



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 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 612-823-4913

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 _____

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma-Inhaler? Y N | <input type="checkbox"/> TBI | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Withdrawal Seizures |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> High Blood Pressure | Date of last seizure: _____ |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes Type <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> Pregnant How far along? _____ | |

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

(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:

- | | |
|---|---|
| <input type="checkbox"/> Active Eating Disorder Y or N | <input type="checkbox"/> Dissociative Identity Disorder |
| <input type="checkbox"/> Antisocial Personality Disorder | <input type="checkbox"/> Schizoaffective Disorder |
| <input type="checkbox"/> Autism/Asperger Syndrome | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Current Suicidal Ideations |
| <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> 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 cessation or going without nicotine? 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: _____

Campus Options:

Minneapolis (Male and Female) - 3231 1st Ave S. Minneapolis, MN 55408

Brainerd (Male and Female) – 2424 Buisnesss 371, Brainerd, MN 56401

Rochester (Male and Female) – 1530 Assissi Dr. NW Rochester, MN 55901

Alexandria (Male Only) – 525 Willow Dr. Alexandria, MN 56308

Duluth (Male Only) – 2 E 2nd St. Duluth, MN 55802

Please indicate 1st, 2nd and 3rd choice: 1st: _____ 2nd: _____ 3rd: _____

Any campus you are unwilling to attend? If so, please indicate which: _____

Fax for all programs: 612-823-4913 Jail line for all programs: 612-238-6136

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: Residential Treatment Program with an optional faith component and a long-term faith-based recovery program known as Life Renewal; (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 Life Renewal 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:

Name: _____
Phone: _____
Name: _____
Phone: _____

Probation/Parole Officer:

Name: _____
Phone: _____
Name: _____
Phone: _____

Prison Caseworker:

Name: _____
Phone: _____

Other (Family member/friend):

Name: _____
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: ____ / ____ / ____