EASTERN BAND OF CHEROKEE INDIANS
TRIBAL EMPLOYMENT RIGHTS OFFICE

MOTHER TOWN HEALING PROGRAM APPLICATION

Please return to:

EBCI TERO
756 Aquoni Rd.
PO Box 1839
Cherokee, NC 28719
Email to: TEROMotherTown@ebci-nsn.gov
Main Phone: 828.359.6421

Mother Town Healing Program

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?

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Applicant Information

Applicant Name:		
EBCI Enrollment Number:		* Attach copy of EBCI Enrollment card
Mailing Address:		
City, State, Zip:		
Phone:		
Email:		

Recovery Information

Are you currently in recovery? ☐ Yes ☐ No

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

Have you accessed residential treatment? ☐ Yes ☐ No

Residential treatment may include Kaniwotiyi or other treatment facilities.

Name of Treatment Facility:	

Are you being referred to the Mother Town Healing Program? ☐ Yes ☐ No

Name of Referring Entity:	
Name of Provider:	
Phone:	
Email:	

Have you:

- ☐ Signed Release of Information Form
- ☐ Included a COPY of EBCI Enrollment
- ☐ provided the BEST phone number or numbers where YOU can be reached

Applicant Signature

Signature of the Person Submitting this Form		*Date*

An Independent Component Unit of the Eastern Band of Cherokee Indians
Cherokee Indian Hospital Authority
Caller Box C-268
Cherokee, NC 28719
Phone: (828) 497-9163 **Fax**: (828) 497-2185

Patient Confidential Communications Individuals have a right to request confidential communications regarding their Protected Health Information (PHI). These requests could require that communications be directed to alternative locations; such as a different mailing address or phone number.

Patient Full Name _____ **DOB** _____

Record Number _____ **Home Phone** _____ **Cell Phone** _____

☐ OK to leave a detailed message
☐ Leave callback name and number ONLY
☐ OK to leave a detailed message
☐ Leave callback name and number ONLY
☐ Text messages for appointment reminders and callback name and Number only

Written Communication:

Address: _____

☒ Ok to mail to the above address any medical information regarding, labs, billing, etc.

Other: Participation, attendance, and care plan

Please list information you **DO NOT** want to be mailed to the address you listed above:

_____

The Privacy Rule and 42 CFR Part 2 generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual or for uses and disclosures for Treatment, Payment and Healthcare Operations (PTO).

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Please list below individuals we may communicate with regarding your PHI without written authorization. This may include diagnoses, test results, treatment plans, behavioral health assessments or _____

_____

Initial Request:

Full Name (1) TERO Mother Town Healing Program
Address: PO Box 1839, Cherokee, NC 29719
Relationship to you: Employer TEROMotherTown@ebci-nsn.gov
Telephone: (D) 828.359.6424 (M) 828.736.6664

Patient Signature: _____ Date: _____
Relationship (if other than self): _____ Date: _____

Use for Revocation Only

☐ I hereby revoke the above signed Confidential Communications Form. It will remain in effect indefinitely, unless I request in writing otherwise.

Patient Signature: _____ Date: _____
Relationship if other than self: _____ Date: _____

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Cherokee Indian Hospital Authority
Caller Box C-268
Cherokee, NC 28719
Phone: (828) 497-9163 **Fax**: (828) 497-2185

Communication Form Process (staff only)

Effective immediately 06/10/2021

- All Communication Forms will be filled out completely by the patient and scanned into VISTA (display 64) by Patient Registration staff and/or Medical Records Staff.
- The Image Description will be named Communication Form,
- When a client/patient requests a revocation of their Communication Form the following process will be followed:
    - The current form in VISTA will be printed off.
    - The bottom check box must be checked stating *"I hereby revoke the above signed Confidential Communications Form. It will remain in effect indefinitely, unless I request in writing otherwise".*
    - The form must be signed and dated by the client/patient.
    - The form will be uploaded into VISTA (display 64) naming the Image Description ***REVOKED Communication Form.

Use for Revocation Only

☐ I hereby revoke the above signed Confidential Communications Form. It will remain in effect indefinitely, unless I request in writing otherwise.

Patient Signature: _____ Date: _____

Relationship if other than self: _____ Date: _____