



**Montana State Approved
Residential Substance Use Disorder Treatment Services
Application**

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 <input type="checkbox"/> F <input type="checkbox"/>	
Physical Address:	Last _____	First _____	Maiden/Middle _____
	Street Address	City, State	Zip
Mailing Address:	Street Address	City, State	Zip
Home #:	Work #:	Cell#	Message Phone:
Birth Date:	Age:		
Social Security #:	County of Residence: _____		
Employed: (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer: _____	Phone: _____	
Education completed: Grade _____	College _____	Post graduate _____	Other/GED: _____
Marital Status (check one) : <input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Divorced <input type="checkbox"/> Committed/cohabiting			
List other persons living in the household/age: _____			
Are you a Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No		Homeless: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race/Ethnicity (check one):			
<input type="checkbox"/> 1. White	<input type="checkbox"/> 3. American Indian	<input type="checkbox"/> 5. Asian/Pacific Islander	<input type="checkbox"/> 7. Hispanic – Puerto Rican
<input type="checkbox"/> 2. Black	<input type="checkbox"/> 4. Alaskan Native	<input type="checkbox"/> 6. Hispanic – Mexican	<input type="checkbox"/> 8. Hispanic –Cuban
Enrolled Tribal member?	Descendant	Tribe	
Check here if you are a person with dependent children under the age of 18 _____			
Children's ages and gender: _____			
Who has legal custody? _____		Who do they live with? _____	
List the name of your Department of Family Services Worker (if it applies):			
Name _____		Phone _____	
Annual Family Income from ALL sources: \$ _____ Last Year _____ Household Size: _____			
Health Insurance _____		Medicaid _____ Medicare _____ NONE _____	
Name of Insured: _____		Relationship(check one): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Insurance Group # _____		ID # _____	
Preauthorization Required: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you currently receive SSDI: <input type="checkbox"/> Yes <input type="checkbox"/> No Monthly \$: _____			
Do you smoke or use tobacco products? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever tried to quit tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What substances/drug of choice are you using now? _____			
Do you experience withdrawal symptoms when you stop using substances?(check one) <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what are the symptoms? (seizures, dt's) _____			
Number of Days in Treatment Prior 12 Months: Inpatient _____ Outpatient _____ Date of last Treatment _____			
Longest period of abstinence following any treatment episode: _____			
Have you received treatment at MCDC in the past?(check one) <input type="checkbox"/> Yes <input type="checkbox"/> No When _____ Did you complete: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever used drugs by injection (check one): <input type="checkbox"/> Never <input type="checkbox"/> During the Last 12 Months <input type="checkbox"/> Currently using			
Have you been involved with AA or NA groups? <input type="checkbox"/> Yes <input type="checkbox"/> No Other. _____			
Do you presently have a sponsor? _____			

Are you pregnant or do you suspect you are Pregnant?(check one) Yes No If Yes How Many Weeks?: _____
If yes. Have you seen a physician/practitioner for your pregnancy? Yes No Who? _____ When?: _____
Who is Physician/practitioner who prescribes your medications: _____ Phone _____
What Pharmacy (s) do you get your medications from? _____ Phone _____
Current Medications and Dosages: Please provide a current medications list from your pharmacy.

Current Diagnosis: Substance Use Disorder _____ Mental Health _____
Physical Health (check one): excellent good fair poor

Current Medical Issues (Diabetes, heart disease, liver disease, etc.).

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

Name of Therapist/Counselor: _____ Phone _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Have you been incarcerated in the last 30 days?(check one) Yes No How Many days? _____
Please list all Legal Involvement:

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

List the name of your probation officer _____ Phone _____

List the name of your attorney _____ Phone _____

Why are you seeking treatment at this time? Is it just for withdrawal management? If so, what is the immediate follow up plan?

Please check the number that best describes your readiness to change your life?

1 2 3 4
I don't want to change maybe I will whatever it takes

The disease of addiction is a serious medical condition that requires the support of many people in your community.

Please list the people in your life that will be supporting you and that we may speak with:

Name _____ relationship to you _____ phone _____
Name _____ relationship to you _____ phone _____
Name _____ relationship to you _____ phone _____

Signature of the applicant _____ YOUR phone number _____

Addiction Counselor (LAC) who is submitting application _____ Counselors phone _____
 AGENCY and ADDRESS _____

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 Can Cope Yet Difficult 2 - Moderate Risk/Difficult 3 - Serious Difficultes/ 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
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>		
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>		
3 Emotional Behavioral or cognitive conditions and complications	<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>		

4 Readiness to change	<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>		
5 Relapse, continued use, or continued problem potential	<i>How long can the patient stay sober/clean? How are they able to stay substance free? 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>		
6 Recovery environment	<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>		

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? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Signed up for IOP | <input type="checkbox"/> Started completing the Level 3 1 application process |
| <input type="checkbox"/> Created a plan with the PO | <input type="checkbox"/> Started applications for health insurance |
| <input type="checkbox"/> Started applications for GED | <input type="checkbox"/> Started applications for sober living home |
| <input type="checkbox"/> Started applications for employment | <input type="checkbox"/> Started applications for housing |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Are you willing to participate in at least one care conference with this patient while they are in treatment: Yes No N/A

Printed name of Counselor: _____ Signature of Counselor _____ Date _____

Additional Information:

Have you participated in any prior substance use or mental health treatment in the past? (check one) Yes No
If yes, please list when and what:

Are you a Montana resident? (check one) Yes No
What is your current living situation?

If you have minor children, what is the percentage of time that they are in your custody?

Do any of your minor children have special needs?

Do you (or your children) receive any of the following? (Please check all that apply)

- TANF
- Food Stamps
- SSI
- Child Support
- MHSP
- Healthy MT. Kids (CHIP)

Have you had a TB test in the last 12 months? (check one) Yes No

Have you had a physical exam in the last 12 months? (check one) Yes No

Are you currently on probation? (check one) Yes No

Have you been admitted to any of the following residential programs in the past (please check those that apply)

- | | |
|--|--|
| <input type="checkbox"/> Share House | <input type="checkbox"/> Rimrock Foundation |
| <input type="checkbox"/> Carole Graham Home | <input type="checkbox"/> TLF (Helena) |
| <input type="checkbox"/> Bozeman Recovery Home (women) | <input type="checkbox"/> RTEC Lighthouse |
| <input type="checkbox"/> Park Recovery Home (Livingston) | <input type="checkbox"/> RTEC Kalispell |
| <input type="checkbox"/> Teen Recovery | <input type="checkbox"/> RTEC White Sky Hope Lodge |
| <input type="checkbox"/> RTEC Olive Branch | <input type="checkbox"/> RTEC Elkhorn |
| RTEC Blue Thunder Lodge | |

For Adolescent Use Only

Are you still attending school? (check one) Yes No

If yes, where?

Who is your legal guardian/custodian _____

Guardian/parent signature. _____ Date _____