Hello and Thank You for your interest in Recovery Center Missoula!

This letter serves to introduce our program to you, outline eligibility requirements, and describe the application/admission process. Whether you are referring someone to the Center, or are seeking help for yourself or a loved one, we hope you will find the application and admission process to be easy. If you have any questions, please contact Recovery Center Missoula (RCM) at any time; 406-532-9900. There will always be someone to answer your call.

RCM is designed to meet the needs of those suffering from substance use disorders/ addiction and co-occurring emotional or psychiatric disorders. The Center utilizes evidence based therapeutic interventions to promote a healing recovery process that can last a life time. Recovery Center Missoula offers inpatient treatment and partial hospitalization/day treatment services to adults 18 and over. If medically indicated, detox services are also available at RCM and can be scheduled according to your specific need.

There are three main application eligibility requirements for admission to RCM:

1. Applicant must meet clinical criteria for inpatient or partial hospitalization services.
2. Applicant must have a current **chemical dependency assessment** with a diagnosis of dependence or addiction, completed by a Licensed Addiction Counselor (LAC). This can be accomplished at Recovery Center Missoula or with a LAC of the applicant's choice. In most situations RCM can have direct communication with the applicant's physician or evaluating counselor to facilitate a timely admission. If assistance is needed in finding an LAC, call RCM and we will provide referral options.
3. Applicant must be at least 18 years of age.

The process for submitting an application to Recovery Center Missoula follows:

1. Print out and complete and return this initial application packet by:

MAIL: Recovery Center Missoula
1201 Wyoming St.
Missoula, MT 59801
ATTN: Admissions

OR

FAX: 406-206-6426
ATTN: Admissions

2. Once the completed application packet has been received, the applicant will be contacted by one of our Admissions Coordinators about any additional documentation necessary to pre-authorize insurance coverage. RCM staff can assist in exploring other resources and options for payment if insurance is not available.

3. An admission date for inpatient services or partial hospitalization will be established once all necessary documentation is complete and financial arrangements are in place.

If you have questions during any part of this process, please do not hesitate to call Recovery Center Missoula, or e-mail rcm@wmmhc.org . We sincerely hope our program may be of service to you.

Respectfully,
Recovery Center Admissions Staff

CLIENT DEMOGRAPHICS

Please answer these questions as they apply to the person receiving services. Make sure to print clearly.

Name: _____

First Middle Last (Maiden)

Preferred Name: _____ Suffix: _____

Date: _____ Social Security Number: _____

Parent or Guardian (if applicable): _____

Birthdate: _____ Gender: ☐Male ☐Female ☐Other

Contact Preference: work/home/cell/other _____ Contact Phone: _____

Work Telephone: _____ Cell Phone Number: _____

Email Address: _____

Mailing Address: _____

City, State: _____ Zip Code: _____

Physical Address (if different): _____

City of Residence: _____ County of Residence: _____

Prior County of Residence: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

Language Preference: _____

Health Insurance Plan: _____

What are your goals for treatment? _____

1. What is your race?

☐White/Caucasian ☐Black/African American ☐American Indian/Alaskan Native
☐Non-Hispanic ☐Asian ☐Native Hawaiian/Pacific Islander
☐Hispanic: Check One ☐More than one race ☐Unknown
☐Mexican ☐Puerto Rican ☐Cuban ☐Other

2. What is your marital status? ☐Single-Unmarried ☐Divorced ☐Separated ☐Married ☐Widowed ☐Other/Unknown

3. Have you ever served in the military? ☐YES ☐NO Active Combat? ☐YES ☐NO

Branch: _____ Type of Discharge? _____

Are you eligible for Veteran's assistance? ☐YES ☐NO

4. Do you receive Social Security?

☐SSI Due to Mental Illness ☐SSDI Due to Mental Illness ☐None
☐SSI Not Due to Mental Illness ☐SSDI Not Due to Mental Illness

5. What is your legal status?

☐Self/None ☐Dept. of Child & Family Services ☐Guardian
☐Dept. of Corrections ☐Parent or Grandparent ☐Other
☐Youth Court ☐Youth Treatment Court ☐Unknown

6. What is your employment status?

☐ Full Time	☐ Retired	☐ Homemaker/Caregiver
☐ Part Time	☐ Disabled/Unable to work	☐ Volunteer/unpaid
☐ Unemployed but able	☐ Supported/Sheltered	☐ No interest in work
☐ Student	☐ Transitional	☐ Other: _____

7. Are you <u>currently</u> in school?

☐ Not in school	☐ Public K-12	☐ Home School
☐ Adult Ed/GED	☐ Vocational School	☐ Private K-12
☐ College Full Time	☐ College Part Time	☐ Other: _____

8. How many years of education have you completed?

☐ Completed____ Grade	☐ Completed High School/GED	
☐ HS Plus 1 Yr College	☐ HS Plus 2 Yrs College	
☐ HS Plus 3 Yrs College	☐ Bachelor's Degree	☐ Graduate Degree

9. Who referred you here? (Select one)

☐ Self	☐ Hospital Inpatient/ER	☐ Friend
☐ Native American Agency	☐ Shelter	☐ Family
☐ Non-Psychiatric Physician	☐ Police	☐ School
☐ Veteran's Administration	☐ Clergy	☐ MT State Hospital
☐ Treatment Center	☐ EAP	☐ Crisis Center
☐ Agency for the Elderly	☐ DDA	☐ Court
☐ Other Mental Health Provider	☐ Residential Facility	☐ Agency for Children
☐ Physician Name _____	☐ Other Mental Health Center	
☐ Other _____		

10. What is your current living situation? (Select one)

☐ Homeless	☐ Personal Care Home
☐ Living independently	☐ Jail
☐ Nursing Home	☐ Child Foster Home
☐ Transient	☐ Adult Foster Home
☐ Hotel	☐ Living with Family/Friend
☐ Hospitalized	☐ Non-Mental Health Group Home
☐ Mental Health Group Home	☐ Living Independently with others
☐ Shelter	☐ Therapeutic Foster Care
☐ Psychiatric Res. Treatment Facility	☐ Supported Independent Living

How long have you lived here? _____

11. What behavioral health services have you received in the past? (Select all that apply)

☐ Montana State Hospital	☐ Outpatient Mental Health Care
☐ Other Inpatient Hospitalization	☐ This Agency
☐ Partial Hospitalization – MH	☐ Psychiatric Residential/Other
☐ Residential Mental Health Care	☐ No Prior Service
☐ Level 1 Outpatient Services CD	☐ Level 2.1 IOP Services CD
☐ Level 2.5 Partial Hosp CD	☐ Level 3.5 Inpatient CD
☐ Level 3.7 Detox CD	

12. Are you coming here voluntarily or are you required to receive services?

☐ Voluntary ☐ Forced Voluntary ☐ Involuntary, Civil ☐ Involuntary, Criminal

13. Are you involved with any of the following Social Service Agencies? (Select all that apply)

- ☐ Alcohol or Drug Services
- ☐ Developmental Disabilities
- ☐ Primary Health Care
- ☐ Bureau of Indian Affairs
- ☐ Housing Agency
- ☐ Juvenile Probation
- ☐ Vocational Rehabilitation
- ☐ Other
- ☐ Department of Child & Family Services
- ☐ School/Special Education
- ☐ Mental Health Center
- ☐ Case Management (not state agencies)
- ☐ Indian Health Services
- ☐ Veteran's Administration
- ☐ PLUK (Parents Let's Unite For Kids)
- ☐ None

14. Are you on Probation? ☐ YES ☐ NO **Are you on Parole?** ☐ YES ☐ NO

Name/phone of Probation /Parole Officer: _____

15. Do you currently have a pending DUI, MIP, or Dangerous Drug Charge? ☐ YES ☐ NO

16. Please complete the substance use screening:

CAGE Ages 18 and over

1. Have you ever felt you should cut down or control your drug use or drinking?	☐ YES ☐ NO
2. Have people annoyed you by criticizing your drug use or drinking?	☐ YES ☐ NO
3. Have you ever felt bad or guilty about your drug use or drinking?	☐ YES ☐ NO
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?	☐ YES ☐ NO

MEDICAL HISTORY

Client Name: _____

Please answer these questions as they apply to the person receiving services. Make sure to print clearly and use a blank piece of paper if additional room is needed.

1. Do you have any ongoing medical issues (e.g. diabetes, heart problems, seizures, liver disease)?
   ☐YES ☐NO If yes, explain: _____
2. When was your last physical exam? _____
   Findings: _____
3. When was your last dental exam? _____
   Findings: _____
4. When was your last vision exam? _____
   Findings: _____
5. Do you have any current medical providers? ☐YES ☐NO
   Name: _____ Practice: _____ Phone #: _____
   Name: _____ Practice: _____ Phone #: _____
6. Do you have any history of head injuries? ☐YES ☐NO
   If yes, explain: _____
7. How many days in the last 30 days have you experienced medical problems? _____
8. How troubled or bothered have you been in the last 30 days by these medical problems?
   ☐Not at all ☐Slightly ☐Moderately ☐Considerably ☐Extremely
9. How important to you now is treatment for these medical problems?
   ☐Not at all ☐Slightly ☐Moderately ☐Considerably ☐Extremely
10. Do you currently use tobacco products? ☐YES ☐NO ☐NEVER
    If yes, what type, how much, and how often? _____
    If no, did you use medication or aids to quit? ☐YES ☐NO Date started: _____
    If current user, are you interested in assistance with quitting? ☐YES ☐NO
11. List your current medications:

Drug	Helpful Y / N	Dosage	Prescribing physician

12. What **pharmacy** do you use? _____

13. Do you have any allergies? ☐YES ☐NO

    If yes, please list: _____

14. Do you experience any limitations as a result of any health circumstance? ☐YES ☐NO

    If yes, please list: _____

15. Have you ever needed reasonable accommodation for the above? ☐YES ☐NO

    If yes, please explain: _____

16. What things do you do that help you stay healthy? _____

17. Current height: _____ Current weight: _____ Circle if rapid **gain** or **loss?**

18. Have you ever been diagnosed with tuberculosis, ARC, AIDS, or HIV? ☐YES ☐NO

19. Are you pregnant or suspect you may be pregnant, or are you trying to become pregnant? ☐YES ☐NO

    If yes, describe any prenatal care you are receiving or problems you may be experiencing. _____

    _____

20. Have you experienced any of the following?

☐ Allergies	☐ Difficulty Sleeping	☐ Memory Problems
☐ Anemia or Blood Disorder	☐ Epilepsy/Convulsions	☐ Migraine
☐ Asthma	☐ Fibromyalgia	☐ Numbness/Tingling in Arms/Legs
☐ Attention Deficit Disorder	☐ Frequent Headaches	☐ Pancreatitis
☐ Been Unconscious	☐ Gastritis	☐ Pregnancy
☐ Bleeding Problems	☐ Glaucoma	☐ Radiation Treatment
☐ Bruise Easily	☐ Head Injuries	☐ Rheumatic Fever
☐ Cancer or Tumor	☐ Heart Problems	☐ Seizures, Convulsions, Fainting Spells or Blackouts
☐ Chest Pains	☐ Hepatitis A	☐ Serious Dental Problems
☐ Chronic Fatigue	☐ Hepatitis B	☐ Sinus Trouble
☐ Chronic Pain	☐ Hepatitis C	☐ Stomach/Digestive Issues
☐ Cirrhosis of the Liver	☐ High/Low Blood Pressure	☐ Stroke
☐ Coordination/Balance Problems	☐ Jaundice	☐ Traumatic Events
☐ Diabetes	☐ Kidney Problems	☐ Ulcer

Thank You!
This information will help us provide you and your family the best possible care.

MENTAL HEALTH DATA SCREEN

Name: _____ Date: _____

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD THE FOLLOWING?	NO	YES	SELF	FAMILY MEMBER RELATION
Depression				
Anxiety Disorder				
Eating Disorder				
Hyperactivity (ADHD, ADD)				
Obsessive Compulsive Disorder or Behaviors				
Nervous Breakdown				
Suicide Attempt				
Completed Suicide				
Schizophrenia				
Panic Attacks				
Substance Use Disorder				
Self-Harm Behaviors				

Please answer the following:	NO	YES
Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?		
Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?		
Have you ever been in a hospital or an emergency room because of a psychological or emotional problem? Please describe:		
Have you ever heard voices no one else could hear or see objects or things, which others could not see?		
Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?		
Did you ever attempt suicide?		
Have you ever had nightmares or flashbacks as a result of being involved in some traumatic or terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed.		
Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?		
Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property?		
Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thought or behavior?		

Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?		
Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in too much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?		
Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly form one activity to another, when you needed little sleep, and believed you could do almost anything?		
Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?		
Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.		
Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family or friends as a result of your gambling?		
Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?		
Have you done any of the following behaviors intentionally: banging your head, pulling your hair, or cutting or burning yourself?		
Do you put yourself or find yourself in high risk-taking or dangerous situations?		
Have you ever put yourself in situations in which you knew you were going to get hurt?		

MOTIVATION AND RECOVERY / RELAPSE AND CONTINUED USE

Name: _____ Date: _____

Please answer the following by marking the appropriate box:

Rate your agreement with the following:	**NO!**	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**	
I am not ready to quit my use of alcohol or other substances						P
I have thought about quitting, but am not quite ready						C
I am ready to quit						P
I have taken steps to quit						A
I have quit						M
Is someone else requiring that you seek assessment or treatment?						C

Describe your willingness to do the following:	**Yes, I want to**	**If I have to**	**Not at all**
Abstain from chemical use throughout			
Attend group/individual therapy sessions			
Submit to random chemical use testing			
Attend AA/NA at least one time weekly			

PREVIOUS TREATMENT EPISODES

Where	**Dates of Service**	**Sober for how long after?**	**Relapse Reason**

Please describe your triggers to use substances:

WITHDRAWAL POTENTIAL

Name: _____ Date: _____

1. Have you used any alcohol and/or any other drugs in the past two weeks?

   ☐ YES IF YES, CONTINUE WITH QUESTION 1-2

   ☐ NO IF NO, when did you last use any alcohol and/or any drugs? _____

2. What did you use? _____ How much did you use? _____

3. What mood-altering chemicals (alcohol/other drugs) have you used in the past seventy-two (72) hours?

What?	**How Much?**	**When last used?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Have you experienced memory loss in the past seventy-two (72) hours? ☐ YES ☐ NO

5. After stopping using alcohol or other drugs, have you ever had any of the following symptoms?

☐ Nausea or Vomiting	☐ Elevated Blood Pressure	☐ Profuse Sweating
☐ Anxiety	☐ Agitation	☐ Depressed Mood
☐ Auditory/Visual Hallucinations	☐ Increased Heart Rate	☐ Severe Shaking
☐ Perspiration or Chills	☐ Headache	☐ Seizures
☐ Disorientation	☐ Sleep Disturbance, (sleeping a lot or inability to sleep)	
☐ Tactile Disturbances, (itching, needle sensations, numbness, feel bugs crawling on or under the skin)		

6. Have you ever had to use a chemical to ease the discomfort of a hangover or coming down from drugs?

   ☐ YES ☐ NO

7. Have you ever been in a detox unit? ☐ YES ☐ NO

   If yes,

Dates of Service:	**Where:**
_____	_____
_____	_____
_____	_____