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

<table>
<thead>
<tr>
<th>Minneapolis (Male &amp; Female)</th>
<th>Duluth (Male &amp; Female)</th>
<th>Brainerd (Male &amp; Female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Admissions Department&lt;br&gt;Minnesota Adult &amp; Teen Challenge&lt;br&gt;3231 1st Avenue S&lt;br&gt;Minneapolis, MN 55404&lt;br&gt;PHONE: 612.373.3366 #1 &amp; #1&lt;br&gt;FAX: 612.823.4913</td>
<td>Attention: Admissions Department&lt;br&gt;Minnesota Adult &amp; Teen Challenge&lt;br&gt;1 East 1st Street&lt;br&gt;Duluth, MN 55802&lt;br&gt;PHONE: 218.740.5510&lt;br&gt;FAX: 218.740.4330</td>
<td>Attention: Admissions Department&lt;br&gt;Minnesota Adult &amp; Teen Challenge&lt;br&gt;603 Oak Street&lt;br&gt;Brainerd, MN 56401&lt;br&gt;PHONE: 218.833.8760&lt;br&gt;FAX: 218.833.8778</td>
</tr>
</tbody>
</table>

*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: ____________________________  ☐ Female  
DOB: _____/____/____  Age: ________  

Current Address:  
Street: ______________________________________  Legal Resident Of:  
City: ____________________________  State: ____________________________  
State: _________  Zip: _________  Zip: _________  County: ____________________________  
Phone: _________  Email: _________  
Height: _____  Weight: ________

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

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: __________________________________________________________

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: _____________________________________________________________________________

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 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: _______________

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 __________/________/________

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