Boyd Andrew Community Services
Women's Transitional
Living Facility
ADMISSIONS APPLICATION

Date: ____/____/____ **Social Security #:** _____-____-_____ **Date of Birth:** ____/____/____

Legal Name: _____
Last First Middle Initial

Phone: **Home:** ____-____-____ **Cell:** ____-____-____ **Work:** ____-____-____

Current Address: _____ **Apt #** _____

_____ _____ _____
City **State** **Zip Code**

Mailing Address: _____ **Apt #** _____

_____ _____ _____
City **State** **Zip Code**

***Complete all sections of this application form. Incomplete or inaccurate applications may not be considered. If a particular section does not apply, write "does not apply". Please complete the release of information found at the end of this packet if you have a referring probation officer, judge or treatment facility.

1. Name, address, and phone number of treatment program you are currently involved with:

Treatment Program: _____ **Phone #**: (_____) _____-_____

Address: _____ **Apt #** _____

_____ _____ _____
City **State** **Zip Code**

2. What is the date you entered the program /_____/_____and the date you are projected to be discharged /_____/_____.

3. Have you participated in previous treatment programs? _____Yes _____No

4. Please list the treatment programs and the dates you participated in the program.

a) _____ Dates: /_____/_____- /_____/_____

b) _____ Dates: /_____/_____- /_____/_____

c) _____ Dates: /_____/_____- /_____/_____

d) _____ Dates: /_____/_____- /_____/_____

e) _____ Dates: /_____/_____- /_____/_____

f) _____ Dates: /_____/_____- /_____/_____

g) _____ Dates: /_____/_____- /_____/_____

Describe the reasons you did not complete any of the treatment programs:

_____

_____

_____

5. Please list all mood-altering chemicals you have used, how much, and the date of your last use:

	DRUG	**HOW MUCH**	**DATE**
a)	_____	_____	_____/_____/_____
b)	_____	_____	_____/_____/_____
c)	_____	_____	_____/_____/_____
d)	_____	_____	_____/_____/_____
e)	_____	_____	_____/_____/_____
f)	_____	_____	_____/_____/_____
g)	_____	_____	_____/_____/_____
h)	_____	_____	_____/_____/_____
i)	_____	_____	_____/_____/_____
j)	_____	_____	_____/_____/_____

Have you ever used mood-altering chemicals with a needle? ____Yes _____No

6. Are you under the care of a physician? ____Yes _____No

7. Are you or could you be pregnant? ____ Yes _____ No _____ Unsure

8. What is the name, address, and phone number of the physician:

Physician: _____ **Phone #**: (_____) _____-_____

Address: _____ **Apt #** _____

_____ _____ _____

City **State** **Zip Code**

9. Have you ever been evaluated by or are being cared for by a mental health professional?_____Yes _____No

10.What is the name, address, and phone number of your mental health professional:

MH Provider: _____ **Phone #: (_____) _____-_____**

Address: _____ **Apt #** _____

_____ _____ _____

City **State** **Zip Code**

11. If you are being treated for a mental health condition, what is the diagnosis? _____

Are you prescribed or currently taking any medications? ___Yes _____No

List of medications and dosages:_____

12. Have you ever had thoughts of suicide or attempts? _____Yes ____No

Please list the last time you thought of suicide, had suicidal thoughts, or a suicide attempt. _____

_____

13. Please explain your history of legal involvement.

_____

_____

_____

14. Are you currently on Probation? _____Yes _____No

Probation Officer: _____ **Phone #**: (_____) _____-_____

Address: _____ **Apt #** _____

_____ _____ _____

City **State** **Zip Code**

15. Why did you decide to seek treatment with this facility? _____

_____

_____

_____

_____

_____

_____

_____

_____

16. How can this program and facility assist you in achieving your goals for recovery? _____

_____

_____

_____

_____

_____

_____

17. What are your thoughts concerning self-help, support groups (ex.AA, NA)? _____

_____

_____

_____

18. Whom are you currently residing with? _____ **Relationship to you:** _____

19. Do you have family in the Helena area? _____Yes _____No **Relationship to you:** _____

20. Have you completed a physical screen/exam in the last 30 days? _____Yes _No

21. Are you required to register as a:

Sex Offender: _____Yes _____No

Violent Offender: _____Yes _____No

22. Please answer the following questions.

a) **Have you ever used drugs with needles? _____Yes _____No**

1) **If YES please indicate your last use. _____Currently _____ In the Last 6 Months**

_____ In the Last 12 Months _____ Other please indicate: _____

b) **Are you currently homeless? _____Yes _____ No**

c) **Have you ever been diagnosed w/Tuberculosis? _____ Yes _____No**

1) **If NO have you ever been screened? _____Yes _____No**

2) **If YES have you received treatment for? _____Yes _____No**

d) **Are you currently receiving SSI or SDI?_____Yes _____No**

e) **Do you have Private Insurance, Medicaid or Medicare? _____Yes _____No**

1) **If YES please attach a copy of your insurance information to application.**

23. Are you currently employed? _____Yes _____No

Current Employer: _____ Phone #: (_____) _____-_____

Address: _____ Apt # _____

_____ _____ _____

City State Zip Code

24. What is your usual trade or occupation? _____

25. After reading a copy of the standards and responsibilities, are there any standards that you disagree with?

_____

_____

_____

***Need a copy of Physical and TB test results within the last year.**

Signature of Applicant: _____ Date: _____/_____/_____

Boyd Andrew Community Services
60 S. Last Chance Gulch Helena, MT 59601
(406) 443-2343, Fax (406)443-5490

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
Yellow sections are for the client to complete. All other sections are for the staff to complete.

Patient Name: _____
LAST FIRST MI MAIDEN

Date of Birth:_____ Social Security #:_____

1. I authorize the use or disclosure of the above patient's health information as follows:

2. The following individual or organization is authorized to receive and disclose information:

Primary Contact/Relationship:_____

Organization Name: _____

Address: _____ City/State/Zip:_____

Phone Number**:** _____Alternate Phone Number: _____

Fax #: _____ Alternate Fax Number: _____

Email Address: _____

from and to: **Boyd Andrew Community Services, 60 S. Last Chance Gulch, Helena, MT 59601**

3. The type and amount of information to be used or disclosed is as follows:
--Provide a specific and meaningful description of the information, including dates where appropriate.--

Discharge Summary ____X__Yes _____No
Progress and/or Progress Notes ___X__Yes _____No
Master Treatment Plan ___X__Yes _____No
BioPsych/Social Assessment ____X__Yes _____No
Mental Health Evaluation __ X Yes _____No
Correspondence/letter ___X__Yes _____No

Other (Please be specific): _____ Dates of Treatment Requesting: _____

4. For the purpose of Continuity of Care or:_____

5. I understand that I have a right to revoke this authorization at any time. To revoke this authorization, I must submit a written request to the Administrative Office Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

6. This authorization will expire on the following date or event: _____

7. Generally, Boyd Andrew Community Services will not condition treatment on the provision of this authorization, unless services are solely for the purpose of creating information for disclosure to a third party.

8. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may no longer be protected by federal confidentiality rules.

9. By initialing here _____ I would like a copy of this authorization.

_____
Signature of Patient Date

_____
Witness Signature Date

_____
Signature of Parent/Personal Representative Date

NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR 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 CFR 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.