EASTERN BAND OF CHEROKEE INDIANS

TRIBAL EMPLOYMENT RIGHTS OFFICE

MOTHER TOWN HEALING PROGRAM

is accepting

APPLICATIONS

Please contact:

EBCI TERO
756 Aquoni Rd.
PO Box 1839
Cherokee, NC 28719
828.359.6421
Email: bjrich@nc-cherokee.com

Fax: 828.359.0068
https://ebci-tero.com/

Mother Town Healing Program Overview

The Mother Town Healing Program ("MTHP") is designed to assist enrolled members in recovery from the use of illegal substances by providing a safe working environment. In doing so, the program will provide training for necessary job skills and discipline to enter or re-enter the workforce in a positive manner. While one of the main goals is for participants to become employable, we also encourage them to begin rebuilding relationships that have been broken during their time in active addiction.

During their tenure in the program, participants will be expected to maintain their relationship with a recovery program (Analenisgi or others), while committing to the work responsibilities of the Mother Town Healing Program. Throughout the program, participants will learn how to foster personal growth and develop a positive self-image. Raising a garden in the heartland of the Cherokee people – the Kituwah fields – is one of the healing aspects of our program activities. Beyond gardening, participants will be expected to learn employment skills and develop their character for future success in the workplace.

To solidify their efforts, participants are encouraged to intern with tribal programs and other entities of the EBCI for at least a 90-day period that will provide a solid working experience that may demonstrate to prospective employers their commitments to career stability and success in the workplace. With the Mother Town Healing Program, participants have an opportunity to nurture and develop themselves through hard work and dedication and earn a chance at becoming a valuable contributor to our tribal workforce.

Program Eligibility

Any EBCI tribal member who meets the program requirements may apply to the Mother Town Healing Program. The program requirements are as follows:

- ✓ Must have attained sobriety and have not used mind altering substances in the past 90 days. *(Sobriety in this context should mean: Free of all mind-altering substances except for prescription medication by health care providers).*
- ✓ Must not be currently employed part/full time or own operate or take part in a business venture.
- ✓ Must be actively involved with a recovery program for least 90 days and it must be verifiable (ie. Analenisgi or other)
- ✓ Must continue to attend a recovery program while within the Mother Town Program and internship positions.

SELECTION PROCESS

Applicants with COMPLETE applications will be contacted at the next hiring cycle. Participation cycles occur when there are vacancies in the program or as participants move on to the internship phase of the program. T.E.R.O. will contact the first applicants to file and proceed until the vacant number of applicants have committed to interview.

INTERVIEW CRITERIA

TERO designed the Mother Town Healing Program to promote sobriety, assist those in recovery with their recovery progress, promote employable skills, provide resources, and assist with gainful employment. Candidates will be interviewed based on the following criteria:

- ✓ Has the candidate maintained a sobriety lifestyle through the applicant process?
- ✓ Does the candidate's general attitude and demeanor fit program standards?
- ✓ Will the candidate actively seek employment and / or continuing education while working the program?
- ✓ Will the program be of benefit to the candidate?
- ✓ Will the candidate have outside commitments requiring excess time away from work?

TRIBAL EMPLOYMENT RIGHTS OFFICE

MOTHER TOWN HEALING PROGRAM APPLICATION

Name (Print): _____

EBCI Enrollment Number: _____ (***Attach copy of EBCI Enrollment)**

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Email Address: _____

Are you currently in recovery? ☐ YES ☐ NO

(Recovery services may include therapy, peer support, AA/NA meetings, treatment, medically assisted recovery program, etc.)

Don't forget to include:

- ☐ Signed Release of Information Form
- ☐ Copy of EBCI Enrollment
- ☐ The BEST phone number or numbers where YOU can be reached

_____ _____

Signature Date

Analenisgi
(Cherokee Indian Hospital Authority)

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Complete all sections, date and sign.

I. I,_____, hereby voluntarily authorize the disclosure of information from my record.
(*Patient Name)*

II. **The information is to be disclosed by:**

Name of Facility: **CIHA / HOSPITAL / ANALENISGI**

Address: _____

City/State: **CHEROKEE, NC**

And is to be provided to:

Name of Person/Organization/Facility: **TERO / MOTHER TOWN HEALING PROGRAM**

Address: **PO BOX 1839** **756 Aquoni Rd**

City/State: **CHEROKEE, NC**

III. The purpose(s) of this use/disclosure is/are: IN SUPPORT OF THEIR RECOVERY & COHESION WITH THE PROGRAM

IV. **The information to be used or disclosed from my health record: (Check appropriate box(es):**

- o Entire Record
- ☒ Only information related to (specify): **TREATMENT PLAN, DRUG TEST RESULTS, ATTENDANCE, AND CARE PLAN COORDINATION**
- o Only the period of events from _____ to _____
- o Other (specify): _____
- o Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist patient privilege)

If you would like any of the following sensitive information disclosed, check the applicable box(es) below.

- ☒ Alcohol/Drug Abuse Treatment Referral
- o Sexually Transmitted Diseases
- o HIV/AIDS-related Treatment
- o Mental Health (Other than Psychotherapy Notes)

I understand that I may revoke this authorization in writing submitted at any time to the Medical Records Department, except to the extent that action has been taken in reliance on this authorization, or if this authorization was obtained as a condition of providing insurance coverage, other law proves the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature. I understand that EBCI will not condition treatment or eligibility for direct care on my providing this authorization.

I further understand that I may refuse to sign this authorization. I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act and the Privacy Act of 1974.

REDISCLOSURE

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit disclosure. When this agency discloses mental health and developmental disabilities, information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

REVOCATION and EXPIRATION

I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid from the time of application for service until the application is denied or until the client is discharged from the agency, not to exceed one year. I understand that I may revoke this consent at any time, except to the extent that information has already been released before I revoke it. I understand that if I refuse to sign this Consent for Release of Information, I will not be denied services.

Signature of Patient: _____ Date: _____

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor.

PATIENT IDENTIFICATION:	NAME (First, MI, Last)	RECORD NUMBER:
	ADDRESS:	
	CITY / STATE / ZIP:	DATE OF BIRTH: