Thank you for your interest in **Minnesota Adult & Teen Challenge (MnTC), Adult Long Term Recovery Program**. Our program is designed to help those who are struggling with life-controlling chemical dependency issues and desire a faith-based 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 at your county of residence or notify admissions of self pay status.
  - Admissions can help you determine where your financial screening may be completed.

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 who enroll into 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.*
First Name: ___________________________  Sex:  
Middle Name: ___________________________  Male  Female
Last Name: ___________________________  DOB: ____/____/____  Age: ________

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

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 _______

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: _______
Phone: _______  Fax: ___________________________
Dates of Treatment: ____/____/____ to ____/____/____
Reason for Treatment: ___________________________
Did you complete the program?  Yes  No

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
- Alcohol Abuse
- Back Problems
- Celiac Disease
- Colitis
- Crohn’s Disease
- Diabetes Type 1
- Diabetes Type 2
- Drug Abuse
- Fetal Alcohol Syndrome
- Gastric Bypass Surgery
- Head Trauma/TBI
- Heart Attack/Stroke/Condition
- Hepatitis
- High Blood Pressure
- HIV/AIDS
- Pancreatitis
- Polycystic Ovarian Syndrome
- Respiratory Problems
- Seizures
- STI/STD
- 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: _________________________________________

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:

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<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Reason</th>
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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 food or environmental 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 representative 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: __________________________________________

Mental Health Medications Currently Taking:

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<th>Medication Name</th>
<th>Dosage</th>
<th>Reason</th>
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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 (VA, Pension, Settlement, etc)? ☐ Yes ☐ No If yes: Monthly amount? ________

Do you have assets titled in your name (house, vehicles, land, trailer)? ☐ Yes ☐ No If yes: Is there an outstanding loan? ☐ Yes ☐ No 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: ________________
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: __________________

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: __________________

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 Minnesota Adult & Teen Challenge program. Furthermore, I understand that Minnesota Adult & Teen Challenge 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.

Please initial indicating that you have received, read and agree to abide by the following documents:

_____ Program Policies and General Information   _____ Prohibited Medication

_____ Break Policy   _____ Room and Board Fee Information

____/____/____  Applicant’s Signature  Date

For Admission Use Only:
Voluntary Compliance with Faith Based Activities

Minnesota Adult & Teen Challenge’s Long-Term Program is a faith-based program that is based upon Christian principles and practices. As such, Minnesota Adult & Teen Challenge is only an appropriate option for people desiring such a program and who are willing to commit to fully participate in it. If you do not want to participate in this program and follow the requirements listed below, please contact our admissions department and we will provide a referral list of other programs that may better meet your needs.

Please read each item carefully and initial your acceptance to each program requirement.

Upon admittance to Minnesota Adult & Teen Challenge, I agree to the following:

___ I will participate in daily devotions, Bible reading, and prayer.

___ I will participate in the Teen Challenge choir which performs Christian songs at weekly church services and special events.

___ I will participate in lecture classes, individualized study courses, group counseling, individual counseling, and other program components that are based on Christian principles.

___ I will attend church services when scheduled.

___ If offered the opportunity to partake in communion or water baptism participation is voluntary.

___ If I object to the religious nature of this program and its requirements, I will notify my Program Manager and receive a referral to another program of my choosing.

-----------------------------------------------------------------------------------------------------------------------------

My signature below indicates that I have carefully considered the Christian nature of the program and have made a free and independent choice to participate in the Minnesota Adult & Teen Challenge program. I also acknowledge that I have been given the opportunity to ask for a referral list of other faith-based and secular programs.

_________________________________________________________________________ /____/____
Applicant’s Signature Date

(THE PAGE MUST BE RETURNED WITH THE APPLICATION)
**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”

Physician/Mental Health Provider or Prior Treatment Center within the past year:

- [ ] Other: Facility/Name: ___________________________ Attention: ___________________________

(Who has the information you want released) Be specific.

- Address: ___________________________ City: ___________________________ State: ______ Zip: ________ Phone: ______

### Receiving Party:

- MnTC Mpls, 3231 1st Avenue S, Mpls., MN 55408 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: ___________________________

### Information to be 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
- Medical History/Physical Exam
- Chemical Dependency/Substance Abuse Records
- Medical/Clinic Notes
- Financial Records
- Mental Health Records
- Legal*
- Other (Specify): ___________________________

Optional Limits: Disclose Records Only Related to the Following:

- Date(s) of Service: ____________________________
- Injury or Illness: ____________________________

### Release Instructions:

- 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:

- 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)

| Authority: Parent Legal Guardian Personal Rep (specify): ____________________________ | Date: ____________________________ | 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. General authority 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.