 **Minnesota Adult & Teen Challenge**

 **In Custody Application**

Applicant’s Full Legal Name: Birth Date: / /

 First Middle Last

Location of Incarceration (County Jail/ Prison): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_Gender: Male Female Other: \_\_\_\_\_\_\_\_\_

Address Prior to Incarceration: City State Zip

Phone Number: ( ) Next Court Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On Probation in which county(s): ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Charges Pending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have any outstanding warrants? [ ]  Yes [ ]  No In which State/County:

Prior Military Service? Yes or No; If yes, Branch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Years \_\_\_\_\_\_\_Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Income per Month: \_\_\_\_\_\_\_\_ Employed: Yes or No Tribal/SSI/RSDI/Unemployment/401K/Pension/Trust Income \_\_\_\_\_\_\_

Are you required to register as a sexual or predatory offender? [ ]  Yes [ ]  No If yes, what Level? **1 2 3** (please circle)

Are you required to [ ]  “Notify the Community” or [ ]  Police Department?

Drug of Choice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (IV, Oral, Smoke, Other) **Last date of use**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you completed a Rule 25 Assessment/Chemical Health Assessment in the past 30 days? [ ]  Yes [ ]  No

Where/When was the Assessment completed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Assessors Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Please ensure the assessor faxes a copy to the Admissions Department at preferred campus.**

**Circle the campus you would like your application to be processed at:**

**Minneapolis (Adult Program)** **Duluth (Adult Male Only)** **Brainerd (Adult Male Only)** **Rochester (Adult Program)**

3231 1st Ave South 2 East Second Street 2424 Business 371 1530 Assisi Drive NW

Minneapolis, MN 55408 Duluth, MN 55802 Brainerd, MN 56401 Rochester, MN 55901

**Fax: 612- 823-4913 Fax: 218-740-4330 Fax: 218-833-8778 Fax: 855-545-2217**

**Minneapolis Jail Line: 612-238-6136**

**Staff Use Only**: Dan Schaeppi Brian Riehm Jenna McMillan James Madigan Amber Jochem Simon Wohlfeil Mike Stansberry Volunteer Name:

**Please check all boxes indicating that you agree to the following:**

* I understand that I am communicating with a Minnesota Adult & Teen Challenge **(**MnTC) staff and/or volunteer, and that any/all disclosures may be shared with other MnTC personnel.
* I understand that**:** (i) MnTC is a drug and alcohol program that offers two programs: a short-term treatment program with an optional faith component and a long-term faith-based recovery program; (ii) if I request the court to order me to this program, I may be required by the courts to complete one or both of the programs in their entirety;(iii)clients in the long-term recovery program must participate in daily devotions, bible reading, church attendance, and other religious activities; (iv) other faith-based and non-faith based treatment programs are available to me; and (v) my signature below indicates that I am voluntarily choosing to seek admittance into MnTC and that, if accepted, I agree to participate in all program requirements.
* I authorize MnTC staff to disclose any/all information needed for, or related to, my application and continuity of services to jail staff, jail volunteers, jail nurses, as well as, the following individuals and/or agencies (below). I also authorize the same individuals and/or agencies to disclose any/all information to MnTC for the same purposes (including, but not limited to, past arrests and convictions, current and pending charges, plea agreements, mental health/medical/treatment notes, jail nursing notes, Rule 25, etc.), as requested by MnTC. I specifically authorize the disclosure/exchange of information related to my chemical dependency and/or substance abuse **\_\_\_\_\_\_\_\_ (*initials*).**

**Attorney/Public Defenders Office: Probation Officer/Parole Officer: Prison Caseworker:** **Other (family member/friend)**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­ \_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prison: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

**I understand that**:

1. My health information is protected under federal confidentiality rules (42 CFR Part 2; and/or HIPAA, 45 CFR 160, 164) and state privacy laws; and disclosure is allowed only with my authorization except in limited circumstances as outlined in state and federal regulations. I understand that I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
2. I can revoke this authorization in writing at any time by providing a written notification to MnTC, except to the extent that action has been taken in reliance on it.
3. Treatment may not be conditioned on my agreement to sign this authorization, unless I am receiving care solely to create protected health information for disclosure to a third party.
4. Communications resulting from this authorization will reveal that I have received, or attempted to receive services at Minnesota Adult & Teen Challenge.
5. Federal confidentiality regulations prohibit re-disclosure of information unless further disclosure is expressly permitted by this Applicant.
6. This Authorization is effective for one year from the date I sign below (or such later expiration date as provided here: \_\_\_\_\_\_\_\_\_\_ unless earlier revoked).

**Applicant’s Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medical History:** Check all that you have been **diagnosed** with:

[ ]  Asthma-Inhaler? Y N

[ ]  Back Problems

[ ]  Celiac Disease

[ ]  Colitis – Flare ups?

[ ]  Crohns Disease

[ ]  Diabetes Type [ ]  1 [ ]  2

[ ]  Gastric Bypass Surgery
[ ]  TBI

[ ]  Heart attack

[ ]  Stroke

[ ]  Hepatitis A, B, C

[ ]  High Blood Pressure

[ ]  Pancreatitis

[ ]  STI/STD

[ ]  HIV/AIDS

[ ]  Seizure Disorder

[ ]  Withdrawal Seizures

Date of last seizure: \_\_\_\_\_\_\_\_

 [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diabetics: Upon admission, you must bring with any necessary materials including lancets, syringes, test strips, meter and insulin and/or medication. These materials will be required to admit into our program.**

Have you ever been tested for Tuberculosis? [ ]  Yes [ ]  No

When/Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result: \_\_\_\_\_\_\_\_\_If positive-Outcome of chest x-ray: \_\_\_\_\_\_\_\_\_\_\_

Did you complete a medication therapy? [ ]  Yes [ ]  No

**If you have tested positive for Tuberculosis, we will need a copy of your X-Ray Results faxed to the Admissions Department at preferred campus prior to admission.**

Do have any allergies? [ ]  Yes [ ]  No

What are you allergic to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of reaction do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been prescribed an EPI pen for your allergy? [ ]  Yes [ ]  No

**If you have been prescribed an EPI pen for your allergy, it will be required to admit into our program.**

Do you require a special diet? [ ]  Yes [ ]  No Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a medical condition restricting you from standing, sitting, climbing stairs and traveling in vans or buses at lengths at a time? [ ]  Yes [ ]  No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health History:** Check all that you have been **diagnosed** with:

[ ]  ADD / ADHD [ ]  Depression [ ]  Schizoaffective Disorder

[ ]  Anorexia/Bulimia **(active)Y or N** [ ]  Dissociative Identity Disorder [ ]  Schizophrenia

[ ]  Anxiety Disorder [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Personality Disorder [ ]  Suicide Thoughts - When?

[ ]  Autism/Asperger’s [ ]  PTSD / Trauma [ ]  Suicide Attempt - When? [ ]  Bipolar Disorder [ ]  Panic Attacks [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently experiencing symptoms of Paranoia, Hallucinations, or Psychosis? [ ]  Yes [ ]  No

List all **current prescribed medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are you able to bring a 30 day supply of your prescribed medications at time of intake or have the means to purchase your medications once you have been admitted either with insurance or self-pay? [ ]  Yes [ ]  No

If you are prescribed medication while in the program, are you willing to be medication compliant? [ ]  Yes [ ]  No

Do you know anyone currently enrolled in a MnTC program? [ ]  Yes [ ]  No

If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Which MnTC location? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your relationship to them?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MnTC is a tobacco free facility, are you ok using a nicotine patch or going without nicotine? [ ]  Yes [ ]  No

Cell phones are not allowed, are you willing to comply with this? [ ]  Yes [ ]  No

Can you read and write in English at a 5th Grade level? [ ]  Yes [ ]  No

If you are completing this application for someone else, list: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_