if needed and Relationship):	Date:
Signature of Witness (if needed):	Date:

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