

Montana Chemical Dependency Center

525 E Mercury Street, Butte, MT 59701
 Phone: 406 496 5400 Fax: 406-496-5437

APPLICATION FOR SERVICES: A phone interview will be conducted with the applicant and with other parties involved in supporting this applicant in treatment and recovery before a final determination is made.

Name: _____		Gender: M F _____	
Last	First	Maiden/Middle	Date
Physical Address: _____		City, State	Zip
Mailing Address: _____		City, State	Zip
County of residence: _____			
Home #: _____		Work #: _____	
Cell#: _____		Message phone: _____	
Birth date: _____		Age: _____	
Social Security #: _____			
Employed: Yes No		Employer: _____	
Phone: _____			
Education completed:		High School/Grade _____	
		College _____	
		Post graduate _____	
other/GED: _____			
Marital Status:		Married Unmarried Divorced Committed/cohabiting	
Are you a Veteran: Yes No		Homeless: Yes No	
Race/Ethnicity:			
White		Native Indian	
Black		Alaskan Native	
		Asian Indian	
Other: _____			
Enrolled Tribal member? Yes No		Descendant? Yes No	
Tribe: _____			
Emergency Contact: _____		Relationship: _____	
Phone: _____			
Address: _____		City/State: _____	
Zip: _____			
Do you have dependent children under the age of 18: Yes No		How many: _____	
Who has legal custody? _____		Who do they live with? _____	
List the name of your Department of Family Services worker-DFS (if it applies):			
Name _____		Phone _____	
List other persons living in the household/age: _____			
Annual Family Income from ALL sources: \$ _____		Last Year _____	
Household Size: _____		Pay Frequency: _____	
Monthly Income: \$ _____		Source of Income: _____	
Health Insurance _____		Medicaid Medicare VA None Other	
Name of Insured: _____		Relationship: Self Spouse Parent Other	
Date of Birth of Insured: _____		Preauthorization Required: Yes No	
Insurance Group # _____		ID # _____	
Do you currently receive SSD/SDI: Yes No		Monthly \$: _____	
Why are you seeking treatment at this time? Is it just for withdrawal management? If so, what is the immediate follow up plan?			
Please mark the number that best describes your readiness to change your life?			
1	2	3	4
I don't want to change		maybe	I will do whatever it takes.

Do you smoke or use tobacco products? **Yes** **No** Have you ever tried to quit tobacco? **Yes** **No**

What substances are you using now: _____

Do you experience withdrawal symptoms when you stop using substances? **Yes** **No**

If yes, what are the symptoms? (Seizures, DT's) _____

Are you pregnant or do you suspect you are pregnant? **Yes** **No** If Yes, how many weeks?: _____

If **Yes**. Have you seen a physician/practitioner for your pregnancy? **Yes** **No**

Who? _____ When?: _____ Have you had an ultrasound/date?: _____

Who is physician/practitioner who prescribes your medications: _____ Phone _____

What pharmacy (s) do you get your medications from? _____ Phone _____

Current Medications and Dosages: * *You must provide a current medications list from your pharmacy.*

Physical Health: **excellent** **good** **fair** **poor** Why: _____

What is your height? _____ Weight? _____

Current Medical Issues (diabetes, heart disease, liver disease, etc.):

Any special medical needs/accommodations (wheelchair, hearing, vision): _____

Current Diagnosis: Substance Use Disorder _____ Mental Health _____

Number or prior treatments: Inpatient _____ Outpatient _____ Date of last treatment _____

Longest period of abstinence following any treatment episode: _____

Have you received treatment at MCDC in the past? **Yes** **No** When _____ Did you complete: **Yes** **No**

Have you ever used drugs by injection: **Never** **Currently Using** **Last 1-12 Months** **More than a year ago**

Have you been involved with AA or NA groups? **Yes** **No** Other: _____

Do you presently have a sponsor? **Yes** **No** _____

Have you been incarcerated in the last 30 days? **Yes** **No** How many days? _____

Please list all legal involvement (Current and Prior):

Are you required to register as a sexual/violent offender? **Yes** **No**

Are you: **On Probation** **Incarcerated** **Mandatory Monitoring**

On Parole **On Pre-Release** **DUI Offender**

Name of your probation officer: _____ Phone _____

Name of your attorney: _____ Phone _____

Signature of applicant _____ **Contact phone number** _____

Addiction Counselor (LAC) who is submitting application _____

Counselors phone _____

Counselor(LAC) completes with the applicant:

DSM-5 Diagnoses _____

Summarize the assessment of your client using the 6 Dimension from the American Society of Addiction Medicine using the last 6-9 months as a time frame.

*Note: Medically monitored intensive inpatient services, 3.7 program meets specifications in at least 2 of the 6 dimension at least 1 of which in 1, 2, or 3.
3.5 meets dimensions in 4, 5, 6*

Dimension	Please refer to ASAMCRITERIA.ORG for further description in each	Severity Rating 0-4 0- Non-issue- stable 1 – Mild discomfort 2 – Moderate risk/ Difficult can cope yet difficult 3 – Serious difficulties/ Impairment difficulty understanding or coping 4 – Severe difficulty, imminent danger/risk	Level of care: Low or Moderate General Guidelines: All “Lows”= Level 1 One “Moderate” = Level 2 Two or more “Moderate” = Level 3
Dim 1: Acute intoxication and or withdrawal potential	<i>What substance/s are of greatest concern? Last use? Other substances used? Method of use? History of withdrawal? History of seizures? Risk of current withdrawal? Diagnoses?</i>		
Dim 2: Biomedical Conditions and Complications	<i>How is their health? Any acute/chronic medical problems? Ability to access (health) care for those medical issues? Immunizations? HIV/STI/pregnancy risk? Nutrition?</i>		

<p>Dim 3: Emotional Behavioral or cognitive conditions and complications</p>	<p><i>History of any mental health concerns? Any current mental health Symptoms? Do they have a diagnosis & by whom? Psychotropic medications? Past history of Mental Health treatment? History of suicide or harm to others? How functional are they?</i></p>		
<p>Dim 4: Readiness to change</p>	<p><i>Individuals (patients) thoughts about being here? Long term plan for substance use? Thoughts about overall situation and plan to address? What does the patient think that they need? What is the patient willing to do? What is important to the patient? Internal vs. external motivation to change?</i></p>		
<p>Dim 5: Relapse, continued use, or continued problem potential</p>	<p><i>How long can the patient stay substance free? How are they able to stay sober/clean? What skills does the patient have? Can the patient stay substance free if they so desire? Does the patient have prior successes in recovery?</i></p>		
<p>Dim 6: Recovery environment</p>	<p><i>Who is in the patients life? What is important to the patient? Is there any legal/child welfare involvement? (current) family issues? Patients education level? Concerns/issues related to parenting? Type of support and from whom does the patient have? How is the patient connected to the community, culture, etc.? What is the patients current housing? Employment? Financial Situation?</i></p>		

What are your recommendations/plan for the treatment and recovery of this application **once they have completed an intensive in patient treatment:** (Please list all: AA NA, IOP, OP, R-Tech homes, drug court, service volunteer activities etc.)

What plans have you begun to address the above long term recovery plan with your patient?

Signed up for IOP_____	Started completing the Level 3.1 application process_____
Created a plan with the PO_____	Started applications for health insurance_____
Started applications for GED_____	Started applications for sober living home_____
Started applications for employment_____	Started applications for housing_____
Other_____	Other_____

Are you willing to participate in at least one care conference with this patient while they are in treatment:

Yes No N/A

REFERRING AGENCY _____

Address: _____

City: _____ State: _____ Zip Code: _____

Printed name of Counselor: _____

Signature of Counselor: _____

Date: _____

NOTE: You may also submit a copy of your own completed Biopsychosocial that includes the ASAM assessment.

RELEASES OF INFORMATION MUST BE INCLUDED WITH APPLICATION

Medical Issues: If the patient has any medical issues we need Medical Records to complete this application,

* Include releases for all medical providers & pharmacy the patient uses

Mental Health History: If this patient has a history of Mental Health Counseling we will need Records from the provider.

* Include releases for all mental health providers

Legal Involvement: Include Releases of Information for Probation officers, attorneys, judges, etc.

* We will not accept an applicant to MCDC without a release for the assigned probation officer.

* RVO/RSO are reviewed on an individual basis.