

# THE NEXUS PROGRAM

## Applicant Information Sheet

PLEASE TYPE OR PRINT

**THIS FORM IS TO BE COMPLETED BY THE INDIVIDUAL REFERRING AN APPLICANT TO:**

**THE NEXUS PROGRAM**

**PO Box 1200**

**Lewistown, MT 59457**

**Fax: (406) 535-6665**

Date: \_\_\_\_\_ Applicant Name: \_\_\_\_\_

DOC ID# or SS#: \_\_\_\_\_ Has Applicant been Sentenced? Last First Middle  
 Yes  No

Present Location of Client:  MSP  MASC  START  Jail \_\_\_\_\_  
 Other \_\_\_\_\_

What is the release destination of this applicant upon completion of the Nexus Program?

- |   |   |
|---|---|
| <input type="checkbox"/> Billings PRC         | <input type="checkbox"/> ISP Location: _____    |
| <input type="checkbox"/> Butte PRC            | <input type="checkbox"/> Parole Location: _____ |
| <input type="checkbox"/> Bozeman Work Release | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> Great Falls PRC      | _____   |
| <input type="checkbox"/> Helena PRC           | _____   |
| <input type="checkbox"/> Missoula PRC         | _____   |

Name and Title of Referring Individual: \_\_\_\_\_

Phone Number of Referring Individual: \_\_\_\_\_ E-Mail address: \_\_\_\_\_

Signature of Referring Individual: \_\_\_\_\_ Date: \_\_\_\_\_

**Please review application for accuracy prior to submitting it to Nexus.**

***Please include any of the following items that are available:***

- Judgment and Commitment papers
- Initial Parole Board Report and Disposition
- Reports of Violation
- Current Medical Release from MSP, START, or MASC
- Montana Mental Health Services Plan Application (if applicable)
- PSI Report
- Psychological Evaluation or Reports
- Any Discharge Summaries from past treatment episodes
- Initial Classification Summary and Report
- Summary of Unit Performance

**NEXUS PROGRAM  
LEWISTOWN, MT  
Phone: (406) 535-6660 or Fax: (406) 535-6665**

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**Application For Admission**

This application is to be completed, in its entirety, by those persons who wish to enter and participate in the NEXUS Program. Please complete all questions and areas to the best of your ability. **A note to the referent, if you could review this application upon its completion to check for accuracy, the screening process will be expedited.** Incomplete, missing, unclear, false, or misleading information on the application will be cause for rejection of admission, and it will be returned, thus delaying possible admission into Nexus..

1. Are you aware that the Nexus Program is an intensive, nine (9) month Residential Modified Therapeutic Community Chemical Dependency Treatment facility that also includes a great deal of cognitive restructuring, thus requiring complete participation and commitment?     Yes     No
  
2. Are you also aware that per statute, following the nine (9) month Nexus Program, most offenders are required to attend and complete a pre-release aftercare program?     Yes     No
  
3. Having the understanding of the demanding schedule, structure and costs involved, in addition to the knowledge that should you be removed from the Nexus due to disciplinary reasons, the MDOC or Federal Correctional Authorities can place you at a higher level of custody, are you willing to make a commitment to participate fully in the Program?     Yes     No

If your answer to questions 2 & 3 are “Yes”, please continue on the next page!

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Name of Referring Officer: \_\_\_\_\_

Phone Number: (    ) \_\_\_\_\_ Location: \_\_\_\_\_

**\*\*\*For screening purposes, please indicate the best time for us to contact you or the name of another officer who may also assist in the screening process in your absence:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Offender's \_\_\_\_\_ DOC ID#: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Current Legal Charges (On your qualifying Court Judgments): \_\_\_\_\_

Length of Sentence: \_\_\_\_\_ Date of Sentence: \_\_\_\_\_

Is your current sentence a new sentence?  Yes  No

Have you previously served time on this sentence?  Yes  No

If yes to the above question, at what location were you incarcerated? \_\_\_\_\_

Did the sentencing Court (Judge) recommend you for Nexus?  Yes  No

Did the Parole Board or Institutional Screening Committee refer you to Nexus?  Yes  No

What are your drug(s) of choice?

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

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

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

Do you have a problem with gambling?  Yes  No

Or do you just gamble while you are high/drinking, and don't consider it a problem?  Yes  No

Have you ever been treated for a Gambling Addiction?  Yes  No

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

<u>Treatment Provider</u>	<u>Completed (Y or N)</u>	<u>Approximate Date of Discharge</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

<u>Treatment Provider</u>	<u>Completed (Y or N)</u>	<u>Approximate Date of Completion</u>
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_____	<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 you last treatment did you stay clean/sober? \_\_\_\_\_

How did you accomplish that? \_\_\_\_\_

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

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

Do you have any past AA or NA experience?  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 "No", skip to **Part 2 on top of page 6.**

If the answer to above was yes, please indicate what the diagnosis was, the person who made the diagnosis, 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.**

(Please list below.)

<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

Do you have a mental health diagnosis?  Yes  No \_\_\_\_\_

If yes, please indicate the diagnosis and person making this diagnosis below!

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Please list the number of dependents you claimed on your last taxes. \_\_\_\_\_

Income on the last taxes you submitted? \$ \_\_\_\_\_

**The above questions are for mental health medication assistance purposes only!**

Are you currently taking any prescribed medication for a Mental Health condition?  Yes  No

If yes, please list the name of the medication, dosage, and frequency:

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

Are you currently suffering from any Eating Disorder?  Yes  No

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

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**Part 2**

Are you currently being treated for any Medical Conditions?  Yes  No

If the answer above is "Yes", please list what your condition is and how often you see a Medical Professional for this condition?

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List the name and address of the Medical Professional who you are receiving treatment from regarding this/these condition(s).

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Would any of these conditions interfere with your treatment at Nexus?  Yes  No

If "Yes", which condition? \_\_\_\_\_

The Nexus Program may have a waiting list for admission and the time frame for availability of an admission date does vary. The admissions staff at Nexus understands that many clients do remain incarcerated until his admission date arrives. We do our best to get you admitted as soon as possible.

**By signing this application for admission, I do believe I have answered all of the questions and provided the information honestly to the best of my ability.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_


The following two (2) pages are a Consent for Release of Chemical Dependency and Medical Information.

**PLEASE JUST SIGN AND DATE (on the x's) AND HAVE A WITNESS SIGN AND DATE THESE RELEASES. DO NOT CHECK ANY OF THE BOXES OR WRITE ANY OTHER INFORMATION ON THE FORMS!!!!!!**

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Nexus Program

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I, \_\_\_\_\_, authorize the exchange of information between the Nexus Treatment Program and the following **treatment** provider:

\_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Fax Number

The following information listed below may be furnished or obtained either in writing or via telephone or fax by the Intake/Screening Committee of Connections Corrections Program.

- CD Evaluation results and recommendations
- Discharge Summary
- Mental Health/Psychological Evaluation and Diagnosis

**I understand that my records are protected under the Federal Confidentiality Regulations (42 CFR Part 2) and cannot be disclosed without my written permission unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and in the event this consent expires automatically one hundred and eighty (180) days from the date listed below.**

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**X**  
\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

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The Nexus Program

Request for the Release of Confidential Medical Records

I, \_\_\_\_\_, authorize the Nursing Staff of the CCCS, Inc.,  
Printed Full Name  
Nexus Program to release or receive medical information from my medical records.

\_\_\_\_\_  
Name of Provider

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Fax Number

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Type of Information to be released:     Verbal     Written

*The purpose of the release/exchange of records/information is for the Transfer of Care:*

To be released:     Progress Notes     Lab Reports     X-Rays     Med Records     Physician's Orders  
 Other \_\_\_\_\_

This information is requested by the Nursing Staff of the Community Counseling, and Correctional Services, Inc., and should be Faxed to (406) 782-6676, or mailed to the above address.

Attention: CCCS, Inc., Nursing Staff

**I understand that my records are protected under the Federal Confidentiality Regulations (42 CFR Part 2) and cannot be disclosed without my written permission unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and in the event this consent expires automatically one hundred and eighty (180) days from the date listed above.**

**X**  
\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date