Badlands Recovery Center

Additional Application Requirements

- **TYPE ALL APPLICATION MATERIALS**
  - Biopsychosocial Assessments
  - Application
  - Releases of Information
  - Financial Forms

- **Biopsychosocial Assessment** completed within 30 days of application by a Montana LICENSED ADDITION COUNSELOR to be submitted with the application for treatment.
  - Please individualize the information to the patient and include ASAM dimensional 1-6 breakdown.

- **Releases of Information** listed below are recommended ROI's that will assist us with appropriate screening of individuals. Mountain Pacific/Telligan Services and Med-Write are used for MEDICAID cliental. Please provide releases for medical providers; behavioral health and mental health providers for the last 12 months if appropriate.
  - Referring party or agency
  - Legal Entities (lawyer, judges, treatment court, probation officer etc.)
  - Department of Family Services
  - Medical & Behavioral Health Providers (seen within last 12 months)
  - Mental Health Providers (seen within last 12 months)
  - Mountain Pacific/Telligan Services
  - Med-Write

- Please bring all medications that are currently being used. Medical costs not covered by Medicaid or insurance will be the responsibility of the client.

- Medicaid applications will need to be submitted along with all required documentation to gain Prior Authorization. Once Prior Authorization is obtained a bed date will be secured.

- When possible, include a **copy of their Medicaid card** (if already on Medicaid) with their application so that we can obtain the necessary information such as their Medicaid number to complete Telligan forms.

- If a patient receives **Medicare Part D** for medications, please include **a copy of card.**

- Private Insurance – Copy of the front and back of card need to be included. Pre-approval is required.

**Please contact the Admissions Coordinator, at 406-377-6001, with any questions or concerns pertaining to the process or information listed above. **

Badlands Recovery Center

700 Little Street
Glendive, MT 59330

Please complete thoroughly and neatly: **Date:**

Name: _____ (Last) _____ (First) _____ (Maiden/Middle) Gender: ☐M ☐F _____

Address: _____ (City) _____ (State) _____ (Zip) County: _____

SSN# _____ Birthdate: _____

Email Address: _____

Home Telephone _____ Cell _____ Work _____

Employed: ☐ Yes ☐ No Employer: _____ Phone _____

Not in Labor Force Specify - ☐Homemaker ☐Student ☐Retired ☐ Disabled ☐ Inmate ☐ Other

Education Competed: High School/Grade _____ College _____ Post Grad _____ Other/HISET _____

Marital Status: ☐ Married ☐ Unmarried ☐ Divorced ☐ Committed/Cohabitating ☐ Widowed(er)

Are you a Veteran: ☐ Yes ☐ No Homeless: ☐ Yes ☐ No

Race/Ethnicity: ☐ White ☐ Asian Indian ☐ Black ☐ Alaskan Native ☐ Hispanic ☐ Other _____

☐ Native Indian Enrolled Tribal Member ☐ Yes ☐ no Descendent ☐Yes ☐ No

Tribe: _____

Do you have dependent children under the age of 18? ☐ Yes ☐ No How many? _____

Do they live with you? _____

Annual Family Income from all sources: $_____ Last Year_____ Household size _____

Pay frequency _____ Monthly Income _____ Sources of Income _____

Health Insurance: _____ ☐Medicaid ☐ Medicare ☐ VA ☐ None ☐ Other

Name of Insured: _____ Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Date of Birth of Insured: _____ Preauthorization Required: ☐ Yes ☐ No

Insurance Group # _____ ID# _____

Do you currently receive SSI/SSDI: ☐ Yes ☐ No Monthly $ _____

How do you rate your physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor Why: _____

What is your height? _____ Weight? _____

Current Medical Issues (diabetes, heart decease, etc.)_____

_____

Badlands Recovery Center

700 Little Street
Glendive, MT 59330

Any special medical needs/accommodations (wheelchair, hearing, vision) _____

Current Diagnosis: Substance Use Disorder: _____ Mental Health: _____

Do you smoke or use tobacco products? ☐ Yes ☐ No Have you ever tried to quit tobacco? ☐ Yes ☐ No

What substances are you using now? _____

Date of last use _____

Do you experience withdrawal symptoms when you stop using substances? ☐ Yes ☐ No

If yes, what are the symptoms? (Seizures, DT's) _____

Are you pregnant or do you suspect you are pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

If yes, have you seen a health provider for your pregnancy? ☐ Yes ☐ No

Who? _____ When? _____ Have you had an Ultrasound/ Date? _____

Who is the Physician/practitioner that prescribes your medication? _____ Phone _____

What pharmacy do you get your medication from? _____ Phone _____

Current Medications and Doses – You must provide a current medication list from pharmacy/health provider.

_____

_____

_____

_____

_____

_____

Number of prior treatments: Inpatient _____ Outpatient _____ Date of last treatment _____

Longest period of abstinence following any treatment: _____

Have you ever used drugs by injection: ☐ Never ☐ Currently ☐ Last 1-12 months ☐ More than a year ago

Have you participated in AA or NA groups? ☐ Yes ☐ No

Do you have a sponsor? ☐ Yes ☐ No _____

Badlands Recovery Center

700 Little Street
Glendive, MT 59330

Have you been incarcerated in the last 30 days? ☐ Yes ☐ No How many days? _____

Please list any legal convictions/involvement (Current and prior): _____

_____

_____

_____

Are you required to register as a sexual/violent offender? ☐ Yes ☐ No

Are you: On Probation Incarcerated Mandatory Monitoring

On Parole On Pre-Release DUI Offender

Name of your probation officer: _____ Phone _____

Name of your Attorney: _____ Phone _____

Signature of applicant: _____ Phone _____ Date _____

Badlands Recovery Center
700 Little Street, Glendive, MT 59330
Telephone: 406-377-6001 Fax: 406-377-6004

Patient Name: _____ _____ _____
(Last) (First) (MI)

DOB: _____ SS#: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require that you request the minimum information necessary to complete required purpose of this release.

- ☒ Continued Care Plan/Transition/Discharge Summary
- ☒ Mental Health Assessment
- ☒ Physician Orders
- ☒ History & Physical
- ☒ Treatment Plan
- ☒ Dates in program
- ☒ BioPsychosocial Evaluation/Assessment
- ☒ Progress Notes
- ☒ Medication Records
- ☒ General Progress in Treatment
- ☒ Continued Stay Reviews
- ☒ TB Skin Test Results
- ☒ Correspondence
- ☒ Interdisciplinary Notes
- ☒ Other: Billing Records

Date Release Revoked:

☐ Other(Please be specific) _____

Purpose of need for disclosure is _____

_____

Permission is hereby given to EXCHANGE information with:

Badlands Recovery Center
700 Little Street, Glendive, MT 59330
Phone: 406-377-6001 Fax: 406-377-6004

AND Name: Med-Write
Address: 1643 Lewis Ave, Su. 7
City: Billings State: MT Zip Code: 59102
Phone number: 877-209-6223
Fax number: _____

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as otherwise permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is **NOT** sufficient for this purpose.

I, the undersigned, have read the above and authorize staff of the disclosing facility named to disclose such information as herein contained. I understand that I may revoke or cancel this authorization at any time. Withdrawal of the authorization does not affect any information disclosed before providing a written notice of such a withdrawal of authorization. **This authorization will remain in effect for 180 days in order to carry out the purpose for which my permission was given.** I understand that the program releasing these records is free from all legal liabilities that may arise from this act. I understand that I have the right to limit the information that is to be disclosed and who can see this information. A photocopy of this authorization is as valid as the original.

_____ _____
Patient Signature Date Facility Witness Signature Date

_____

I Cancel My Permission To Disclose The Information Described On This Form.

_____ _____
Patient Signature Date Facility Witness Signature Date

This notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse treatment made to you with the consent of such patient. This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part2) and the Health Insurance and Portability and Accountability Act of 1996 (HIPAA 45 C.F.R. Parts 160 & 164) Federal laws prohibit you from making any further disclosure of this information unless it is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 of HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules and laws restrict any use of the information to criminally investigate of prosecute any alcohol or drug abuse patient.

Badlands Recovery Center will not make signing this authorization a condition of treatment, payment or enrollment/eligibility for benefits unless the authorization is mandatory.

Badlands Recovery Center
700 Little Street, Glendive, MT 59330
Telephone: 406-377-6001 Fax: 406-377-6004

Patient Name: _____ _____ _____
(Last) (First) (MI)

DOB:_____ SS#:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require that you request the minimum information necessary to complete required purpose of this release.

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- ☒ Mental Health Assessment
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- ☒ Treatment Plan
- ☒ Dates in program
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- ☒ Progress Notes
- ☒ Medication Records
- ☒ General Progress in Treatment
- ☒ Continued Stay Reviews
- ☒ TB Skin Test Results
- ☒ Correspondence
- ☒ Interdisciplinary Notes
- ☐ Other: _____

Date Release Revoked:

☐ Other(Please be specific) _____

Purpose of need for disclosure is _____

_____

Permission is hereby given to EXCHANGE information with:

Badlands Recovery Center
700 Little Street, Glendive, MT 59330
Phone: 406-377-6001 Fax: 406-377-6004

AND Name: Mountain Pacific/Telligan Medicaid Services
Address: 3404 Cooney Drive
City: Helena State: MT Zip Code: 59602
Phone number: 800-219-7035
Fax number: _____

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Badlands Recovery Center
700 Little Street, Glendive, MT 59330
Telephone: 406-377-6001 Fax: 406-377-6004

Patient Name: _____ _____ _____
(Last) (First) (MI)

DOB:_____ SS#:_____

AUTHORIZATION FOR RELEASE OF INFORMATION (REFERRING AGENCY)

Extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require that you request the minimum information necessary to complete required purpose of this release.

- ☒ Continued Care Plan/Transition/Discharge Summary
- ☒ Mental Health Assessment
- ☐ Physician Orders
- ☐ History & Physical
- ☒ Treatment Plan
- ☒ Dates in program
- ☒ Biopsychosocial Evaluation/Assessment
- ☒ Progress Notes
- ☐ Medication Records
- ☒ General Progress in Treatment
- ☒ Continued Stay Reviews
- ☐ TB Skin Test Results
- ☒ Correspondence
- ☒ Interdisciplinary Notes
- ☐ Other: _____

Date Release Revoked:

☐ Other(Please be specific) _____

Purpose of need for disclosure is _____
_____

Permission is hereby given to EXCHANGE information with:

Badlands Recovery Center
700 Little Street, Glendive, MT 59330
Phone: 406-377-6001 Fax: 406-377-6004

AND Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone number: _____
Fax number: _____

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as otherwise permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is **NOT** sufficient for this purpose.

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Patient Signature Date Facility Witness Signature Date

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Badlands Recovery Center
700 Little Street, Glendive, MT 59330
Telephone: 406-377-6001 Fax: 406-377-6004

Patient Name: _____ _____ _____
(Last) (First) (MI)

DOB: _____ SS#: _____

AUTHORIZATION FOR RELEASE OF INFORMATION (MEDICAL)

Extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require that you request the minimum information necessary to complete required purpose of this release.

- ☐ Continued Care Plan/Transition/Discharge Summary
- ☐ Mental Health Assessment
- ☒ Physician Orders
- ☒ History & Physical
- ☒ Treatment Plan
- ☐ Dates in program
- ☐ Biopsychosocial Evaluation/Assessment
- ☒ Progress Notes
- ☒ Medication Records
- ☐ General Progress in Treatment
- ☐ Continued Stay Reviews
- ☐ TB Skin Test Results
- ☒ Correspondence
- ☐ Interdisciplinary Notes
- ☐ Other: _____

Date Release Revoked:

☐ Other(Please be specific) _____

Purpose of need for disclosure is _____
_____

Permission is hereby given to EXCHANGE information with:

Badlands Recovery Center
700 Little Street, Glendive, MT 59330
Phone: 406-377-6001 Fax: 406-377-6004

AND Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone number: _____
Fax number: _____

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as otherwise permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is **NOT** sufficient for this purpose.

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Patient Signature Date Facility Witness Signature Date

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Badlands Recovery Center
700 Little Street, Glendive, MT 59330
Telephone: 406-377-6001 Fax: 406-377-6004

Patient Name: _____ _____ _____
(Last) (First) (MI)

DOB: _____ SS#: _____

AUTHORIZATION FOR RELEASE OF INFORMATION (MENTAL HEALTH)

Extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require that you request the minimum information necessary to complete required purpose of this release.

- ☐ Continued Care Plan/Transition/Discharge Summary
- ☒ Mental Health Assessment
- ☐ Physician Orders
- ☐ History & Physical
- ☒ Treatment Plan
- ☐ Dates in program
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- ☒ Progress Notes
- ☐ Medication Records
- ☐ General Progress in Treatment
- ☐ Continued Stay Reviews
- ☐ TB Skin Test Results
- ☒ Correspondence
- ☐ Interdisciplinary Notes
- ☐ Other: _____

Date Release Revoked:

☐ Other(Please be specific) _____

Purpose of need for disclosure is _____
_____

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Badlands Recovery Center
700 Little Street, Glendive, MT 59330
Phone: 406-377-6001 Fax: 406-377-6004

AND Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone number: _____
Fax number: _____

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Badlands Recovery Center
700 Little Street, Glendive, MT 59330
Telephone: 406-377-6001 Fax: 406-377-6004

Patient Name: _____ _____ _____
(Last) (First) (MI)

DOB: _____ SS#: _____

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- ☐ TB Skin Test Results
- ☐ Correspondence
- ☐ Interdisciplinary Notes
- ☐ Other: _____

Date Release Revoked:

☐ Other(Please be specific) _____

Purpose of need for disclosure is _____
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Badlands Recovery Center
700 Little Street, Glendive, MT 59330
Phone: 406-377-6001 Fax: 406-377-6004

AND Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone number: _____
Fax number: _____

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