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.

Minneapolis (Adult/Teen Programs)	Duluth (Adult Male Only)	Brainerd (Adult Male Only)	Rochester (Adult)
Minnesota Adult & Teen Challenge	Minnesota Adult & Teen Challenge	Minnesota Adult & Teen Challenge	Mn Adult & Teen Challenge
3231 1st Avenue South	2 East Second Street	2424 Business 371	1530 Assisi Drive NW
Minneapolis, MN 55408	Duluth, MN 55802	Brainerd, MN 56401	Rochester, MN 55901
Direct: (612) 373-3366 #1	Direct: 218-740-5510	Direct: (218) 833-8748	Direct: (507) 288-3733
Fax: (612) 823-4913	Fax: 218-740-4330	Fax: 218-833-8778	Fax: 855-545-2217
Males & Females			Males & Females

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:______________
Last Name:______________________ **DOB:** ____/____/____ **Age:** _________

☐Male
☐Female

Current Address:
Street: ____ **Height:** _____ **Weight:** _____
City: ____
State: _____________ Zip: _______________
Phone: ______________ Email: ______________

Legal Resident Of:
State: _____________________
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 __________

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

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 <u>NOT</u> a Hospital Based Setting
If it is determined your needs exceed our care ability; you will be referred to a more suitable placement.

<u>Medical History:</u> (Check all that apply to your current and past conditions)

☐ Asthma
☐ Alcohol Abuse
☐ Back Problems
☐ Celiac Disease
☐ Colitis
☐ Crohns Disease
☐ Diabetes ☐ Type 1 ☐ 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: _________________________________
____

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 <u>under doctor supervision</u>.)

Non-Psychiatric Medications:

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

<u>Special Needs:</u>

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
☐ Anorexia
☐ Anti-Social Personality Disorder
☐ Anxiety Disorder/Panic Attacks
☐ Autism/Aspergers
☐ Bipolar Disorder
☐ Borderline Personality Disorder
☐ Bulimia
☐ Depression
☐ Dissociative Identity Disorder
☐ Hallucinations
☐ Hearing Voices
☐ Homicidal Tendencies/Thoughts
☐ Insomnia
☐ Narcissistic Personality Disorder
☐ Paranoia
☐ Personality Disorder __________
☐ Physical Abuse
☐ PTSD/Trauma ______________
☐ Rape
☐ Schizoaffective Disorder
☐ Schizophrenia
☐ Sexual Abuse
☐ 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 (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 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: ___________________________

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: ____________________

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

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**

(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.**	Physician/Mental Health Provider or Prior Treatment Center within the past year: ☐ **Other:** Facility/Name: ____________ Attention: ____________ Address: ____________City: ____________ State: ____ Zip: ________ **Phone:** __________
Receiving Party: (*Where* do you want the information sent?) **Be specific.**	☐ **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: (*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.