Thank you for your interest in **Minnesota Adult & Teen Challenge (MnTC) Community Outpatient (COP) Program.** Our program is designed to help adults (18+ years old) who are struggling with life-controlling chemical dependency issues. An optional faith-based component is available upon request.

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

- Complete the application by phone, or fax, mail or email it the campus to which you are applying.
- Secure funding by private pay; applying for a Rule 25 Chemical Health Assessment at your Minnesota County of residence; or by completing an insurance assessment at one of our campuses.
- Please note: Admissions can clarify the funding options; payment rate(s) and also determine where your assessment may be completed.

PHYSICAL LOCATIONS OF OUTPATIENT

Minneapolis (Male & Female)	**Duluth (Male & Female)**	**Brainerd (Male & Female)**
Attention Admissions Department Minnesota Adult & Teen Challenge 3231 1st Avenue S Minneapolis, MN 55404 **PHONE: 612.373.3366 #1 & #1** FAX: 612.823.4913	Attention: Admissions Department Minnesota Adult & Teen Challenge 1 East 1st Street Duluth, MN 55802 **PHONE: 218.740.5510** FAX: 218.740.4330	Attention: Admissions Department Minnesota Adult & Teen Challenge 603 Oak Street Brainerd, MN 56401 **PHONE: 218.833.8760** FAX: 218.833.8778

Connect for Lobby Hours / Applications by Phone Available / Call to Schedule Assessment

MINNEAPOLIS EVENING SCHEDULE

Men and Women's

- (3) Evening Hours: Monday, Tuesday, Thursday 6 p.m. – 9 p.m. scheduled by counselor
- Tuesday Night is Family Education Night
- Counseling will be scheduled by the counselor

DULUTH SCHEDULE

- Men Group Hours: Monday, Tuesday, Thursday 1 p.m. – 4 p.m.
- Evening Hours: Monday, Tuesday, Thursday 5 p.m. – 8 p.m.
- Women Group Hours: Monday, Tuesday, Thursday 10 a.m. – 12:30 p.m.
- Counseling will be scheduled by the counselor

BRAINERD SCHEDULE

- Day Hours: Monday, Tuesday, Thursday from 1 p.m. - 4 p.m.
- Evening Hours: Monday, Tuesday, Thursday from 5 p.m. – 8 p.m.
- Counseling will be scheduled by the counselor

COMMUNITY OUTPATIENT APPLICATION

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?** _____

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_____

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 on campus)

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:

PHYSICAL HEALTH

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

_____

If Yes, what medications?_____

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 or other medications? ☐Yes ☐No

If Yes, what medications?_____

MENTAL HEALTH

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

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

Do you have any mental health diagnoses? If so, what are they? _____

_____

Are you currently taking any medication for your mental health diagnoses? _____

_____

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:

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

Primary Insurance

Insurance Provider:_____ Member ID Number:_____
Address: _____ Group Number: _____
City:_____ State:_____ Zip:_____ Provide Phone: ( )_____-_____

Secondary Insurance

Insurance Provider:_____ Member ID Number:_____
Address: _____ Group Number: _____
City:_____ State:_____ Zip:_____ Provide Phone: ( )_____-_____

Do you have a County Case worker (Rule 25 Assessor): ☐ Yes ☐ No If yes, please provide the information:

Case Worker's Name: _____
Address:_____
City: _____State: _____Zip Code: _____
Phone: _____Fax: _____

For Admission Use Only:

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, Tribal, Pension, Trust, 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?: _____

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:
_____

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

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

For Admission Use Only:

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: _____

PROHIBITED MEDICATIONS

Minnesota Adult and Teen Challenge prohibits the use of all addictive medications due to their interference with the recovery process. **The following classifications of prohibited medications include, but are not limited to:**

- Barbiturates (including those combined with acetaminophen, caffeine or aspirin; e.g. Fiorocet, Fiorinal)
- Benzodiazepines
- Methadone
- Narcotic pain relievers and pain relievers with potential for dependence and abuse
- Opiates
- Stimulant medications used to treat Attention Deficit Disorder & Attention Deficit/Hyperactivity Disorder

_____ ____/____/____
Applicant's Signature Date