 **Minnesota Adult & Teen Challenge**

 **In Custody Application**

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

First Middle Last

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

Address Prior to Incarceration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_ State: ­­­­­­­\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Charges Pending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next Court Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on Probation or Parole **If** yes, which County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have any outstanding warrants? [ ]  Yes [ ]  No Which County/State? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are you required to notify [ ]  The Community or [ ]  The Police Department?

Do you have an active CPS case? [ ]  Yes [ ]  No If yes, which county? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug of Choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (IV, Oral, Smoke, Snort) Last Date of Use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Where/When was the Assessment completed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assessor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**\*Please ensure that assessor faxes a copy of to the Admissions Department at Preferred Campus\***

***\*\*Our goal at MnTC is to provide you with the best care possible, but we need your help to do this. Please share any medical concerns that you have, so that our Nursing Department can be better prepared to keep you safe and healthy while you are in the program.\*\****

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Income**

Do you currently receive any income? [ ]  Yes [ ]  No

***(Examples: Tribal/SSI/RSDI/Unemployment/401k/Pension/Trust Fund/Spousal Support)***

What is the source from where you receive income? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much do you receive on a monthly basis? **$:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you pay court ordered child support [ ]  Yes [ ]  No

If yes, **$** amount and Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are under the age of 26, do your parent’s claim you on their income taxes? [ ]  Yes [ ]  No

Have you applied for Medical Assistance before? [ ]  Yes [ ]  No If so, what county: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have applied for MA in the past, do you know your username and password? [ ]  Yes [ ]  No

**Military**

Prior Military Service? [ ]  Yes [ ]  No Branch? \_\_\_\_\_\_\_\_\_\_\_ Years \_\_\_\_\_\_ Date of Discharge\_\_\_\_\_\_\_\_\_\_\_\_

Have you been referred by Veterans Affairs [ ]  Yes [ ]  No

Do you have funding approval through the Community Care Network provided by Veterans Affairs? If so, please list your case manager and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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**

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

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

[ ]  Asthma-Inhaler? Y N [ ]  TBI [ ]  Seizure Disorder

[ ]  Back Problems [ ]  Heart Attack [ ]  Withdrawal Seizures

[ ]  Celiac Disease [ ]  High Blood Pressure Date of last seizure: \_\_\_\_\_\_\_

[ ]  Crohn’s Disease [ ]  Pancreatitis [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Diabetes Type [ ]  1 [ ]  2

***\*Please explain any box checked: (Date of diagnosis and how it impacts your daily life)\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***(Diabetics: Upon admission, you must bring any necessary materials including lancets, syringes, test strips, meter, 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 you 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.)***

MnTC does not accommodate special diets. ***Do you understand this?*** [ ]  Yes [ ]  No

At MnTC, you will be required to, at times, stand, sit, climb stairs, and travel in vans or buses at long lengths of time? ***Do you understand this requirement?*** [ ]  Yes [ ]  No

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

[ ]  Active Eating Disorder **Y or N** [ ]  Dissociative Identity Disorder

[ ]  Antisocial Personality Disorder [ ]  Schizoaffective Disorder

[ ]  Autism/Asperger Syndrome [ ]  Schizophrenia

[ ]  Bipolar Disorder [ ]  Current Suicidal Ideations

[ ]  Borderline Personality Disorder [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing symptoms of **Paranoia, Hallucinations, or Psychosis**? [ ]  Yes [ ]  No

***\*Please explain any box checked: (Date of diagnosis and how it impacts your daily life)\** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 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 in the program. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check all the 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 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, dispositional advisors, 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 Defender: Probation/Parole Officer:**

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

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Prison Caseworker: Other (Family member/friend):**

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

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CPS Caseworker:**

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

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that:**

1. My health information is protected under federal confidentiality rules (42 CFR Part 2; and/or HIPPA, 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: \_\_\_\_/\_\_\_\_/\_\_\_\_**