To: Central Care Mission Clients
From: Spence Pfleiderer, *CEO and President*

To Our New Clients,

Welcome to Central Care Mission,

Central Care Mission has been providing care to men in need for over 30 years. Our staff and leadership team are committed to your successful completion of the program. Central Care Mission operates on an annual budget determined by its President and CEO along with the Board of Directors.

Congratulations! You have made a commitment to recovery and renewal that will lead to your transition back to the community of your choice once you have completed the phased recovery program. Part of that program requires you to address financial issues in your life; debt, probation, court costs, child support, and back taxes to name a few. Our purpose is to create and maintain a clean, safe environment for all of our clients. In order to accomplish this goal, we currently charge **$170** per week to each client for program fees and **$10** per day for transportation provided.. Although we require no money to enter into the program, a one-time fee of **$135** to your account is assessed upon entry, to be deducted on top of the first week's program and gas fees. It is necessary that you work in order to afford your time in the program.

As you enter into the program, you are also entering into an agreement with Central Care Mission. You agree to turn all personal finances over to the care and management of staff; all income, including income tax returns, are to be submitted through the proper channels upon receipt. Staff will assist you in meeting your financial obligations and help you start a savings account as you progress through the program. ***You also agree to graduate the self-paced program and a commitment of 1-year for program fees that are due during the first year of the program. If you leave the Mission or have been asked to leave the mission for any reason prior to graduating the program, you will forfeit $1,000.00 of any remaining savings as payment of any outstanding annual program fees due at the time of your departure***. If you choose on your own accord to leave Central Care Mission and do not return to claim the balance of your savings within 30 calendar days all funds will be returned to Central Care Mission.

This agreement is put in place to ensure that you are committed to this program. CCM relies on client program fees for approximately one third of the total operating budget annually. If you have any questions, please ask a staff member before you sign this agreement.

I, _____ fully agree to the terms listed above and will abide by it to the fullest.

Signature: _____ Date: _____

Kindest Regards,
Spence Pfleiderer, *President and CEO*
Central Care Mission, *Board of Directors*

Limited Power of Attorney

(*to be executed upon admittance to CCM*)

Know all by these present:

That the undersigned, _____ does hereby appoint Spencer T. Pfleiderer, President of Central Care Mission, as his/her attorney to receive, endorse, and collect payroll checks and/or debit card payroll funds received by Central Care Mission from Team Staffing, Select Staffing, and any staffing agency or person employing for work performed while the undersigned is a client of Central Care Mission, made payable in favor of _____, and to give full discharge for same; hereby ratifying and confirming all that said attorney shall lawfully do or cause to be done by virtue hereof.

WITNESS the signature of the undersigned, this _____ day of _____, 2019.

_____

(*Signature of grantor*)

_____

(*Signature of witness*)

Personally appeared before me the above-named _____, known or proved to me to be the same person who executed the foregoing instrument, and acknowledged to me that he executed the same as his free act and deed. WITNESS my signature, official designation, and seal.

_____

[**IMPRESS SEAL HERE**] (*Signature of attesting officer*)

Partnership Agreement

Central Care Mission has partnerships with many private employers. This includes, but is not limited to: Accounts Receivable Inc, Ace Staffing, All Glass Construction Inc, All Wood Construction Inc, Coleman-Allied Moving, Dynamic Tours Inc, Fence Outlet, GAG Pest Control, Gary's Glass, GEM Supply, KBI Staffing, Labor for Hire Inc, Jack Jennings & Sons Inc., Mid-State Plumbing, McCree General Contractors, Team Staffing Inc, Titan Electric, and TNG Inc. By working at one of these employers, you understand that your job is tied to Central Care Mission. This means that if you leave the mission or are asked to leave prior to graduating, you will no longer hold your position at one of these employers. By signing this document, you understand and fully agree to these terms.

Accepted and Agreed:

Client Name (Printed): _____

Client Signature: _____

Date: _____

Witness Name (Printed): _____

Witness Signature: _____

Date: _____

Authorization to Release Paychecks and Security Pledge

(*to be signed upon acceptance into CCM*)

I, _____, hereby authorize and agree that Team Staffing, Ace Staffing, or other staffing agencies may release any and all paychecks of the undersigned, earned while the undersigned was a client of Central Care Mission, to an authorized representative of Central Care Mission. This authorization shall remain in force and effect and apply to any paycheck made payable to the undersigned for work performed while the undersigned was a client of Central Care Mission, notwithstanding the fact that the undersigned may no longer be a client.

The undersigned pledges to Central Care Mission that all paychecks and wages made payable to the undersigned and earned by the undersigned while a client of Central Care Mission should be used as a security deposit of payment for all fees and costs owed to Central Care Mission.

The undersigned releases and holds harmless all staffing agencies from any claim of liability arising out of the staffing agency delivering the undersigned's paychecks to Central Care Mission in accordance with the terms of the agreement.

Accepted and Agreed:

Client Name (Printed): _____

Client Signature: _____

Date: _____

Client Waiver and Release from Liability

(*to be signed upon acceptance into CCM*)

I, _____, for, and in exchange of fair consideration, the receipt of which is acknowledged, hereby waive and release, indemnify, hold harmless, and forever discharge Central Care Mission of Orlando, Inc. ("Central Care Mission") and its agents, employees, officers, directors, representatives, successors, assigns and agents of and from any and all claims, debts, costs, demands, contracts, expenses, causes of action, lawsuits, damages, and liabilities of every kind and nature whatsoever, whether known or unknown, in law or equity, that I ever had or may have, arising from or in a way related to my participation in any of the events, activities or fundraisers conducted by Central Care Mission on the premises of Central Care Mission or elsewhere conducted for the benefit of Central Care Mission or associated with the Central Care Mission program.

By this waiver and release, I agree to assume any and all risks associated with such event, activity or fundraiser and I take full responsibility for my actions arising out of my involvement in such activities, events or fundraisers.

I sign this document freely and of my own accord and not under any duress or threat of duress, without inducement or harassment. I certify that I am over the age of 18, a United States citizen, and am legally authorized to sign this document on my own behalf.

Accepted and Agreed:

Client Name (Printed): _____

Client Signature: _____

Date: _____

VIDEO RELEASE FORM

I, _____, hereby grant permission to Central Care Mission of Orlando, Inc. the rights of my image, in video or still, and of the likeness and sound of my voice as recorded on audio or videotape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for ANY USE which may include but is not limited to:

- Presentations;
- Courses;
- Online/Internet Videos;
- Media;
- News (Press);

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is a ten-year time limit on the validity of this release and there is no geographic limitation where these materials may be distributed within the United States of America.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name. _____

Street Address/P.O. Box. _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Email Address_____

Signature _____ Date_____

If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature_____ Date_____

Rev. 08/11/2020

Keith B. Vennum, MD

Psycho-pharmacology Medicine and Mental Health Counseling

(Patient Authorization for Release of Health Records to External Parties)

I authorize ***Keith B. Vennum*** to disclose information from the health records of: (*Client Name*)

_____

Date of Birth: _____

The information contained in this form is to be disclosed to Central Care Mission, Spence Pfleiderer, and whoever he may designate regarding the dispensing and control of medications at Central Care Mission

Address: 4027 Lenox Blvd., Orlando, Florida 32811

I authorize this information to be disclosed in the following ways:

Written/Photocopy/Paper

Verbal

Fax

Electronic Mail

Purpose of this disclosure: Dispensing of medication and coordination of care while a client of Central Care Mission

Dates of Treatment:

From: _____ **To:** _____

Specific reports to be disclosed:

Progress Notes

Laboratory Reports

Discharge Summary

Radiology Reports

Consultation Reports

X-ray Films or Other Images

Photographs/Videotapes

Records from other facilities

Entire Health Records (Including, but not limited to; information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities)

Other: _____

I give specific authorization to disclose the following information:

HIV Test Results

Documentation of AIDS Diagnosis

Drug and Alcohol Abuse Treatment Records

Psychiatric/Mental Health Treatment Records

1) I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Keith B. Vennum, MD in writing.

2) My treatment will not be based on the completion of this authorized form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Florida privacy regulations.

Unless revoked earlier, this authorization expires in one year unless I specify another time:

Specified Date: _____

I release the individuals or organizations named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

Signature of Patient (*or Patient Representative*): _____

Date: _____

Printed Name of Patient (*or Patient Representative*): _____

Authority of Representative to act for Patient (*Relationship to Patient*): _____

Consent to Background Check

In connection with your program participation, residency and/or employment with Central Care Mission of Orlando, Inc., notice is hereby given that a consumer report and/or investigative consumer report may be obtained from a consumer reporting agency for program participation or employment purposes. These reports may contain information about your character, general reputation, personal characteristics and mode of living, whichever are applicable. They may involve personal interviews with sources such as your neighbors, friends, or associates. The reports may also contain information about you relating to your criminal history, credit history, driving and/or motor vehicle records, education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time after the receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report prepared by contacting Central Care Mission and Protect My Ministry (14499 N. Dale Mabry Hwy., Suite 201 South, Tampa, FL 33618; Phone: 1-800-319-5518). For information about Protect My Ministry's privacy practices, see www.protectmyministry.com. The scope of this notice and below authorization is not limited to the present and, if you are hired or granted residency, will continue throughout the course of your employment and boarding, allowing Central Care Mission to conduct future screenings for retention, promotion, or reassignment, as permitted by law and unless revoked by you in writing.

Acknowledgement and Authorization

By signing below, I hereby authorize the obtaining of consumer reports and/or investigative consumer reports by Central Care Mission at any time after receipt of this authorization and throughout the course of my employment and residency, if applicable.

Print Name: _____

Signature: _____

Last Four Digits of SSN: _____

Date: _____

Background Check Information

(*required upon admittance to CCM*)

First Name: _____

Middle Name: _____

Last Name: _____

Mother's Maiden Name: _____

Other Names Used: _____

Date of Birth: _____

Gender: **Male / Female**

Social Security Number: _____

Ethnicity (circle one):

White

Black/African American

Hispanic

Asian/Pacific Islander

Alaskan Native/American Indian

Driver's License or I.D. #: _____

Date License was Issued: _____

Address: _____

City: _____

State/Zip: _____

E-Mail Address: _____

Basic Information

Intake Date: _____

Name:_____

Social Security Number: _____

Age:_____

Date of Birth:_____

Place of Birth:_____

Phone Number: _____

Ethnicity: _____

How tall are you? _____

*How much do you weigh?*_____

What is the color of your hair? _____

*What are the color of your eyes?*_____

Do you have any tattoos? Where are they located?

_____

List another program you've previously been enrolled in:

_____

_____

Did you graduate your previous treatment program(s)?

_____

How did you hear about Central Care Mission?

_____

_____

Were you referred to CCM by Compassion Corner or Goodnews Breakfast?

_____

_____

*What is your **1st** drug of choice?*

_____

*What is your **2nd** drug of choice?*

_____

*What is your **3rd** drug of choice?*

_____

PLEASE LIST SOMEONE WE MAY CONTACT IN THE CASE OF AN EMERGENCY
(Emergency Contact Information)

Name: _____

Number: _____

Relation: _____

Personal History

Please circle 'YES' or 'NO' to the applicable items listed:	
You have never finished ***high school*** or completed your ***GED***:	**YES / NO**
You have received your ***high school diploma*** or ***GED***:	**YES / NO**
You have received your ***AA Degree***:	**YES / NO**
You have received your ***BS Degree***:	**YES / NO**
You have received your ***MA Degree***:	**YES / NO**
Are you currently working?	**YES / NO**
Do you have a valid Driver's License?	**YES / NO**
Are you registered to vote?	**YES / NO**
Do you smoke tobacco, vape, or dip?	**YES / NO**
Were you living with family prior to CCM?	**YES / NO**
Were you living with friends prior to CCM?	**YES / NO**
Were you homeless prior to CCM?	**YES / NO**
Were you in another shelter or program prior to CCM?	**YES / NO**
Were you in the hospital or a mental health facility prior to CCM?	**YES / NO**
Were you in jail or prison prior to CCM?	**YES / NO**
(Note: If you are not currently paying a legal lease/rent in your name then you are technically homeless)	
Are you currently homeless?	**YES / NO**
If you're currently homeless, 1st time?	**YES / NO**
If you're currently homeless, 2nd time?	**YES / NO**
If you're currently homeless, 3rd time?	**YES / NO**
If you're currently homeless, 4th time?	**YES / NO**
If you're currently homeless, 5th time?	**YES / NO**

What is the time frame to the nearest month you've been homeless for?

_____

What state have you spent the most time in?

_____

Family & Benefits

What is your current marital status? _____	Have you been divorced? How many times? _____	Number of mothers to biological children? _____
Are you required to pay child support? YES / NO	If you owe child support, how much per month? _____	How many children do you have? _____
Are you estranged from family? YES / NO	Were you raised in foster care? YES / NO	Were you raised by a single parent? YES / NO
Are your parents divorced? YES / NO	Was your parent a drug addict, homeless, or alcoholic? YES / NO	Are you a victim of family violence or abuse? YES / NO

Are you a Veteran? Yes / No	Are you receiving VA benefits? Yes / No	Are you receiving food stamps? (SNAP) Yes / No
What is your benefit coverage? _____	Are you receiving SSI, SSDI, or other benefits besides the VA? List here: _____	If you receive SSI, SSDI, or other benefits, list financial details: _____

Do you have any pending medical or dental appointments?	**YES / NO**
If you have any pending medical or dental appointments, list the details: _____	
Are you currently taking any medication?	**YES / NO**
What medication do you need that you aren't taking? _____	
List the name(s) of medication you are currently taking: _____	
Do you have a physical or mental disability?	**YES / NO**
If you have a physical or mental disability, list the details: _____	
Please circle 'YES' or 'NO' to any of the applicable conditions listed:	
You have experienced or are experiencing ***Schizophrenia***:	**YES / NO**
You have experienced or are experiencing ***Depression*****:**	**YES / NO**
You have experienced or are experiencing ***Anxiety*****:**	**YES / NO**
You have experienced or are experiencing ***Bi-Polar*****:**	**YES / NO**

You have experienced or are experiencing ***Paranoia*:**	**YES / NO**
You have experienced or are experiencing ***Attention Deficit Disorder*:**	**YES / NO**
You have experienced or are experiencing ***Hyperactivity*:**	**YES / NO**
You have experienced or are experiencing ***Anger Issues*:**	**YES / NO**
You have experienced or are experiencing ***Hypertension*:**	**YES / NO**
You have experienced or are experiencing ***Obsessive Compulsive Disorder*:**	**YES / NO**
You have experienced or are experiencing ***PTSD*:**	**YES / NO**

Other: _____

Please circle 'YES' or 'NO' to any of the applicable diseases listed:

You have ***no diseases***:	**YES / NO**
You have ***HIV/AIDS***:	**YES / NO**
You have ***STD's***:	**YES / NO**
You have ***HEP C***:	**YES / NO**

Other: _____

Legal

Have you been convicted of a misdemeanor? **YES / NO**	**Have you been convicted of a felony?** **YES / NO**	**Do you have any pending court dates or charges?** **YES / NO**
Are you on probation? **YES / NO**	**Please list your Probation Officer's name and number:** _____	**Were you in jail prior to your 18th birthday?** **YES / NO**

When and where have you been incarcerated?

_____

Please circle 'YES' or 'NO' to the applicable charges listed:

Have you ever been charged or convicted of ***Domestic Violence*****?**	**YES / NO**
Have you ever been charged or convicted of a ***DUI***?	**YES / NO**
Have you ever been charged or convicted of ***Assault***?	**YES / NO**
Have you ever been charged or convicted of ***Battery***?	**YES / NO**
Have you ever been charged or convicted of ***Fraud***?	**YES / NO**
Have you ever been charged or convicted of ***Theft***?	**YES / NO**
Have you ever been charged or convicted of ***Murder***?	**YES / NO**
Have you ever been charged or convicted of ***Man Slaughter***?	**YES / NO**
Have you ever been charged or convicted of ***Trespassing/Camping***?	**YES / NO**
Have you ever been charged or convicted of ***Possession***?	**YES / NO**

Other:

_____

Job Information

Name:_____

Date of Intake:_____

Driver's License: YES / NO

State of Driver's License: _____

Driver's License Number: _____

Social Security Card: YES / NO

Work Boots: YES / NO

Steel Toe: YES / NO

If you have felonies list the details; if not, please write 'not applicable':

_____

_____

_____

Work Skills (i.e. Carpentry)

_____

_____

_____

_____

_____

Notes (i.e. Disabilities)

_____

Chemical History

Type of Drug	Date First Used	Amount Per Day	Duration	MG Per Day
Vicodin (OPIATE, LESSER)				
Percocet (OPIATE, LESSER)				
Percodan (OPIATE, LESSER)				
Oxycodone (OPIATE, LESSER)				
Hydrocodone (OPIATE, LESSER)				
Lortab (OPIATE, LESSER)				
Darvocet (OPIATE, LESSER)				
OxyContin (OPIATE, TIME RELEASE)				
Roxicodone (OPIATE, TIME RELEASE)				
MS-Contin (OPIATE, TIME RELEASE)				
Dilaudid (OPIATE, TIME RELEASE)				
Fentanyl (OPIATE, TIME RELEASE)				
Methadone (OPIATE, TIME RELEASE)				
Xanax (BENZODIAZEPINE)				
Valium (BENZODIAZEPINE)				
Klonopin (BENZODIAZEPINE)				
Soma (BENZODIAZEPINE)				
Morphine				
Heroin				
Cocaine				
THC				
Alcohol				
Nicotine				

Treatment and Detox History

Date	Program Type (Inpatient/Outpatient)	Reason for Admission

Criteria for referral to detox or treatment program:

- Multiple substance abuser; combination of 3 substances such as opiates, benzo's, and soma
- If patient stops drinking, they get delirium tremens (shaking, confusion, hallucinations)
- Opiate levels are above 300mg per day or methadone levels of over 30mg per day
- Major health issues such as heart, lung, kidney, or liver problems