Thank you for your interest in **Minnesota Adult & Teen Challenge (MnTC) Adult, Life Renewal Treatment Program.** Our program is designed to help those who are struggling with life-controlling chemical dependency issues and desire a faith-based component as part of the approach to recovery.

To complete the admissions process you must complete the following steps:

- Complete the attached application and fax or mail or email admissions@mntc.org it in to the location to which you are applying.
- Secure funding by applying for a Rule 25 at your county of residence or by completing an insurance assessment.
    - Admissions can help you determine where your assessment may be completed

Minneapolis Admissions
Mn Adult & Teen Challenge
3231 1st Ave South
Minneapolis, MN 55408
612.373.3366 #1
Fax: 612.823.4913

Rochester Admissions
Mn Adult & Teen Challenge
1530 Assisi Drive NW
Rochester, MN 55901
507-288-3733
Fax: 855-545-2217

Brainerd Admissions
Mn Adult & Teen Challenge
2424 Business 371
Brainerd, MN 56401
218-833-8748
Fax: 218-833-8778

Upon receipt of your application, an admissions representative will contact you and begin processing your application. In processing applications a number of things are taken into consideration including: mental health, medical condition, past and present legal status, funding eligibility, and level of care required. The length of the application process can vary from one day to two weeks depending on the need for notes and funding confirmation.

MnTC is a voluntary program. Please carefully review all of the information in this packet to determine if our program is right for you. If not, please contact our admissions office to request a referral list of other programs.

It's important that your contact information is current. If you are submitting an application and have relocated please be sure to notify our admissions department of your current contact information. If you have a friend or family member assisting you in the application process, please complete the Release of Confidential Information form.

Important Applicant Information:

- Applicants that complete the licensed treatment program and transfer to the long term recovery program will also be assessed for outpatient treatment services. If eligible for these services, it is required for the client to attend the afternoon programming and counseling services as part of their recovery program. Exceptions would be: the inability to procure funding or 12 months of continuous abstinence from drugs and alcohol.
- Applicants requiring detoxification must do so prior to entry.
- Applicants are strongly encouraged to enter the program with at least a 30 day supply of all currently prescribed medications (with the exclusion of prohibited medication) or an active prescription and open insurance coverage.
- A physical examination is required prior to admission for out of state residents.
    - Tests for HIV, STD's, Tuberculosis and Hepatitis are required as part of the physical exam.
- Mn applicants may be approved for admission prior to having a physical examination, provided they agree to have a physical immediately upon entering our program.
    - Tests for HIV, STD's, Tuberculosis and Hepatitis are required as part of the physical exam.

Please return only the Application, Voluntary Compliance with Faith Based Activities document, and Release of Information form to the admissions office. The other materials are for your records.

First Name:_____ **Sex:**
Middle Name:_____ ☐Male
Last Name:_____ **DOB:** ____/____/____ **Age:** _____ ☐Female

Current Address:
Street: _____ **Height:** _____ **Weight:** _____
City: _____ **Legal Resident Of:**
State: _____ Zip: _____ State: _____
Phone: _____ Email: _____ County: _____

Do You Have Any Relatives Or Friends Currently In Our Program? ☐Yes ☐No **Who?** _____

Have You Previously Been In Our Program? ☐Yes ☐No **How Many Years Ago?** _____

As of today, do you plan to attend the Long Term Recovery Program after graduating from the Short Term Life Renewal Treatment Program? ☐Yes ☐No ☐Undecided _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Engaged ☐Separated

Citizenship: ☐United States ☐Other (If Other) **Do you have a Green Card or verifying document?** ☐Yes ☐No

Race: ☐Native American ☐Asian ☐Black ☐Hispanic ☐Multi Racial ☐White ☐Other_____

Do You Read And Write English At A 5th Grade Level or Above: ☐Yes ☐No

Do You Have A High School Diploma? ☐Yes ☐No **If No, Do You Have A GED?** ☐Yes ☐No

I Mainly Need Help With: (Check All That Apply) ☐Alcohol Addiction ☐Drug Addiction ☐Other: _____

Last date of use? _____ **Substance used:** _____

Do You Use Tobacco? ☐ Yes ☐ No (Tobacco use is not permitted at any time while enrolled in the program)

Have You Ever Been Treated For Chemical Addiction? ☐ Yes ☐ No How many times? _____

Prior Treatment Facility: (list the most recent treatment program you have been in)

Name of Facility: _____
Address: _____
City: _____State: _____ Zip: _____
Dates of Treatment: ____/____/____ to ____/____/____
Reason for Treatment: _____
Did you complete the program? ☐ Yes ☐ No

For Admission Use only:

In your own words, tell us why you want to come to Minnesota Adult & Teen Challenge and the main issues you believe you need to deal with while in the program: (Please **print** clearly)

PHYSICAL HEALTH

Please be advised that MnTC is NOT a Hospital Based Setting
If it is determined your needs exceed our care ability; you will be referred to a more suitable placement.

Medical History: (Check all that apply to your current and past conditions)

☐ Asthma	☐ Drug Abuse	☐ HIV/AIDS
☐ Alcohol Abuse	☐ Fetal Alcohol Syndrome	☐ Pancreatitis
☐ Back Problems	☐ Gastric Bypass Surgery	☐ Polycystic Ovarian Syndrome
☐ Celiac Disease	☐ Head Trauma/TBI	☐ Respiratory Problems
☐ Colitis	☐ Heart Attack/Stroke/Condition	☐ Seizures
☐ Crohns Disease	☐ Hepatitis	☐ STI/STD
☐ Diabetes ☐ Type 1 ☐ Type 2	☐ High Blood Pressure	☐ Tuberculosis

Do you have any current medical concerns? If yes, please be specific:_____
_____

Are you currently being treated by a doctor? ☐Yes ☐No

Primary Physician Clinic:_____
Address: _____
City: _____State: _____ Zip:_____
Phone: _____ Fax: _____
Dates of Treatment: ____/____/____ to ____/____/____
Reason for Treatment: _____
_____

For Admission Use Only:

Are you pregnant? ☐ Yes ☐ No Due Date:____/____/_____

Are you allergic to any medications? ☐ Yes ☐ No If Yes, what medications?_____
_____

Are you being treated with prescribed narcotics/benzodiazepine/opiate/prohibited medications? ☐Yes ☐No
If Yes, what medications?_____
(Applicants on these types of medications or ingesting any of the above will need to complete the taper regimen prior to admission or switch to approved medications under doctor supervision.)

Non- Psychiatric Medications:

Medication Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		

Special Needs:

Do you have any type of disability?	☐ Yes	☐ No	Type: _____
Do you have any chronic conditions?	☐ Yes	☐ No	Type: _____
Do you have any medical restrictions?	☐ Yes	☐ No	Type: _____
Do you have any other type of special needs?	☐ Yes	☐ No	Type: _____
Do you have any allergies?	☐ Yes	☐ No	Type: _____
Do you require a special diet?*	☐ Yes	☐ No	Type: _____

MnTC is NOT a hospital based setting; therefore, any special dietary accommodations or substitute meal requests are unable to be accommodated. Please speak to your admissions rep to discuss your needs.*

MENTAL HEALTH

Mental Health History: (Check all that apply to your current and past conditions)

☐ ADD / ADHD	☐ Depression	☐ Personality Disorder _____
☐ Anorexia	☐ Dissociative Identity Disorder	☐ Physical Abuse
☐ Anti-Social Personality Disorder	☐ Hallucinations	☐ PTSD/Trauma _____
☐ Anxiety Disorder/Panic Attacks	☐ Hearing Voices	☐ Rape
☐ Autism/Aspergers	☐ Homicidal Tendencies/Thoughts	☐ Schizoaffective Disorder
☐ Bipolar Disorder	☐ Insomnia	☐ Schizophrenia
☐ Borderline Personality Disorder	☐ Narcissistic Personality Disorder	☐ Sexual Abuse
☐ Bulimia	☐ Paranoia	☐ Suicide Thoughts/Attempts

Have you thought about, or attempted suicide in the past 3 months? ☐Yes ☐No If yes, how long ago: _____

Primary Psychiatrist/Psychologist Clinic: _____
Address: _____
City: _____State: _____ Zip:_____
Phone: _____ Fax: _____
Dates of Treatment: ____/____/____ to ____/____/____
Reason for Treatment: _____

For Admission Use Only:

Mental Health Medications Currently Taking:

Medication Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

FINANCIAL INFORMATION (to be used to help determine eligibility for financial assistance)

Are you presently employed? ☐Yes ☐No If yes, what is your monthly income? _____
Do you receive any other income (SSI, disability, etc)? ☐Yes ☐No If yes, what is the monthly amount? _____

Do you have assets titled in your name (house, vehicles, land, trailer)? ☐Yes ☐No If yes: Is their an an outstanding loan? ☐Yes ☐No If yes: Balance Due? _____ Co-Signer?: _____
If yes: Balance Due? _____ Co-Signer?: _____

Do you currently receive any government assistance? Please circle (SSI, Disability, MA/GA, Other: _____)
Do you have medical insurance? ☐Yes ☐No If yes, please provide the following information:
Insurance Provider:_____ Member ID Number:_____
Address: _____ Group Number: _____
City:_____ State:_____ Zip:_____ Provide Phone: ( )_____-_____

Do you have a County Case worker: ☐Yes ☐No If yes, please provide the following information:
Case Worker's Name: _____
Address:_____
City: _____State: _____Zip Code: _____
Phone: _____Fax: _____

For Admission Use Only:

LEGAL ISSUES

Are you currently on probation? ☐ Yes ☐ No State/County: _____
Are you currently on parole? ☐ Yes ☐ No State/County: _____
Do you currently have any court cases pending? ☐ Yes ☐ No State/County: _____
Are you currently under investigation for anything? ☐ Yes ☐ No State/County: _____
Do you currently have any outstanding warrants? ☐ Yes ☐ No State/County: _____

Have you ever been convicted of a violent crime? ☐ Yes ☐ No If yes, please list each conviction and date:

_____

Have you ever been convicted of a sex related crime: ☐ Yes ☐ No If yes, please list each conviction and date:

_____

Are you currently facing charges for a violent or sex related crime? ☐ Yes ☐ No If yes, please describe fully:

_____

Are you required to register as a sexual or predatory offender? ☐ Yes ☐ No
If yes, what Level? 1 2 3 **Are you required to "Notify the Community" or police department?** (please circle)

Probation Officer's Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

For Admission Use Only:

Attorney's Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

For Admission Use Only:

EMERGENCY CONTACTS

Primary Contact Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____ Email: _____

Secondary Contact Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____ Email: _____

APPLICANT'S STATEMENT

By my signature below, I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that should an investigation disclose untruthful or misleading answers, I may be discharged from the MnTC program. Furthermore, I understand that MnTC is a Christian, faith-based program and that I have made a free and independent choice to enroll. I understand that other program options are available to me and I have had an opportunity to request a referral. I agree that that I will settle any and all previously unasserted claims, disputes or controversies arising out of or relating to my application, participation in and discharge from the MnTC program with MnTC by final and binding arbitration in accordance with the applicable American Arbitration Association rules of arbitration in effect on the date that arbitration is requested by either me or MnTC. I agree that all administrative costs of arbitration shall be divided equally among the parties. Please initial indicating that you have received, read and agree to abide by the following documents:

____ Program Information ____ Break Policy _____ Prohibited Medication

_____ ____/____/____
Applicant's Signature Date

Twelve Steps to Recovery and Voluntary Participation in Faith Based Activities

All traditional 12-Step treatment programs recognize the importance of spirituality as it relates to sobriety and recovery. The Minnesota Department of Human Services licenses various models of treatment, many in which faith plays a very active role. Upon your request, MnTC will help you incorporate the Christian faith into your personal application of the 12 steps.

Step 1 – Admit we are powerless over our addiction – that our lives have become unmanageable.

Step 2 – Come to believe that a Power greater than ourselves could restore us to sanity.

Step 3 – Make a decision to turn our will and our lives over to the care of God as we understand God.

Step 4 – Make a searching and fearless moral inventory of yourself.

Step 5 – Admit to God, to ourselves and to another human being the exact nature of our wrongs.

Step 6 – Are entirely ready to have God remove all these defects of character.

Step 7 – Humbly ask God to remove our shortcomings.

Step 8 – Make a list of all persons we have harmed, and become willing to make amends to them all.

Step 9 – Make direct amends to such people wherever possible, except when to do so would injure them or others.

Step 10 – Continue to take personal inventory and when we are wrong promptly admit it.

Step 11 – Seek through prayer and meditation to improve our conscious contact with God as we understand God, praying only for knowledge of God's will for us and the power to carry it out.

Step 12 – Having had a spiritual awakening as a result of these steps, we try to carry this message to other addicts, and to practice these principles in all our affairs.

While participating in the MnTC Life Renewal Program, you have the option of participating in religious activities and having your treatment plan supplemented with religious materials; please notify your counselor or intake specialist if you desire this. If you choose to decline to participate in a particular religious activity please notify a program staff and an alternative activity will be provided for you. If at any point you change your mind about having religious materials in your treatment plan, please notify your counselor. If you are dissatisfied with the MnTC program, please notify your counselor and/or program director and we will seek to resolve the issue or else work with you to find a program that will better meet your needs.

No provider of substance abuse services receiving federal funds from the U.S. Substance Abuse and Mental Health Services Administration may discriminate on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in religious practices.

My signature below indicates that I have carefully considered the optional faith components of the program and have made an informed, free and independent choice to participate in the MnTC program. I also acknowledge that I will be provided with a referral list of other programs (both religious and secular) in the event that I object to the religious nature of the program and its activities. I have further been informed that I may ask for a copy of this list at any time prior to admission or during the program.

_____
Applicant's Name (Please print)

_____ _____
Signature Date Date

(THIS PAGE MUST BE RETURNED WITH THE APPLICATION)

THIS PAGE MUST BE RETURNED WITH THE APPLICATION IF YOU WANT US TO TALK TO SOMEONE ELSE ABOUT YOUR ENROLLMENT

Minnesota Adult & Teen Challenge Authorization to Release & Disclose Client Information

Instruction: If **any** section is incomplete this form may be invalid and the request may not be processed.

Client Information	**Name:** _____ **Date of Birth:** _____ **Address:** _____ **Phone:** _____ **City:** _____ **State:** _____ **Zip:** _____
Health Care Provider/ Individual: "Disclosing Party" (***Who*** has the information you want released) **Be specific.**	☐ **MnTC Mpls**: 1619 Portland Ave. S., Mpls., MN 55404 **Attention:** _____ ☐ **MnTC Brainerd**: 2424 Business 371, Brainerd, MN 56401 **Attention:** _____ ☐ **MnTC Duluth**: 2 East Second St., Duluth, MN 55802 **Attention:** _____ ☐ **MnTC Rochester:** 1530 Assisi Dr NW, Rochester, MN 55901 **Attention:** _____ ☐ **Other:** Facility/Name: _____ Attention: _____ Address: _____City: _____ State: ____ Zip: _____ P**hone:** _____
Receiving Party: (***Where*** do you want the information sent?) **Be specific.**	☐ **MnTC Mpls,** 1619 Portland Ave. S., Mpls., MN 55404 **Attention:** _____ ☐ **MnTC Brainerd,** 2424 Business 371, Brainerd, MN 56401 **Attention:** _____ ☐ **MnTC Duluth,** 2 East Second St., Duluth, MN 55802 **Attention:** _____ ☐ **MnTC Rochester:** 1530 Assisi Dr NW, Rochester, MN 55901 **Attention:** _____ ☐ **Other:** Facility/Name: _____ Attention: _____ Address: _____ City: _____ State: ____ Zip: _____ P**hone:**_____
Information to be Released: (***What*** do you want sent or released?)	☐ Any and All Records (including those specified below) ☐ I authorize the Disclosing Party and Receiving Party to exchange information necessary for my ongoing treatment, coordination of care and/or for payment purposes. (Check if Applicable) Only Records Checked Below: ☐ Discharge Summary/Notes ☐ Personal* ☐ Progress/Clinic Notes ☐ Legal* ☐ Medical History/Physical Exam ☐ Financial Records ☐ Mental Health Records ☐ Rule 25 ☐ Chemical Dependency/Substance Abuse Records ☐ Other (*Specify*):_____ Optional Limits: Disclose Records Only Related to the Following: ☐ Date(s) of Service:_____ ☐ Injury or Illness:_____
Release Instructions: (***How*** and ***When*** do you want the information?)	**Date** the information is needed (please allow 7-10 days for processing): _____ **Release Method** format requested: (check one) ☐ Paper ☐ Fax ☐ Email ☐ Verbal ☐ Other (*specify*): _____
Purpose of Release: (***Why*** is the information needed?)	☐ Treatment/Continued Care ☐ Personal* ☐ Progress Notes ☐ Transfer of Care ☐ Financial/Insurance ☐ Legal* ☐ Other (*Specify*): _____ ***Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524**

I agree that: (i) this Authorization is effective for one year from the date I sign below (or such later expiration date as provided here: _____ unless earlier revoked; **(ii)** my information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse; **(iii)** I can revoke this Authorization, in writing, at any time, but my revocation will not apply to any information to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; **(iv)** I can send a request for revocation or questions about disclosures to the Medical Record Department at the MnTC address listed above; **(v)** once my information is disclosed it may be re-disclosed and not be protected by federal privacy rules, and the facility cannot prevent the re-disclosure; **(vi)** I can refuse to sign this Authorization and still be assured treatment; **(vii)** I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. §164.524; **(viii)** a photocopy/fax of this Authorization will be treated in the same manner as the original; and **(ix)** MnTC records may include records that it received from other organizations. If these records have been used by MnTC and filed in the record MnTC maintains about me, these records may be released with my MnTC records.

By signing below I acknowledge that I have read and understand this form, and authorize release of the information as described above.

_____ _____

Client Signature **Date**

_____ _____

Parent/Legal Guardian Signature (when applicable) **Date**

Authority: ☐ Parent ☐ Legal Guardian ☐ Personal Rep (*specify)*: _____ Print Name: _____

The information disclosed pursuant to this Authorization includes records protected by Federal confidentiality rules (42 C.F.R. part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Minnesota Adult & Teen Challenge SAMPLE Release & Disclose Client Information

Instruction: If any section is incomplete this form may be invalid and the request may not be processed.

Client Information	**Name:** Jane Doe **Date of Birth:** 01/02/34 **Address:** 1234 Memory Lane **Phone:** 123-456-7890 **City:** Anytown **State:** MN **Zip:** 55000
Health Care Provider/ Individual: "Disclosing Party" (***Who*** has the information you want released) **Be specific.**	☐ **MnTC Mpls**, 1619 Portland Ave. S., Mpls., MN 55404 **Attention:** _____ ☐ **MnTC Brainerd**, 2424 Business 371, Brainerd, MN 56401 **Attention:** _____ ☐ **MnTC Duluth**, 2 East Second St., Duluth, MN 55802 **Attention:** _____ **X Other:** Facility/Name: **Your Clinic/PO/Detox** Attention: **Your Rep or Admissions** Address: **123 1st Ave. N** City: **Mpls** State: **MN** Zip: **55000** **Phone: 890-678-1234**
Receiving Party: (***Where*** do you want the information sent?) **Be specific.**	**X MnTC Mpls,** 1619 Portland Ave. S., Mpls., MN 55404 **Attention:** **Your Rep or Admissions** ☐ **MnTC Brainerd,** 2424 Business 371, Brainerd, MN 56401 **Attention:** _____ ☐ **MnTC Duluth,** 2 East Second St., Duluth, MN 55802 **Attention:** _____ ☐ **Other:** Facility/Name: _____ Attention: _____ Address: _____ City: _____ State: ____ Zip: _____ **Phone:** _____
Information to be Released: (***What*** do you want sent or released?)	**X** Any and All Records (including those specified below) **X** I authorize the Disclosing Party and Receiving Party to exchange information necessary for my ongoing treatment, coordination of care and/or for payment purposes. (**Check if Applicable**) Only Records Checked Below: **X** Discharge Summary/Notes ☐ Personal* **X** Progress/Clinic Notes ☐ Legal* ☐ Medical History/Physical Exam ☐ Financial Records **X** Mental Health Records ☐ Rule 25 ☐ Chemical Dependency/Substance Abuse Records ☐ Other (*Specify*):_____ Optional Limits: Disclose Records Only Related to the Following: ☐ Date(s) of Service:_____ ☐ Injury or Illness:_____
Release Instructions: (***How*** and ***When*** do you want the information?)	**Date** the information is needed (please allow 7-10 days for processing): _____ **Release Method** format requested: (check one) **X** Paper **X** Fax **X** Email **X** Verbal ☐ Other (*specify*): _____
Purpose of Release: (***Why*** is the information needed?)	**X** Treatment/Continued Care ☐ Personal* **X** Progress Notes ☐ Transfer of Care ☐ Financial/Insurance ☐ Legal* ☐ Other (*Specify*): _____ ***Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524**

I agree that: (i) this Authorization is effective for one year from the date I sign below (or such later expiration date as provided here: _____ unless earlier revoked; **(ii)** my information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse; **(iii)** I can revoke this Authorization, in writing, at any time, but my revocation will not apply to any information to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; **(iv)** I can send a request for revocation or questions about disclosures to the Medical Record Department at the MnTC address listed above; **(v)** once my information is disclosed it may be re-disclosed and not be protected by federal privacy rules, and the facility cannot prevent the re-disclosure; **(vi)** I can refuse to sign this Authorization and still be assured treatment; **(vii)** I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. §164.524; **(viii)** a photocopy/fax of this Authorization will be treated in the same manner as the original; and **(ix)** MnTC records may include records that it received from other organizations. If these records have been used by MnTC and filed in the record MnTC maintains about me, these records may be released with my MnTC records.

By signing below I acknowledge that I have read and understand this form, and authorize release of the information as described above.

_____ _____

Client Signature **Date**

_____ _____

Parent/Legal Guardian Signature (when applicable) **Date**

Authority: ☐ Parent ☐ Legal Guardian ☐ Personal Rep (*specify*): _____ Print Name: _____

Program Policies & General Information

The Minnesota Adult & Teen Challenge (MnTC) program is a licensed residential treatment program with a faith component. The program assists individuals in recovering from drug and alcohol abuse and the life-controlling problems associated with it.

MnTC does not discriminate on the basis of race, color, creed, religion, sex, national and ethnic origin, marital status, public assistance, sexual orientation, family status, or disability in the administration of its educational, admission, or program policies or procedures.

Each resident will have access to our "Client Manual" which covers the policies of the program. MnTC reserves the right to make changes in policy whenever necessary. When a change in policy occurs, residents and staff will be notified and the "Client Manual" will be updated to reflect the change. Highlighted below are some basic requirements/guidelines all MnTC residents are expected to adhere to while in the program. This is not a complete list, but will serve as a basic example of what will be expected:

Mail

Incoming mail is normally distributed to the client on the day it is received. Mail from individuals who are not on the client's approved correspondence list will be given to the Program Supervisor. The Program Supervisor will meet with the client and determine if the individual should be added to the correspondence list. If so, the mail will be given to the client. If not, the mail will be returned to the individual who sent it.

Anytime outgoing mail is addressed to an individual who is not on the client's correspondence list, the Program Supervisor will meet with the client and determine if the individual should be added. If so, the mail will be sent out and the individual will be added to the correspondence list. If not, the mail will be returned to the client who will dispose of it in the presence of the staff.

Visitation

Visitors can be a tremendous source of encouragement and motivation for clients. Visitation is limited to individuals whose names are approved on the client's Correspondence List.

All clients may receive visits and/or communication from their physician, religious advisor, county caseworker, attorney, and parole/probation officer. These visits may occur at any reasonable hour provided they schedule the visit in advance through the Program Supervisor who will instruct the charge staff to add their names to the client's correspondence list. All other visitors are subject to the following policy:

Visiting hours are posted at both the men's and women's residences. Visitations are to take place within the client's facility. Visiting hours for men and teen boys are on Sunday from 1:30 – 3:30pm or Wednesday evenings from 7:00 – 9:00pm. Visiting hours for women and teen girls are on Sunday from 2:30 - 4:30pm or Thursday evenings from 6:00 – 8:00pm. (Visitation may also be scheduled during special events or Holiday times.) Family Night is Tuesday evenings from 7:00 – 8:30pm.

The maximum number of visitors a client may have during any visitation period is five unless prior approval has been provided by client's Program Supervisor or primary counselor.

One Week Limited Communication Period

After admission to the program, for the first week clients will not be allowed to communicate (phone calls, letters, visits etc.) with anyone other than clergy, legal officials (county caseworker, attorney, and parole/probation officer), or in the case of family emergencies. The only exceptions to this are teen clients who will be allowed to communicate with their parents/guardians and parents who will be allowed to communicate with their minor children. The reason for this is to help the client settle into a daily routine in the program and to prevent the passing of contraband during this critical period. Exceptions to this rule must be approved by the client's Program Manager and/or Program Director.

Phone Time

Outgoing Calls:
Clients in the Life Renewal Program are authorized to have two 10 minute phone times per week. Individual phone time could consist of more than one call. Clients with minor children may be considered for additional phone time to assist the client in developing and maintaining healthy parenting relationships with their minor child(ren). Additional phone time is at the discretion of the Program Supervisor.

Incoming Calls:
Incoming calls are prohibited except in extreme emergencies.

Medical/Dental Care

Clients have the right to medical and dental care during their stay at Minnesota Adult & Teen Challenge. Clients are responsible for all of their health care expenses. Provisions will be made to transport clients to their primary physicians or mental health professionals if the appointments are within the local metro area (10 mile radius). Approval will be provided for safe self-transport to appointments with client's primary physicians or mental health professionals outside of the metro area.

The Treatment Director will meet with clients whose medical care or number of outside appointments interferes with their treatment plan goals to determine whether or not the client will be able to continue in the program and/or whether a medical transfer or discharge is indicated.

Employment/Living Standards

Due to the nature and schedule of our program, residents are not able to seek employment or be employed throughout the duration of their treatment.

- All residents will be required to participate in general housekeeping and clean-up assignments.

Possession/Use of Drugs, Alcohol & Tobacco

Possession and/or use of drugs, alcohol and tobacco are prohibited while enrolled in our program.

- For the safety of all participants, residents may be subject to drug and/or alcohol tests at any time without prior notice. Residents who test positive for drugs and/or alcohol use while in our program may be discharged from MnTC. In addition, residents their rooms, and their personal property may be searched at any time without prior notice or approval to ensure the safety of our environment.

Daily Schedule

Residents participate in all daily scheduled programming and activities, with the exception of optional recreational activities. Residents can expect a typical weekday at MnTC to include the following: chapel, classes, counseling, groups, and individual study time.

- Saturday's are less structured and include time in the afternoon for visits from approved family and friends. No more than 7 visitors can attend at one time.
- All gifts and packages are subject to inspection by staff for items we cannot allow.

Prescription Medications

Clients are responsible for purchasing their own medications regardless of whether they are prescription or non-prescription.

Clients who take prescription medications are strongly encouraged to take them exactly as prescribed by their doctor. They may however, refuse to take any dose of medication provided they indicate that choice in the medication log and sign the entry. Clients may never take any medication belonging to another client.

If a client wishes to discontinue a medication without their physician's approval he/she will meet with the Program Nurse for guidance about their decision. The client will need to sign a form indicating their decision to discontinue their medication against the advice of staff. Any discontinued medication, whether discontinued by the client or a health care provider will be destroyed by the Program Nurse after obtaining authorization from the client.

If subsequent medical treatment is required as a result of refusing to take prescribed medications, the client may be discharged from the program depending on the frequency and severity of the required treatment. The parent(s) and/or legal guardian(s) will be notified if an adolescent client refuses to take their prescribed medication.

Clients are not permitted to fill their own prescriptions. This must be done by Teen Challenge staff. The Program Supervisor must be notified of any medication prescribed while the client is away from the program on pass and holiday breaks.

Non-Prescription Medications:

Non-prescription medications, vitamins, dietary supplements, and other over the counter health aids may be purchased by clients for their own consumption. Clients may have a total of three vitamin and /or supplement preparations, with the exception of protein or body building supplements and herbal preparations which are not allowed.

Teen Challenge provides certain non-prescription medications such as acetaminophen, ibuprofen, and Pepto-Bismol. Clients may be given these types of medications for minor health concerns. Low dose aspirin (81 mg) may be taken when used to lower the risk of heart attack and stroke.

Storage:
All prescription and non-prescription medications must remain in their original containers and kept in a locked storage container under the control of Minnesota Adult & Teen Challenge staff. The only exceptions are topical creams, asthma inhalers, eye drops, and certain diabetes supplies.

The Program Supervisor will be notified when clients have a need to maintain these items in their possession. Clients are not, however, permitted to keep any other medications in their possession at any time except as outlined in the distribution section of this policy. All medications brought into our facility that are not in their original container will be destroyed. If replacement is required, it will be done at the expense of the client.

Refills:
Clients, who need their prescription medications refilled, should submit a Client Request form to their program staff several days before they are completely out. This will allow sufficient time to get the medications refilled without missing any doses. Clients are responsible for the payment of all medications purchased for their use.

Distribution and Documentation:
It is the client's responsibility to come for their medications at the scheduled times and location designated by the Program Supervisor. Program staff is present to assist and observe the clients in the self-administration of their medications. The staff member and the client will sign the medication log for both prescription and non-prescription medications. Vitamins and supplements will not require documentation unless prescribed by a health care provider.

Sometimes a client's schedule may prevent him/her from being at the designated location where medication is being dispensed. When this happens, he/she will be given a sufficient supply of medication ahead of time to last until his/her expected return. The client must keep the medication in his/her possession and take it at the appropriate time.

Female Appearance & Dress Code

Hair:
Hair is to be neat, clean and must not bring unusual attention to the individual. Hair color is to be consistent with a natural/normal hair color.

Jewelry:
Jewelry must be conservative and may not draw undue attention to the individual. Chains are not permitted. Clients are strongly encouraged to leave expensive jewelry and other valuable items with family or friends. Minnesota Adult & Teen Challenge does not accept responsibility for lost, damaged, or stolen items.

Make-up:
Make-up must be applied conservatively and may not draw unusual attention to the individual.

Perfume/Cologne
Any product containing alcohol is not permitted. This would include perfumes, colognes, and other hygiene items. If alcohol is not a main ingredient, certain hygiene items may be approved by the program manager or director, such as: shampoo, conditioner, or lotions. Non-alcoholic perfumes, colognes, and fragrant soap are permitted when used in moderation. Others may have a high sensitivity to fragrances, therefore clients are asked to be mindful of the amount of these products they use. If these products are not being used in moderation, the client may be asked to reduce or discontinue the use of these products.

Dress Code:
The standards for dress are modest, conservative, neat and clean. Shoes are required for all activities except sleeping and showering; shoelaces are to be tied at all times. No clothing may be worn that promotes secular groups or messages not consistent with MnTC values. If there are questions regarding this policy, the client should be directed to their program supervisor. Pajamas are not allowed to be worn outside the floor or living area. Sunglasses may only be worn outside and are to be removed upon entering the building. High heels may not exceed 2 inches. If there are questions regarding this policy, the client should be directed to their Program Supervisor.

There are 3 general classifications of dress at Minnesota Adult & Teen Challenge Life Renewal Program. The appropriate appearance standards for female activities are:

Class/Chapel/Casual

- To be worn during classes, and whenever deemed appropriate by staff.
- Shirts, blouses, casual slacks, skirts, dresses, dress jeans, or shorts. Tank tops can only be worn with a shirt over it or have a 3 inch wide strap. No skinny or tight jeans.
- Clothing must not be torn, have holes or be patched.
- Clothing must not be torn, have holes or be patched.
- Clothing cannot be tight, revealing (no bra straps or cleavage), or excessively baggy.
- Skirts and dresses are to be knee length or longer, and slits no higher than knee length.
- Shorts are to be no shorter than a credit card (lengthwise) above the knee.
- Hats are not allowed during this time.
- Any pants or jeans worn must be able to have one inch (two inches total) of fabric pinched without stretching to meet tightness requirements. This will be measured at mid-thigh on the front side of the leg.

Recreational/Leisure /Meals

- To be worn during recreational sports and activities.
- May wear sweat suits, T-shirts, gym trunks or shorts – no spandex workout clothing is allowed.
- One-piece bathing suits may be worn for swimming.
- Pants with words on the behind are not approved at any time.
- Bandanas covering the whole head can only be worn during free time.

Work

- Dress appropriate for the type of work being done. If unsure as to what is appropriate, the client should ask staff on duty. Closed toed shoes may be required.

Male Appearance & Dress Code

Hair:
Hair is to be neat, clean and must not bring unusual attention to the individual. Hair color is to be consistent with a natural/normal hair color.

Jewelry:
Jewelry must be conservative and may not draw undue attention to the individual. Chains are not permitted. Male clients may not wear jewelry in any body piercing except ears. Clients are strongly encouraged to leave expensive jewelry and other valuable items with family or friends. Minnesota Adult & Teen Challenge does not accept responsibility for lost, damaged, or stolen items.

Colognes
Any product containing alcohol is not permitted. This would include colognes and other hygiene items. If alcohol is not a main ingredient, certain hygiene items may be approved by the program manager or director, such as: shampoo, conditioner, or lotions. Non-alcoholic colognes and fragrant soap are permitted when used in moderation. Others may have a high sensitivity to fragrances, therefore clients are asked to be mindful of the amount of these products they use. If these products are not being used in moderation, the client may be asked to reduce or discontinue the use of these products.

Dress Code:
The standards for dress are modest, conservative, neat and clean. Pants must be worn above the hips, supported with a belt or suspenders, and may not be excessively baggy. Shorts are to be no shorter than a credit card (lengthwise) above the knee. Hats and sunglasses may only be worn outside, and are to be removed upon entering a building. Shoes or sandals are required for all activities except sleeping and showering. No clothing may be worn that promotes secular groups or messages not consistent with MnTC values. If there are questions regarding this policy, the client should be directed to their Program Supervisor.

There are 3 general classifications of dress at Minnesota Adult & Teen Challenge Life Renewal Program. The appropriate appearance standards for male activities are:

Class/Chapel/Casual
- To be worn during classes, and whenever deemed appropriate by staff.
- Shirt, sweater, casual slacks, dress jeans or shorts. No skinny or tight jeans are allowed. May wear dress shoes, casual shoes or athletic shoes unless otherwise directed. No hats may be worn at this time.

Recreational/Leisure
- To be worn during recreational sport activities and free time in the facility.
- May wear: sweat suits, T-shirts (including sleeveless), gym trunks or shorts. Shirts are required at all times. Sleeveless shirts should not be worn off the floor during business hours (8AM-5PM).
- Hats may be worn during recreational/leisure time.

Work
- Dress appropriate for the type of work being done. If unsure as to what is appropriate, the client should ask staff on duty. Closed toed shoes may be required.

Approved Personal Belongings

The following is a list of items residents should bring if they have them. If they don't have them and don't have the means to purchase them, many of them may be provided at no cost.

Please note due to space limitations residents may only bring two plastic garbage bags worth of belongings.

- Clothing: See dress code above. Winter/rain/light jacket, gloves, underwear, socks etc.
- Toiletries: soap, comb, toothbrush/paste, shampoo, deodorant, razor/shaving cream, blow dryer. *Females:* makeup, sanitary items, etc.
- Medications: 30 day supply of all prescription medications (prohibited medications), non-prescription medications. Must be in a labeled, original container.
- Misc.: Bible, devotional, envelopes/stamps, umbrella, personal items, single serving non-perishable snacks, nicotine patches (NO GUM), clear water bottle.

Prohibited Personal Belongings

Storage space for personal items is limited so residents will only be allowed to bring **(2) plastic disposable bags worth of belongings.**

SUITCASES and BACKPACKS are not allowed for safety reasons. In addition to the two bags limit residents may not bring any of the following items. If they do, they will be required to immediately dispose of them or mail them home at their own expense.

- Expensive jewelry/clothing or other valuable items
- Items of sentimental value
- DVD players/DVDs, video games, radios, TVs, CD players/CDs, computers, cell phones, digital camera
- Personal vehicles
- Drugs or drug paraphernalia, alcohol & tobacco
- Suitcases
- Pictures containing drug/alcohol or sexual content
- Women: Jeans with writing on the backside
- Clothes w/skulls, peace signs, holes, frayed edges
- Bleach
- Backpacks
- Tools/Weapons of any kind
- Any product containing alcohol is not permitted. This would include perfumes, colognes, and other hygiene items. If alcohol is not a main ingredient, certain hygiene items may be approved by the program manager or director, such as: shampoo, conditioner, or lotions.
- Essential Oils
- Aerosols of any kind (mousse, hairspray, body spray, etc.)
- Women: Any kind of razor with a blade, including make-up sharpener(s). (electric razors allowed)

Passes

Clients of the Licensed Program are not allowed on passes except in the case of situations or events that promote treatment goals, i.e. visits to sober or half-way houses as part of after-care planning or emergency situations. Emergencies require special and immediate consideration. Upon verification of a qualifying emergency, the Primary Counselor will contact the referral and Probation or Parole Officer, if one is assigned to that client, to authorize an Emergency Pass. If so, the Primary Counselor shall complete the "Client Emergency Pass" form and ensure the client is aware of the date and time the pass expires. The amount of time allowed for the emergency pass will depend on the nature and location of the emergency, and the Probation or Parole Officer assigned to that client.

Qualifying Emergencies:
Emergencies that qualify for approval of an emergency pass include the death, severe injury, or severe illness of a close family member, or circumstances that threaten their immediate safety.

Abuse of Pass Privileges:
Clients, who abuse their pass privileges by failing to return from pass on time, falsifying information on their pass requests, deceiving or attempting to deceive staff with regards to passes, will face disciplinary action. Clients returning from pass will be checked to insure prohibited items are not brought into our facility. Any client caught attempting to bring prohibited items into our facility will face disciplinary action or discharge. Returning clients will be required to take a urinalysis test.

Transportation:
Clients are responsible for their own transportation to and from our facility when going on pass.

Chiropractic Appointments

For chiropractic appointments, clients must provide their own transportation. These may only take place on Saturdays and be within 5 miles of their respective building.

Program Fee Information

The majority of the residents in MnTC are eligible to have some or all of the program costs paid for by their county. To determine eligibility and apply for funding, applicants must contact their county social services agency and request a Rule 25 assessment prior to admission. If an applicant is determined to be ineligible for funding, fees must be paid for out of pocket.

In the event that a resident leaves the program prior to completion, fees will be pro-rated so that residents are charged only for the days they are enrolled in the program. Residents are considered enrolled in the program even though they may be temporarily away from our facility due to emergency. Residents will be charged for the day they are admitted into the program but will not be charged for the day they are discharged.

Residents are required to pay for the first 30 days of the program at the time of admission. The next payment is due on the 31st day of the program.

PLEASE READ below if you will be receiving a RULE 25 ASSESSMENT

- You have the right to request placement with a provider that will honor your religious preferences:
  - *"The placing authority must authorize chemical dependency treatment services that are appropriate to the client's…religious preference…The placing authority maintains the responsibility and right to choose the specific provider"* (Section 9530.6620, Sub point 9).

- You have the right to request a specific provider, such as Minnesota Adult & Teen Challenge:
  - *"The placing authority must consider a client's request for a specific provider. If the placing authority does not place the client according to the client's request, the placing authority must provide written documentation that explains the reason for the deviation from the client's request…"* (Section 9530.6620. Sub point 14).

- You have the right to appeal if you do not receive appropriate placement:
  - *"A client has the right to a fair hearing under Minnesota Statues…if the client…(F) is denied a placement that is appropriate to the client's race, color, creed, disability, national origin, religious preference, marital status, sexual orientation, or sex"* (Section 9530.6655, Sub point 2).

For further information, please see the Rule 25 Chemical Dependency Assessment and Placement Rules and Laws:
July 1, 2008

If you are currently a resident of one of the following counties you must schedule your Rule 25 assessment prior to MnTC approving your application:

County	Blue Earth	Carver	Dodge	McLeod	Ottertail	Wabasha
Phone	507.304.4335	952.361.1644	507.635.6170	320.864.3144	218.998.8640	651.565.3034

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Prohibited Medications

Minnesota Adult and Teen Challenge prohibits the use of all addictive medications due to their interference with the recovery process. Applicants must agree to our medication policy, and request a titration/taper schedule from a Health Care Provider for his/her current prohibited medication so that it may not be stopped abruptly.

MNTC policy requires that titrations/tapers be completed as quickly as reasonably possible. Please have your physician fax the titration/taper schedule for the above medications to MnTC Admissions at 612-823-4913.

In the rare circumstance that an alternate medication is unavailable, Minnesota Adult & Teen Challenge is not an appropriate treatment option and a referral list of other treatment programs in the area will be provided.

The following classifications of prohibited medications include but are not limited to:

- All Medical Marijuana
- All meds used for the treatment of Alcohol or Opiate dependence and/or withdrawal.
  Clients may be on a tapering dose of Suboxone at time of admission. Taper may not last longer than 3 months, and must be completed at least 1 week before discharge.
- All Barbiturates
- All Medications used specifically for weight loss
- All Benzodiazepines
- All Medications for Smoking Cessation
  Clients are allowed up to a 10 week taper of Nicotine Patches. These patches are to be purchased by the client.
- All Muscle Relaxants
- All Stimulant Medications
  Only Strattera & Intuniv are allowed for treatment of ADD/ADHD
- All Performance Enhancing Steroids or Supplements
- All Narcotic pain relievers and pain relievers with potential for dependence and abuse
  MnTC Nursing staff will work with clients and their health care provider following a surgery or an injury.
- Sleep Aids
  Clients with a psychiatric diagnosis MAY use their prescribed Mental Health medications that also help treat sleep disturbances.
  Benadryl will not be allowed as a sleep aid, but will be allowed if prescribed Specifically for Anaphylaxis. (Severe life threatening allergic reaction)
  Melatonin is the only "sleep aid" allowed.