



Community, Counseling, and Correctional Services, Inc.

Pre-Release Application

Name: _____

Center: _____

AO#: _____

Date: _____

Unit: _____

Section I: (Filled out by applicant)

Pre-Release: Why do you want to be accepted at the Pre-Release Center?

How would going to Pre-Release affect employment, family relations, finances, and your ability to participate in treatment services? (Be specific, which of these apply to you.)

Prior Community Placement: Please describe any previous attempts to complete a pre-release or other community placement. List locations and dates:

Have you had any thoughts of self-harm or attempts at suicide? If so, when:

Please describe reasons for failures in prior supervision placements: (i.e. Technical violations, dirty UA's, or new crime in the community):

Release plan: Upon discharge, where do you plan to settle? (At time of release.)

Later:

What are your goals upon release?

Employment: Do you have a job offer or prospects upon release? Yes ___ No ___ Give details (i.e. name of employer, type of work, phone number and address). Summarize your employment history.

Education: Do you have a GED? Yes___ No___ Give details of education beyond GED level, including vocational training.

CHEMICAL DEPENDENCY QUESTIONS:

1. Have you ever been in detox for drug or alcohol use? Yes___ No___ If yes, list where and when:

2. Have you ever been assessed for a drug/alcohol problem? Yes___ No___ If yes, list by whom, where, and when:

3. Have you been told that you need to go to treatment for drug and/or alcohol problems? Yes___ No___ If yes, list by whom and when:

4. List all treatment(s) for drug and/or alcohol: (If more space is needed, continue listing on back of this page.)

Name of Treatment Program	Type of Treatment: inpatient, outpatient, intensive outpatient	Date	Complete Yes/No
1.			
2.			
3.			

4.			
5.			

5. Have you ever attended AA/NA? Yes ___ No ___

6. Have you ever had an AA/NA sponsor? Yes ___ No ___

7. How many DUIs have you been convicted of: _____

8. List the drug and/or alcohol related charges you were convicted of:

Charge/Date	Charge/Date
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

9. Do you have health problems as a result of your alcohol/drug use? Yes ___ No ___ If yes, please describe problems and any treatments (if applicable).

10. Complete the following Release of Information form by filling in all areas marked with an (X). Under 'Name of Program to Disclose Information' list the most recent treatment provider or assessment provider.

**AUTHORIZATION OF DISCLOSURE
GENERAL CONSENT FORM**

I, _____ Date of Birth _____ Date _____
(Offender/Patient Name)

authorize _____
(Name of Program to Disclose Information) to disclose to: Staff and Screening Committees of Alternatives, Inc. (Billings Prerelease), Community Counseling & Correctional Services (Butte Prerelease), Great Falls Transition Center (Great Falls Prerelease) Missoula Correctional Services, Inc. (Missoula Prerelease) and Helena Prerelease Center.

(Name and Title of Person(s) or Organizations to which disclosure is to be made)

The following identifying information from my records (specify extent or nature of information to be disclosed):

Fainting/Dizzy Spells	Chest Pain
Glaucoma/Eye Problems	Heart Murmur
Hepatitis: A	Heart Attack
B	Coronary Insufficiency
C	Pacemaker
Headaches	Stroke
Hearing Difficulty	Angina
High Cholesterol	Abnormal Bleeding
Immune Deficiency/Lupus	Blood Pressure ___ High ___ Low ___ Normal
Inflammatory Rheumatism	Hemophilia
Kidney Trouble	Are you taking blood thinners
Liver Disease	Other: (Please explain)
Replacement (Knee, Hip, or Joint)	
Sinus Condition	
Thyroid	Women Only YES NO
Venereal Disease	Are you pregnant
	Are you taking birth control
Are you currently taking any of the following:	Are you allergic or have you reacted to
YES NO	YES NO
Antibiotics or sulfa drugs	Local anesthetics
Anticoagulants (blood thinners)	Penicillin
Medicine for high blood pressure	Other Antibiotics
Cortisone (steroids)	
Tranquilizers	Barbiturates, sedatives or sleeping pills
Aspirin	Aspirin
Insulin, tulbutamide (orinase) or similar drug	Food
Digitalis or drugs for heart trouble	Other
Nitroglycerin	
2. Have you ever received treatment for a medical condition requiring admission to a hospital, on-going care, or surgery? ___ YES ___ NO	
If yes, explain date, location, diagnosis, treatment, etc.:	
3. Have you ever taken medication for any behavioral, mental, or emotional problem? ___ YES ___ NO If yes, please list name and dosage of all medications.	
4. Is there any physical or emotional condition that you believe requires accommodation? (lifting or activity restrictions, assistance in ambulation, etc.) ___ YES ___ NO	
If yes, please explain.	
Has reasonable accommodation been made in the past? ___ YES ___ NO	
If yes, please explain.	
Is there anything that would limit your ability to participate fully in any correctional setting (prerelease, boot camp, ISP, MSP, etc.) ___ YES ___ NO	
If yes, please explain.	
5. Has your ability to function/work/interact with others been impaired due to mood and/or mind altering drugs? ___ YES ___ NO	
If yes, please explain.	

Have you had legal difficulties due to mood and/or mind altering drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please explain. Include alcohol (beer, wine, or liquor), any drugs, medications or inhalants.	
a. Were you using or under the influence of any substance at the time of arrest or at the time this crime was committed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, what were you using?	
b. Have you or anyone in your family had a history of substance abuse or been in treatment (out-patient or in-patient) for substance abuse?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please explain.	
c. Do you know if your mother used alcohol during the time she was pregnant with you?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please explain.	
6. Have you ever engaged in high-risk behaviors such as IV drug use or multiple sexual partners?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If so, please explain.	
7. Have you ever been on S.S.I., S.S.D. or Medicaid?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If so, please explain.	
8. Do you have any lifting, standing or other physical limitations?	<input type="checkbox"/> YES <input type="checkbox"/> NO

You are to pay court ordered restitution in the amount of: \$_____

DISCLAIMER:

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

I hold harmless the Community, Counseling, and Correctional Services, Inc. for failure on my part to disclose information.

Offender Signature

Date

Witness

TREATMENT HISTORY:

Educational/Vocational/Employment Skills:

Treatment Program	Court Order	Court Recd.	Treatment Needs	Rejected Failed	In Group	Completion Date
SOP TX	-	-	-	-	-	-
M.H. TX	-	-	-	-	-	-
Anger Management	-	-	-	-	-	-
ED. GED	-	-	-	-	-	-
CP&R	-	-	-	-	-	-
CD	-	-	-	-	-	-
OTHER	-	-	-	-	-	-

HEALTH STATUS CATEGORY:

Parole Eligibility Date: _____ **Discharge Date:** _____

Prior Disposition:

Detainers: (Yes/No) _____

Counties:

For:

Last Disciplinary or Misconduct Report:

WAIVER

I HAVE BEEN INFORMED OF the Pre-Release Program and I understand that I am being considered for placement, have read, understand, and accept the terms and conditions listed below.

Offenders Initials:

_____ **1. I understand that the Pre-Release Centers are not legally bound to accept any referral for pre-release placement.**

_____ **2. I authorize the release of all medical, psychological, chemical dependency and criminal history information to be forwarded to the Pre-Release Centers for appropriate screening and handling of my case.**

_____ **3. I will abide by all terms of placement.**

_____ **4. I will abide by all Pre-Release Center rules.**

_____ **5. I am responsible for all medical and treatment costs.**

_____ **6. Although a Pre-Release Center resident, I continue to be an Inmate, and recognize that any unauthorized absence from the Center constitutes a Felony Escape, which carries a year consecutive sentence.**

_____ **7. If I am returned to prison for other than medical reasons, I may be issued a Class II.**

_____ **8. If I am returned to prison I will be allowed to bring only the property that is allowed to new inmates.**

_____ **9. I am responsible for all debts incurred to the Pre-Release Center while a resident.**

_____ **10. I am responsible for all debts incurred to Community Treatment Providers while a resident.**

Client Signature: _____

Date: _____

