

## APPLICATION FOR ADMISSION TO ACCD FACILITY

Name: \_\_\_\_\_ DOC ID#: \_\_\_\_\_

This application is to be completed in its entirety by the person who wishes to enter and participate in the program. Please complete all questions and areas to the best of your ability. If you need any help in reading, understanding or answering the questions, the person making your referral is available to assist you.

**DO YOU NEED ASSISTANCE?**  Yes  No

Once completed, the person making your referral should review the application for accuracy and completeness. Incomplete, missing, unclear, false, or misleading information on the application will be cause for rejection, and the application will be returned, thus delaying possible admission.

1. I understand that my application will be screened by an independent screening committee and may be denied for specific reasons outlined by the Department of Corrections (DOC).  Yes  No
2. Having the understanding of the demanding schedule, structure and costs involved, and knowing that I may be placed at a higher level of custody should I be removed from the program due to disciplinary reasons, and that I will be charged with felony escape if I walk away, or attempt to walk away, I am willing to make a commitment to participate fully in the program.  Yes  No
3. I understand that I must be able to fulfill program objectives with reasonable accommodations for mental or medical conditions.  Yes  No
4. I am aware that I am required to personally contribute for room and board costs, and the amount depends on the program.  Yes  No
5. For persons who have a medical marijuana card: I understand that according to DOC rules, I will not be allowed to use medical marijuana while participating in the program.  Yes  No

**#6- #9, For each applicable number, check the program you are applying to, and then answer the question:**

6.  **Prerelease Center**
  - a) I understand the Prerelease Centers are not legally bound to accept any referral for placement.  Yes  No
  - b) I agree that I will authorize the release of all medical, psychological, chemical dependency and criminal history information to be forwarded to the Prerelease Centers for appropriate screening and handling of my case.  Yes  No
  - c) I will abide by all terms of placement and all Prerelease Center rules.  Yes  No
  - d) I understand I am responsible for all medical and treatment costs unless I am an inmate worker.  Yes  No
  - e) I am aware that if I am approved for this program, I will enter the program on inmate status.  Yes  No
  - f) I am aware that I am responsible for all debts incurred to the Prerelease Center and the Community Treatment Provider while a resident.  Yes  No
  - g) I agree to reimburse the DOC for the cost of a bus ticket if I do not have the ability to prepay.  Yes  No
7.  **Connections Corrections Program – sixty (60) to ninety (90) days**  
 **Elkhorn Treatment Center Program – nine (9) months**  
 **Nexus Program – nine (9) months**  
 **Passages Alcohol and Drug Treatment Program – sixty (60) to ninety (90) days**  
 **WATCh Program – six (6) months**
  - a) I am aware that the residential chemical dependency treatment program I am being referred to is very intensive and includes a great deal of chemical dependency counseling with cognitive/behavior restructuring, thus requiring complete participation and commitment.  Yes  No
  - b) I am aware that if I am approved for this program, I will enter the program on inmate status unless I am a probationer (CCP or ADT).  Yes  No
8.  **Elkhorn Treatment Center Program**  
 **Nexus Program**
  - a) I am aware that Montana statutes require offenders to attend and complete a prerelease aftercare program that is approximately six (6) months long, following the nine (9) month Elkhorn or Nexus Program.  Yes  No
9.  **Elkhorn Treatment Center Program**
  - a) I am aware that I will be required to wear an electronic bracelet.  Yes  No

**PART I APPLICANT INFORMATION**

Name: \_\_\_\_\_ DOC ID#: \_\_\_\_\_  
Last, First, Middle

Date of birth: \_\_\_\_\_ Current age: \_\_\_\_\_ Ethnicity/Tribe: \_\_\_\_\_

Place of birth: \_\_\_\_\_

Current legal charges (on your court judgments): \_\_\_\_\_

Length of sentence: \_\_\_\_\_ Date of sentence: \_\_\_\_\_

Are you serving more than one sentence?  Yes  No

Number of previous felony charges (not including current): \_\_\_\_\_

Details of felony charges (include charge, date/year, and state): \_\_\_\_\_

Are you in the process of having a Suspended or Deferred sentence(s) revoked?  Yes  No

Is your sentence being revoked due to continued substance abuse?  Yes  No

Approximately when, what and how much did you consume most recently? \_\_\_\_\_

Are you required to register as a sexual or violent offender?  Yes  No Sexual offender  
 Yes  No Violent offender

I have:  a GED  post high school education  I want to get my GED  
 a high school diploma  a college degree

Give details of education beyond GED level (if any) including vocational training:

<u>Name of Program or Training</u>	<u>Completed?</u>	<u>Approximate Dates Attended</u>
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Marital Status:  Single  Married  Separated  Divorced  Common Law # of Previous Marriages: \_\_\_\_\_

List parents, brothers, sisters, spouse or significant other, and children:

<u>Name (First, Last)</u>	<u>Age/DOB</u>	<u>Occupation/Address</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you required to pay child support?  Yes  No From what state(s)? \_\_\_\_\_

If Yes, give the amount of support for each child: \$ \_\_\_\_\_

Are you current?  Yes  No If No, how delinquent are you? \$ \_\_\_\_\_

Do you currently have any family members incarcerated or under supervision of the Montana DOC?  Yes  No

If Yes, please provide the following information:

1. Name and relationship: \_\_\_\_\_

Where incarcerated or supervised? \_\_\_\_\_

2. Name and relationship: \_\_\_\_\_

Where incarcerated or supervised? \_\_\_\_\_

Have you ever been involved in gang activities?  Yes  No If Yes, describe your involvement past and present, if you have been validated, and when: \_\_\_\_\_

Why do you want to be accepted into this program? \_\_\_\_\_

List previous attempts to complete community placement (prerelease, treatment, ISP, etc.) including locations and dates: \_\_\_\_\_

Describe reasons for failures in prior community placements (i.e. technical violations, dirty UAs, or new crime): \_\_\_\_\_

List and explain any conduct violations in prior placements: \_\_\_\_\_

How would coming to this program affect employment, family relationships, finances, and ability to participate in treatment services? Be specific on which of these apply to you.

What are your goals upon release? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you plan to apply for Interstate Compact?  Yes  No If Yes, to where? \_\_\_\_\_

Where do you plan to live or reside upon release? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a job offer or prospects upon release?  Yes  No If Yes, give details:  
\_\_\_\_\_  
\_\_\_\_\_

Summarize your employment history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a medical marijuana card?  Yes  No If Yes, what is your medical condition for this card?  
\_\_\_\_\_

Check each drug that you have ever used, even once:

- |                                      |                                    |                                    |   |   |
|--------------------------------------|------------------------------------|------------------------------------|---|---|
| <input type="checkbox"/> Alcohol     | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Cocaine   | <input type="checkbox"/> Methamphetamine            | <input type="checkbox"/> Amphetamines   |
| <input type="checkbox"/> Heroin      | <input type="checkbox"/> Narcotics | <input type="checkbox"/> Ecstasy   | <input type="checkbox"/> PCP                        | <input type="checkbox"/> Benzodiazepine |
| <input type="checkbox"/> Barbiturate | <input type="checkbox"/> Methadone | <input type="checkbox"/> Oxycontin | <input type="checkbox"/> Other (please list): _____ |   |

Check your drug(s) of choice:

- |                                      |                                    |                                    |   |   |
|--------------------------------------|------------------------------------|------------------------------------|---|---|
| <input type="checkbox"/> Alcohol     | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Cocaine   | <input type="checkbox"/> Methamphetamine            | <input type="checkbox"/> Amphetamines   |
| <input type="checkbox"/> Heroin      | <input type="checkbox"/> Narcotics | <input type="checkbox"/> Ecstasy   | <input type="checkbox"/> PCP                        | <input type="checkbox"/> Benzodiazepine |
| <input type="checkbox"/> Barbiturate | <input type="checkbox"/> Methadone | <input type="checkbox"/> Oxycontin | <input type="checkbox"/> Other (please list): _____ |   |

When you use, generally how much do you use per day? \_\_\_\_\_  
\_\_\_\_\_

Method of use (check all that apply)?  Drink  Snort  Drop  Smoke  Shoot

Which drugs and/or alcohol did you last use and when? \_\_\_\_\_  
\_\_\_\_\_

Have you ever overdosed on drugs and/or alcohol?  Yes  No If Yes, when? \_\_\_\_\_  
\_\_\_\_\_

Has your ability to function/work/interact with others been impaired due to drug/alcohol use?  Yes  No  
If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been assessed for a drug/alcohol problem?  Yes  No If Yes, list by who, where and when:

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Have you ever been told you need to go to treatment for drug/alcohol problems?  Yes  No

If Yes, list by who and when: \_\_\_\_\_

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Has anyone in your family had a history of substance abuse or been in treatment for substance abuse?  Yes  No

If Yes, explain: \_\_\_\_\_

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Do you know if your mother used alcohol during the time she was pregnant with you?  Yes  No

If Yes, to what extent? \_\_\_\_\_

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Have you ever been to an **inpatient or residential** treatment (like MCDC)?  Yes  No If Yes:

<u>Treatment Provider</u>	<u>Completed?</u>	<u>Approximate Date Discharged</u>
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Have you ever been to an **Outpatient** Treatment Program?  Yes  No If Yes:

<u>Treatment Provider</u>	<u>Completed?</u>	<u>Approximate Date Completed</u>
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

How long after your last treatment did you stay clean/sober? \_\_\_\_\_

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How were you able to stay clean/sober? \_\_\_\_\_

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What was your longest period of abstinence from chemicals? \_\_\_\_\_

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What do you see as the main cause(s) of your inability to stay clean/sober? \_\_\_\_\_

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Do you have a problem with gambling or sometimes wonder if you have a problem with gambling?  Yes  No  
 If Yes, do you think your gambling problem is as severe as your chemical usage?  Yes  No  
 Do you gamble while you are high/drinking, and don't consider it a problem?  Yes  No  
 Have you ever been treated for a gambling addiction or talked to someone about your concerns with gambling?  Yes  No  
 Do you have any past self-help experience (i.e., AA, NA or GA)?  Yes  No  
 If Yes, did you have a sponsor?  Yes  No Did you work the steps?  Yes  No

Have you ever received a mental health diagnosis from a mental health professional?  Yes  No  
 If the answer is Yes, list below the diagnosis, the person who made the diagnosis, location of person, and the approximate date of the diagnosis. **This is extremely important information. You may qualify for the State of Montana's Mental Health Services Plan, and your medications, etc., could be paid for by the DPHHS.**

<u>Disorder</u>	<u>Person Making Diagnosis</u>	<u>Location</u>	<u>Approximate Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been eligible or have you ever received Medicaid, Medicare, or SSDI benefits prior to your incarceration?  Yes  No

Did you receive any Medicaid or Medicare benefits due to one of the above-listed disorders?  Yes  No

Have you ever been involved with the Montana Mental Health Services Plan (MHSP) at a Montana Community Mental Health Center such as Western Montana Mental Health, Golden Triangle, etc., for a mental health condition other than substance abuse?  Yes  No If Yes, indicate which facility and who treated you:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List the number of dependents you claimed on your last taxes. \_\_\_\_\_  
 Provide the amount of income on the last taxes you submitted. \$ \_\_\_\_\_

**This is for mental health medication assistance purposes only.**

Have you been prescribed any medication for a mental health condition?  Yes  No  
 Are you currently taking any prescribed or over-the-counter medication for a mental health condition?  Yes  No  
 If Yes to either of these questions, list the name of the medication, the dosage, and how often it is taken (frequency):

<u>Name of Medication</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever experienced any trauma, abuse or grief in your life?  Yes  No

Have you ever participated in treatment for trauma, abuse or grief, either in a group or individually?  Yes  No

If Yes, when and where? \_\_\_\_\_

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### PART II HEALTH QUESTIONNAIRE

**BE HONEST NOW SO IT DOES NOT CHANGE YOUR PLACEMENT LATER OR AFFECT YOUR HEALTH CARE**

Childhood Illnesses:  Measles  Mumps  Rubella  Chickenpox  Rheumatic Fever  Polio

Immunizations and Dates (if known):

Tetanus \_\_\_\_\_  Hepatitis \_\_\_\_\_  Chickenpox \_\_\_\_\_  
 Pneumonia \_\_\_\_\_  Influenza \_\_\_\_\_  MMR \_\_\_\_\_

Do you have or have you ever had:

Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Tumor/Cancer/Cyst	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Weakness/Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Abnormal Heart Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Heart Valve Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Fainting/Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Glaucoma/Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Coronary Insufficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Hepatitis C	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Hearing Difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Abnormal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Immune Deficiency/Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Blood Pressure	<input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Normal
Inflammatory Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Kidney Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Are you taking Blood Thinners?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Other: (Please Explain):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently
Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently		
Sinus Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently		
Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	<b>Women:</b> Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently	Are you taking Birth Control?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever received treatment for a medical condition requiring admission to a hospital, ongoing care, or surgery?

Yes  No If Yes, explain (date, location, diagnosis, treatment, etc.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently on a "waiting" list for medical/dental attention?  Yes  No If Yes, describe the reason you need this attention.

\_\_\_\_\_

\_\_\_\_\_

Is a doctor or provider treating you now for any medical or dental problems?  Yes  No  
If Yes, list what you are being treated for and how often you see a medical professional for these conditions.

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List the name and address of the medical professionals you are receiving treatment from regarding these conditions.

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Would any of these conditions interfere with your treatment in this program?  Yes  No If Yes, explain:

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Do you use any special equipment to help with your everyday activities (cane, walker, hearing aid)?  Yes  No

If Yes, explain: \_\_\_\_\_

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Have you been prescribed any medications?  Yes  No

Are you currently taking any prescribed medication?  Yes  No

If Yes to either of these questions, list the name of the medication, the dosage, and how often it is taken (frequency):

Name of Medication

Dosage

Frequency

<u>Name of Medication</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you required to carry any medications on your person?  Yes  No If Yes, which medications and why?

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Have you ever engaged in high-risk behavior such as IV drug use or multiple sexual partners?  Yes  No

If Yes, explain: \_\_\_\_\_

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Do you now, or have you ever, followed any special diets?  Yes  No If Yes, what kind and why?

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Are you currently suffering from, or have concerns you may have an Eating Disorder?  Yes  No

Are you currently experiencing thoughts of self-harm?  Yes  No

Have you ever caused harm to yourself?  Yes  No If Yes, when? \_\_\_\_\_

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Are you having any problem with your liver?  Yes  No If Yes, please explain:

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Are you spitting or coughing up blood?  Yes  No  
 Are you spitting or coughing up anything?  Yes  No  
 Are you short of breath when you walk or climb stairs?  Yes  No  
 If female, are you pregnant or think you might be pregnant?  Yes  No  
 Do you have any open or draining sores?  Yes  No

If Yes, where? \_\_\_\_\_

Are you feeling sick today?  Yes  No      If Yes, what is going on? \_\_\_\_\_

Are you allergic or have you reacted to the following:

Local anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		

### DISCLAIMER

**Read and initial each statement. If you don't understand a statement, ask for an explanation before you initial.**

\_\_\_\_\_ **I understand the above questions and have answered truthfully and to the best of my knowledge.**

\_\_\_\_\_ **I understand that failure to disclose any medical information may affect my placement.**

\_\_\_\_\_ **I understand that if I choose to not honestly answer the above questions, the state of Montana and/or the Department of Corrections cannot be held responsible.**

The following is a list of the most common medications (but not limited to) that are **NOT** allowed at ACCD Facilities. Should you be currently taking any of these medications, you should taper off of these meds under a Medical Doctor's care

1. Any form of **Narcotic Pain Medications**. Some examples are: Lortabs, Percodan, Percocet, Oxycodone, Oxycontin, Methadone, Codeine, Morphine, etc., including all generic forms.
2. Any form of **Sedatives or Tranquilizers**. Some examples are: Xanax, Valium, Klonopin, Clonazepam, Diazepam, Paxipam, Halazepam, Lorazepam, Oxazepam, Prazepam (anything that ends in pam).
3. Any type of **Sleeping Pill or Sleeping Aid**. Trazodone, Desyrel, Amitriptyline, Sonata, etc.
4. Any form of **Muscle Relaxant**: Soma, Carisoprodol, Flexeril, Cyclobenzaprine, etc.

The above list is not the complete list of addictive prescriptions that are the most common not-approved medications. Also, if the screening committee does approve you for treatment, and you are taking any approved medications (considered on a case by case basis), then you must have either a 60 day supply of these medications, or a current prescription of approved medications and the financial means of filling such prescriptions. **Note, if you do arrive on any medications not approved by the program, you will be taken off said medications under the direction of the medical staff. If the program does not have the medical means to address these medication issues, you may be moved to a higher level of custody to facilitate a tapering off of the medication, and you may have to re-apply to the program.**

**By signing this application for admission, I have answered all of the questions and provided the information honestly to the best of my ability, and understand the contents therein. By providing false or misleading information in this application may result in denial of acceptance or revocation from the program.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

The following pages are consents for release of medical information and chemical dependency information.

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*State of Montana*  
**DEPARTMENT OF CORRECTIONS**  
**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

Offender's Full Name \_\_\_\_\_

Address or Location \_\_\_\_\_

DOC I.D. # \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Complete appropriate section and include all information and signatures.**

**SECTION I: Release of information contained in offender's case record.**

I, \_\_\_\_\_, authorize the Department of Corrections to release  
Offender

information from my case file to the following person:

Name \_\_\_\_\_

Relationship to Offender \_\_\_\_\_

Offender's Signature \_\_\_\_\_

Date \_\_\_\_\_

**SECTION II: Release of healthcare, treatment, or other types of information and/or records.**

I, \_\_\_\_\_, authorize \_\_\_\_\_  
(Offender) Facility/Agency/Person

to release the following records covering the period from \_\_\_\_\_ to \_\_\_\_\_. I further authorize the exchange of information between the facility/agency/person and the Department for the purpose of: \_\_\_\_\_

Authorization expires: \_\_\_\_\_

**Check all that are specifically authorized:**

**Healthcare Information:**

Discharge Summary

Progress Notes

Operative Notes

History and Physical

Laboratory Tests

Pathology Report

Consultation Reports

Emergency Room Report

X-ray/Imaging Reports

Immunization Record

Complete Health Record

Other: \_\_\_\_\_

**Treatment Information:**

CD Evaluation results/recommendations

Mental Health/Psychological Evaluation/Diagnosis

Discharge Summary

Other: \_\_\_\_\_

**OTHER:** \_\_\_\_\_

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or Hepatitis A, B or C. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
2. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on this authorization. The revocation is effective from the time it is communicated to the provider. Unless otherwise revoked, this authorization is valid for up to 30 months from the date of execution below. If no expiration is specified, this authorization will automatically expire six (6) months from the date of signing. This authorization does not permit the release of health care information relating to health care that the patient receives more than six (6) months from the date of execution below. (§50-16-527, MCA)
3. The Montana Department of Corrections, Montana State Prison, Montana Women’s Prison, its health care providers, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information pursuant to the Uniform Health Care Information Act, §50-16-501 through §50-16-553, MCA, or the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d.
4. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
 Signature of Offender or Offender’s Representative \_\_\_\_\_  
 Date

Relationship to the offender: \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness \_\_\_\_\_  
 Date

\_\_\_\_\_  
Signature and Title of Department of Corrections Representative \_\_\_\_\_  
 Date

cc: Offender File