Montana Chemical Dependency Center

525 E Mercury Street, Butte, MT 59701
Phone: 406 496 5400 Fax: 406-496-5437

APPLICATION FOR SERVICES: ***A phone interview will be conducted with the applicant and with other parties involved in supporting this applicant in treatment and recovery before a final determination is made.***

Name: _____ _____ _____ Gender: ☐ M ☐ F _____
Last First Maiden/Middle Date

Physical Address: _____ _____ _____ _____
City, State Zip

Mailing Address: _____ _____ _____
City, State Zip

County of residence: _____

Home #: _____ Work #: _____ Cell#: _____ Message phone: _____

Birth date: _____ Age: _____ Social Security #: _____

Employed: ☐ Yes ☐ No Employer: _____ Phone: _____

Education completed: ☐ High School/Grade _____ ☐ College ____ ☐ Post graduate_____ ☐ other/GED: _____

Marital Status: ☐ Married ☐ Unmarried ☐ Divorced ☐ Committed/cohabiting

Are you a Veteran: ☐ Yes ☐ No Homeless: ☐ Yes ☐ No

Race/Ethnicity:

☐ White ☐ Native Indian ☐ Asian Indian ☐ Other: _____
☐ Black ☐ Alaskan Native ☐ Hispanic

Enrolled Tribal member? ☐ Yes ☐ No Descendant? ☐ Yes ☐ No Tribe: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Do you have dependent children under the age of 18: ☐ Yes ☐ No How many: _____

Who has legal custody? _____ Who do they live with? _____

List the name of your Department of Family Services worker-DFS (if it applies):

Name _____ Phone _____

List other persons living in the household/age: _____

Annual Family Income from ALL sources: $_____ Last Year_____ Household Size: _____

Pay Frequency: Annually Monthly Income: $_____ Source of Income: None

Health Insurance _____ ☐ Medicaid ☐ Medicare ☐ VA ☐ None ☐ Other

Name of Insured: _____ Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Date of Birth of Insured: _____ Preauthorization Required: ☐ Yes ☐ No

Insurance Group #_____ ID #_____

Do you currently receive SSD/SDI: ☐ Yes ☐ No Monthly $: _____

Why are you seeking treatment at this time? Is it just for withdrawal management? If so, what is the immediate follow up plan?

Please mark the number that bests describes your readiness to change your life?

☐ 1 ☐ 2 ☐ 3 ☐ 4

I don't want to change maybe I will do whatever it takes.

Do you smoke or use tobacco products? ☐ **Yes** ☐ **No** Have you ever tried to quit tobacco? ☐ **Yes** ☐ **No**

What substances are you using now: _____

Do you experience withdrawal symptoms when you stop using substances? ☐ **Yes** ☐ **No**

If yes, what are the symptoms? (Seizures, DT's) _____

Are you pregnant or do you suspect you are pregnant? ☐ **Yes** ☐ **No** If Yes, how many weeks?: _____

If **Yes**. Have you seen a physician/practitioner for your pregnancy? ☐ **Yes** ☐ **No**

Who? _____ When?:_____ Have you had an ultrasound/date?:_____

Who is physician/practitioner who prescribes your medications:_____ Phone_____

What pharmacy (s) do you get your medications from?_____ Phone_____

Current Medications and Dosages: * *You must provide a current medications list from your pharmacy*.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Physical Health: ☐ **excellent** ☐ **good** ☐ **fair** ☐ **poor** Why:_____

_____

What is your height?_____ Weight?_____

Current Medical Issues (diabetes, heart disease, liver disease, etc.):

_____

_____

Any special medical needs/accommodations (wheelchair, hearing, vision): _____

_____

Current Diagnosis: Substance Use Disorder_____ Mental Health_____

Number or prior treatments: Inpatient_____ Outpatient_____ Date of last treatment_____

Longest period of abstinence following any treatment episode: _____

Have you received treatment at MCDC in the past? ☐ **Yes** ☐ **No** When_____ Did you complete: ☐ **Yes** ☐ **No**

Have you ever used drugs by injection: ☐ **Never** ☐ **Currently Using** ☐ **Last 1-12 Months** ☐ **More than a year ago**

Have you been involved with AA or NA groups? ☐ **Yes** ☐ **No** Other: _____

Do you presently have a sponsor? ☐ **Yes** ☐ **No** _____

Have you been incarcerated in the last 30 days? ☐ Yes ☐ No How many days?_____

Please list all legal involvement (Current and Prior):

_____

_____

_____

Are you required to register as a sexual/violent offender? ☐ Yes ☐ No

Are you: ☐ On Probation ☐ Incarcerated ☐ Mandatory Monitoring

☐ On Parole ☐ On Pre-Release ☐ DUI Offender

Name of your probation officer:_____Phone_____

Name of your attorney:_____Phone_____

Signature of applicant _____Contact phone number_____

What are your recommendations/plan for the treatment and recovery of this application **once they have completed an intensive in patient treatment:** (Please list all: AA NA, IOP, OP, R-Tech homes, drug court, service volunteer activities etc.)

What plans have you begun to address the above long term recovery plan with your patient?

Signed up for IOP_____ Started completing the Level 3.1 application process_____
Created a plan with the PO_____ Started applications for health insurance_____
Started applications for GED_____ Started applications for sober living home_____
Started applications for employment_____ Started applications for housing_____
Other_____ Other _____

Are you willing to participate in at least one care conference with this patient while they are in treatment**:**

☐ **Yes** ☐ **No** ☐ **N/A**

REFERRING AGENCY _____

Address: _____

City: _____ State: _____Zip Code: _____

Printed name of Counselor: _____

Signature of Counselor: _____

Date:_____

NOTE: You may also submit a copy of your own completed Biopsychosocial that includes the ASAM assessment.

RELEASES OF INFORMATION MUST BE INCLUDED WITH APPLICATION

Medical Issues: If the patient has any medical issues we need Medical Records to complete this application,

* Include releases for all medical providers & pharmacy the patient uses

Mental Health History: If this patient has a history of Mental Health Counseling we will need Records from the provider.

* Include releases for all mental health providers

Legal Involvement: Include Releases of Information for Probation officers, attorneys, judges, etc.

* We will not accept an applicant to MCDC without a release for the assigned probation officer.
* RVO/RSO are reviewed on an individual basis.