GEORGE HAWKINS MEMORIAL TREATMENT CENTER
P.O. Box 175, Clinton, Oklahoma 73601
Phone: 580.331.2370 | Fax: 405-422-8282

Greetings!

George Hawkins Memorial Treatment Center is a 90-day treatment program that exists to impact the lives of tribal men and women who suffer from substance abuse, by providing hope and guidance to them through proven therapies and spiritual growth. Our treatment and recovery counselors customize a comprehensive treatment plan for each patient that addresses physical, mental, spiritual, and emotional health needs. Each treatment team works hand in hand, side by side with patients to heal from addiction and reclaim their lives through recovery.

In this packet, you will find the Client Residential Admission Packet for the George Hawkins Memorial Treatment Center. Our Treatment Center is exclusively for Native Americans with a valid CDIB, with priority given to Cheyenne and Arapaho tribal members. Please complete the forms and return to the Admission's Office at the contact information above. You will be placed on our waiting list once we receive all the requested documents listed on Page 2. 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.

Admission Criteria

- → 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 & mentally capable of carrying out the basic detail duties that are rotated among clients each week.
- → 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.
- → 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.
- → 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. Assault charges will need to be accompanied with a police report.
- → Priority will be given to Native Americans who are enrolled tribal members to the Cheyenne Arapaho Tribes.
- → Client or prior referring agency is responsible for transportation to and from our facility.
- → Each client will be required to have a full physical prior to admittance. A client with a mental health history must include a psychiatric report.
- → Client must be willing and able to participate in his/her treatment program.

If you have questions, please contact our admissions office at (580) 331-2375 or (580) 331-2370.
Please remit application and addition documents to: P.O. Box 175, Clinton, OK 73601

Thanks – Admissions!

Checklist

On this page, you will find all the required documents that we need in order for your application to be complete. You may turn in everything at once, or separately, and we will keep everything is a file for you. We cannot stress how important it is to get everything turned in that we request. You are placed on the waiting list as a first come, first serve basis, but in order to be placed on the waiting list, everything on the check list must be received.

Admissions Checklist

- ☐ Client Information Sheet
- ☐ Certificate Degree of Indian Blood (CDIB copy)
- ☐ Release of Information (necessary is anyone conducting business on your behalf)
- ☐ Court Ordered Documents (Required if court ordered)

Health/Medical Related Documents

- ☐ Health Examination Form (blank copy page 4. Must be signed by physician)
- ☐ Hepatitis Profile* (A, B, C in lab format)
- ☐ Tuberculosis/PPD Skin Test*
- ☐ Updated list of Immunizations (obtain from medical records)
- ☐ Current list of all Medications (obtain from medical records)
- ☐ Copy of Covid Vaccination card (if applicable)

PLEASE NOTE THE FOLLOWING

COVID-19 PROTOCOLS: You must have a covid test completed within 30 days to comply with program eligibility. This will include requesting your results being in a hard copy form. It is strongly encouraged that all clients have their covid vaccine prior to being admitted. We can do vaccinations on site on day of admission.

*LAB TESTS: (TB/PPD, HEP) must read negative in order to qualify for admission. Positive test results are handled as special circumstances.

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.

ASSESSMENT PRIOR: Once on the waiting list, you will receive a call to schedule an in-person assessment with our clinical team 2-weeks prior to being admitted. The assessment will take place at the Treatment Center in Clinton, OK. This is a requirement for all potential clients.

STAY IN CONTACT: 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. If you change addresses or your contact number, please update us with that new information asap.

CLIENT INFORMATION

TODAYS DATE	TRIBE AGENCY		GENDER
FIRST NAME	M.I.	LAST NAME	
ADDRESS	CITY|STATE|ZIP		
DATE OF BIRTH	SOCIAL SECURITY NO.		
HOME TELEPHONE/CELL PHONE			
CONTACT NUMBER TO LEAVE A MESSAGE WITH			
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, THIS MUST BE FILLED OUT)

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

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.

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:

RELEASE OF INFORMATION

(Referral agencies, attorney, parent/guardian conducting business for applicant)

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 PERSON/ORGANIZATION/FACILITY	**NAME OF FACILITY** George Hawkins Memorial Treatment Center
ADDRESS	**ADDRESS** P.O. Box 175, 10320 N. Airport Road
CITY/STATE/ZIP	**CITY/STATE/ZIP** Clinton, OK 73601

The purpose or need for the disclosure is:

☐Further Medical Care ☐Attorney ☐School ☐Personal Use ☐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.