



MentorWorks Application Cover Letter

NOTE: Applications will not be processed without a criminal history. If you are NOT incarcerated in Salt Lake County Jail, you must obtain a criminal history (from your facility or BCI [\$15] @ 3888 W. 5400 S., Salt Lake City, UT) or presentence investigation report and include it with your application.

MentorWorks is a tobacco-free transitional housing and after-care program. It is **not** a substance-abuse, or mental-health treatment program. However, IOP treatment options are currently being pursued and may be available in the near future. We provide a safe, sober environment, food, clothing, transportation, AA meetings, relationship (e.g., fatherhood, motherhood) classes, and assistance in locating resources for employment, education, long-term housing, etc. Two key components of the MentorWorks program include the potential for health insurance enrollment and premium payment as well as access to a Housing Acquisition Fund (HAF) which begins at Week 9. The HAF involves accrual of \$50 per week (\$900 max) for fully compliant participants that will be realized in the form of a check written directly to a landlord, for example, upon program exit.

Following are a few expectations of MentorWorks participants:

- RISE (Recovery In Sober Environments) advancement (our demarcation of program progress)
- Maintain complete sobriety and provide regular, random drug and alcohol screen tests upon demand
- Attendance at all MentorWorks recovery and house meetings
- Obtain full-time employment, including becoming a “Job-Ready, Job Seeker”
- Completion of financial literacy training and developing and following a financial plan and budget
- Create and participate in our Breathe Free Tobacco Cessation Plan
- Provide leadership service and support to fellow program participants (esp. newer participants)
- On-time payment of weekly program fees
- Create and regularly revise a “Success Plan” that maps out your path to successful reentry
- Develop a program of spirituality (including building a relationship with your Higher Power).

MentorWorks requires a 16-week commitment. Program fees are \$200 a week plus an initial \$100 commitment fee. **A \$900 payment for the first 4 weeks is due after you have had your interview with one of our caseworkers/mentors and must be received or committed before you will receive an admittance letter to the program.** Your deposit should be sent to us as a check which will be held until intake. If you are unable to pay now, a commitment in writing is required from a business or ecclesiastical leader stating intention to sponsor you for the first 4 weeks (\$900) or, with an approved exception, 2 weeks (\$500). We do not take Medicaid payments. There may be other sources of funds for you to consider (e.g., PATR/ATR). Beds are available on a first come, first served basis. Application acceptance puts you in the queue for program placement. You must call upon release to confirm availability. Deposits will be returned if a spot is not available.

Please contact us by mail, email, or phone with questions (*collect calls not allowed*). The program handbook and all materials will be presented at intake. Full admittance into our program and home requires reading, understanding, and signing the last page of the handbook as your contract with MentorWorks. Final acceptance is determined during the intake interview.

Sincerely,

Joseph White, Ph.D.
Executive Director

Alan Brewer
Supervisor

John Stone, BSW, CHS
Supervisor



MentorWorks Sober-Living Program Application

This application must be completely filled out and submitted prior to screening, admittance, and intake. Be as thorough as possible. This information is confidential and will not be shared with outside agencies.

Name (First, Middle, Last): SS#: Offender #: Gender: M/F
Date of Birth: Age City/State Last Residence: Race: Hispanic Descent? Yes/No
Phone: Incarceration Facility: Block: Reference (Relative/Friend/Organization):
DATES: Incarceration (Current): Release (anticipated): Last Hearing: Next Hearing:
Annual Income (Previous Year): \$ (Current Year): \$ Disabilities (list all-mental, physical, etc.):

Criminal History: Summarize (when/where occurred)-beginning with most current:

- Outstanding offenses (unresolved/pending):

Substance Abuse History: Summarize (substances used, age first use, sobriety date, any treatment received):

Medical History: Summarize (physical/mental health):

Discharge Plan: (Get Current ID/Drivers License, etc.):

Treatment Plan: Summarize:

Employment Plan (Short/Long Term):

Housing Plan (Short/Long Term):

Change Plan (2-3 things you will do differently to change outcomes & why?):

My signature indicates willingness & ability to pay (or arrange payment) for & commit to MW's 16 week Sober Living Program. I am willing to be contacted on my cell phone (once obtained) by anyone involved with my recovery & payment. Fees are \$200 a week plus a \$100 processing fee & includes a bed, bedding, utilities, clothes, meals, support for transportation, employment, recovery (recovery programming, group & individual mentoring), life skills (e.g., fatherhood, etc.), & health insurance assistance (where available).

Signature: Date: / /

Signature (Proxy): (Relationship:) Date: / /

Send application to: MentorWorks Applications, 1878 W. 12600 S. #230, Riverton, UT 84065. Call 801-923-3351 or email info@mwut.org for questions or notification of payment arrangements.

Payment other than cash (only Cashier's Check, Money Order, Company/Organization Check) should be made to MentorWorks.

ALL PAYMENTS ARE CONSIDERED TAX DEDUCTIBLE DONATIONS.



MentorWorks Consent and Authorization for Release of Information

"Consent and Authorization for Release of Information, Pursuant to Section 63-2-59, Archives and Records Service and Information Practices Act, Utah Code Annotated 1953."

Name: _____ Date: _____

Offender # (If Applicable): _____ SSN: ____/____/____ DOB: ____/____/____

- A. I hereby request and authorize (1) Adult Probation and Parole, (2) local police and sheriff agencies, (3) Foundation for Family Life/MentorWorks staff, and/or (4) any other professionals associated with my recovery to provide the following information with said agencies and herewith release said agencies from any and all liability for disclosure and release of such information.
- B. The specific information requested may involve content related to my medical, health, psychosocial, physical, criminal history, and any other background or assessment-related materials specific to my reentry, recovery, and/or the terms and conditions of my parole/probation.
- C. The purpose for this information is to assist in my recovery process and to support my efforts to successfully complete my probation/parole experience – ultimately to stay out of jail and remain drug/alcohol free.

Other purposes may also include: _____

- D. Any information disclosed from my records in accordance with this request will not be forwarded to or used by any other agency or organization without my knowledge and written consent.
- E. Expiration date: (1 year later)

Name (Print)

Witness Name (Printed)

Name (Signature)

Witness Name (Signature)

NOTE: By signing this release form, I understand I may request and authorize MentorWorks (MW) to contact the listed person or persons to provide the specific information requested and that it may pertain to my personal health and recovery (including my criminal record, terms & conditions of parole/probation, treatment plans, medical history, and psychosocial evaluations, etc.) or for reference purposes only with no liability to MentorWorks. Related to my program participation, I authorize MW staff, Adult Parole & Probation, and/or police to search my property physically and/or through canine units, even if I have a lock on my door (MW Staff will have access via a copy of the key).

I also understand that I may authorize Salt Lake County Jail, Utah Dept. of Corrections (including their clinical services), or other county/local jails, and/or Adult Probation and Parole to release to MW specified information relating to my discharge summary, case action plan, programming & education history, medical & psychosocial histories, evaluations & assessments, LSI-R scores, background checks, etc. according to GRAMA laws. I understand I may authorize my case worker and parole/probation officer to communicate with MW regarding my plans & progress. I understand I am authorizing my ecclesiastical leaders & family to communicate with MW about my progress. I understand this information will not be shared with outside parties without my permission & that this agreement ends one year from the date at the top of this page. Finally, I understand I may be invited to share my success story, photos, videos, etc. related to participation in MW's program & that my signature provides approval for usage of my stories, photos, etc., if & when MW program staff request them from me, and that I will be notified of the location of such usage.



Family Information Sheet

Name: _____ Date: _____

This form is designed to help MentorWorks understand your family situation. Your participation in MentorWorks family-related activities can help you think through, resolve, and repair your most important relationships, especially with your children (if any). Please provide as much information as possible. More information can be added later, if needed. Your signature authorizes MW to use this information in a confidential manner for and in behalf of your recovery plan.

Father: _____

Address: _____ Phone: _____

Mother: _____

Address: _____ Phone: _____

Siblings (If Any): Names: _____ Ages: _____

Address: _____ Phone: _____

Name: _____ Age: _____

Address: _____ Phone: _____

Spouse (or Ex-Spouses): _____

Relationship Status: _____ Address: _____ Phone: _____

Children (If Any): Name: _____ Age: _____

Address: _____ Phone: _____

Name: _____ Age: _____

Address: _____ Phone: _____

Name: _____ Age: _____

Address: _____ Phone: _____

Name: _____ Age: _____

Address: _____ Phone: _____

Another Relative (Aunt, Uncle, Cousin, Grandparent, etc.): _____

Relationship: _____ Phone: _____

Address: _____

Which family members are you closest with and why: _____

Which family members do you most want to improve relations with and why: _____

What do you want to do most for your children (or future children)? How will you do it?: _____

Signature: _____ **Date:** ____/____/____



HIPAA Authorization (For Use of Protected Health Information)

- 1. **I HEREBY AUTHORIZE** (list doctors; therapists; AP&P, prison, & jail personnel, etc. or simply say "ALL"): ALL
- 2. **TO RELEASE INFORMATION TO:** Foundation for Family Life/MentorWorks: 1878 W. 12600 S. #230, Riverton, UT, 84065
- 3. **INFORMATION REGARDING:** _____

Print First & Last Name
Date of Birth

4. **PURPOSE OF DISCLOSURE:** For purposes providing a successful mentoring experience, I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

5. **TYPE OF INFORMATION DISCLOSED:**

- | | | | |
|-----------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------|----------------------|
| <input checked="" type="checkbox"/> Discharge summary | <input checked="" type="checkbox"/> Cardiac testing | <input checked="" type="checkbox"/> Emergency Room Record | ___ Other (Specify): |
| <input checked="" type="checkbox"/> History and Physical | <input checked="" type="checkbox"/> Consultations | <input checked="" type="checkbox"/> Therapy Notes (OT, PT, Speech) | |
| <input checked="" type="checkbox"/> X-ray | <input checked="" type="checkbox"/> Lab | <input checked="" type="checkbox"/> Anesthesia Records | |
| <input checked="" type="checkbox"/> Operative/Pathology Reports | <input checked="" type="checkbox"/> Toxicology Reports | <input checked="" type="checkbox"/> Drug Tests | |

6. **EXPIRATION:** End of participation in program

7. **FFL/MW & REPRESENTATIVES:**

- a) May use and share my protected health information to conduct research.
- b) May disclose my protected health information which may include the research product to the Sponsor of the research or others as listed below:

All Staff
Name of Staff (if unknown, write "All Staff")

Other (if none write "none") Cell Phone

- c) Will obtain my authorization to release my protected health information to anyone other than those stated above.
- d) May disclose my protected health information to representatives of government agencies where required by law.
- e) Agree to protect my health information by using and disclosing it as permitted by me in this authorization. Furthermore, no publication about this project or research will reveal my identity without my written permission. These limitations continue even if I revoke (take back) this authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Refuse to Sign This Authorization: I am under no obligation to sign this form. If I do not sign this form, I may not be allowed to participate in the MentorWorks program.

Right to Receive Copy of This Authorization: If I agree to sign this authorization, I will be provided with a signed copy.

Right to Revoke Authorization: I may revoke my authorization in writing at any time. To revoke this authorization, I must write to FFL at the address listed above in the header. If I revoke this authorization, I may no longer be allowed to participate in the program. Furthermore, even if I revoke this authorization, the project may still use and disclose health information they already have obtained as needed to maintain the reliability of the program.

SIGNATURE OF PARTICIPANT **DATE SIGNED**

SIGNATURE OF PARTICIPANT'S LEGAL REPRESENTATIVE/RELATIONSHIP (if applicable) **DATE SIGNED**

Note 1: All fields in the first section of this application are required for submission
Note 2: By clicking submit you will receive a pop-up prompt - enter your email address. An automatic email draft will be created in the email account you entered. Sign in to your email and go to your drafts box ,then send the email draft with the attached application