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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☐ F☐** _____
Last First Maiden/Middle Date

Physical Address: _____
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) ☐Yes ☐No **Employer:** _____ **Phone:** _____

Education completed: Grade_____ **College** ____ **Post graduate**_____ **Other/GED:**_____

Marital Status (check one) : ☐ Married ☐ Unmarried ☐ Divorced ☐ Committed/cohabiting
List other persons living in the household/age: _____

Are you a Veteran: ☐ Yes ☐ No **Homeless: ☐ Yes ☐ No**
Race/Ethnicity (check one):
☐1. White ☐3. American Indian ☐5. Asian/Pacific Islander ☐7. Hispanic – Puerto Rican
☐2. Black ☐4. Alaskan Native ☐6. Hispanic – Mexican ☐ 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): ☐Self ☐Spouse ☐Parent ☐Other**
Insurance Group #_____ **ID #**_____
Preauthorization Required: ☐ Yes ☐ No
Do you currently receive SSDI: ☐ Yes ☐ No Monthly $:

Do you smoke or use tobacco products? (check one)**☐ Yes ☐ No** Have you ever tried to quit tobacco? **☐ Yes ☐ No**
What substances/drug of choice are you using now?
_____
Do you experience withdrawal symptoms when you stop using substances?(check one) **☐ Yes ☐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)**☐Yes☐No** When_____ Did you complete: **☐Yes☐No**

Have you ever used drugs by injection (check one): **☐Never ☐During the Last 12 Months ☐Currently using**

Have you been involved with AA or NA groups? **☐Yes ☐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 bests 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 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
1 Acute intoxication and or withdrawal potential	*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?*		
2 Biomedical Conditions and Complications	*How is their health? Any acute/chronic medical problems? Ability to access (health) care for those medical issues? Immunizations? HIV/STI/Pregnancy Risk? Nutrition?*		
3 Emotional Behavioral or cognitive conditions and complications	*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?*		

4 Readiness to change	*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?*		
5 Relapse, continued use, or continued problem potential	*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?*		
6 Recovery environment	*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?*		

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)

☐ Signed up for IOP
☐ Created a plan with the PO
☐ Started applications for GED
☐ Started applications for employment
☐ Other_____
☐ Started completing the Level 3 1 application process
☐ Started applications for health insurance
☐ Started applications for sober living home
☐ Started applications for housing
☐ 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)

- ☐ Share House
- ☐ Carole Graham Home
- ☐ Bozeman Recovery Home (women)
- ☐ Park Recovery Home (Livingston)
- ☐ Teen Recovery
- ☐ RTEC Olive Branch
- ☐ RTEC Blue Thunder Lodge
- ☐ Rimrock Foundation
- ☐ TLF (Helena)
- ☐ RTEC Lighthouse
- ☐ RTEC Kalispell
- ☐ RTEC White Sky Hope Lodge
- ☐ RTEC Elkhorn

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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 _____