

Application – Adult Life Care Program

Thank you for your interest in North Dakota Adult & Teen Challenge. Our program is designed to help those who are struggling with life- controlling chemical dependency issues and who desire a Christian, faith-based approach to recovery.

To complete the admissions process you must:

- Carefully review all of the information in this packet to determine if our program is right for you. If not, please contact our admissions office to request a referral list of other programs.
- Complete the attached application (**please print legibly**) and fax or mail it to the address below. **If you receive assistance in completing this application, or want us to correspond with any other persons regarding your application, be sure to complete the attached “Authorization for Release of Confidential Information” form. (This can be found on page 14 of the application.)**

North Dakota Adult & Teen Challenge
Attention: Admissions Department
1406 2nd St NW
Mandan, ND 58554
Phone: (701) 667-2131
Fax: (701) 663-3494

Adult & Teen Challenge is a voluntary program. Upon receipt of your application, an admissions representative will contact you and begin processing your application. The length of the application review process can vary, but usually takes approximately 5 to 10 business days. In processing applications, a number of things are taken into consideration including: mental health conditions, medical conditions, past and present legal issues, funding eligibility, and level of care required.

It is important that your contact information is current. If you submit an application and have relocated, **please be sure to notify our Admissions Department of your current contact information.**

Important Applicant Information:

- Applicants will not be admitted without a photo identification and social security card. If you do not possess these items at the time of application, please begin the process to receive them before admittance.
- Applicants must go through detoxification prior to entry if needed.
- Applicants are strongly encouraged to enter the program with at least a 30-day supply of all current prescribed medications (with the exclusion of prescribed narcotics). Only three prescribed and three over the counter medications are allowed.
- **A physical examination is required prior to admissions (See Page 15).** Some applicants may be approved for admissions prior to having a physical examination, provided they agree to have a physical immediately upon entering our program. **The student will be responsible for the cost of the physical exam.** Test for HIV, Tuberculosis and Hepatitis B & C are required as part of the physical exam.

Thank you again for your interest in our program. We look forward to the opportunity to help you in your recovery from drug and alcohol abuse.

Application – Adult Life Care Program

Program Policies & General Information (Please keep pages 1 - 6 for your records.)

The North Dakota Adult & Teen Challenge Life Care Program is a Christian residential recovery program. It consists of at least 12 months of instruction using a spiritual education model. The program assists individuals in permanently recovering from drug and alcohol abuse and the life-controlling problems associated with it.

Adult & Teen Challenge does not discriminate on the basis of race, color, creed, religion, sex, national and ethnic origin, marital status, public assistance, sexual orientation, family status, or disability in the administration of its educational, admission, or program policies procedures.

Applicants must be committed to complete the entire program to be eligible for admission. Program participants (students) are required to participate in daily devotions, chapel, individual discipleship, choir and classes. Daily assignments are a program requirement. Students who do not keep up with their daily assignments and those who fail to demonstrate satisfactory growth may be required to stay beyond the 12 month period.

Each student will have access to our “Student Manual” which covers the policies of the program. Adult & Teen Challenge reserves the right to make changes in policy whenever necessary. When a change in policy occurs, students and staff will be notified and the “Student Manual” will be updated to reflect the change. Highlighted below are some basic requirements/guidelines all Adult & Teen Challenge students are expected to adhere to while in the program. This is not a complete list of rules, but will serve as a basic example of what will be expected:

Appearance & Dress Code

Personal hygiene must be maintained in a neat and clean manner. Students are not allowed to bring any hygiene items which contain any form of alcohol in the first three ingredients. **Please be sure to check ingredients before packing hygiene items.**

- Dress requirements for students include two main dress codes:
 - Class/Special Events dress:
Males- collared shirts or nice t-shirts*, casual slacks, dress jeans or shorts, dress shoes.
Females- shirts*, blouses, casual slacks, skirts, dresses, dress jeans or shorts (tank tops may be worn with a shirt over it), dress shoes.
 - Leisure/recreational dress:
Shorts (must cover $\frac{3}{4}$ of thigh), t-shirts*, sweat pants, and jeans.
- *Please do not bring t-shirts which include images portraying drugs, alcohol, tobacco, skulls, or secular bands. Females, do not bring leggings or yoga pants.
- Students may not wear jewelry or hairstyles that attract unusual attention. Hair color must be of a normal color.

Approved Personal Belongings

The following is a list of items students should bring if they have them*. If the student does not have these items and does not have the means to purchase them, many of these items may be provided at no cost.

- Clothing: See dress code above. Winter/rain/light jacket, gloves, underwear, socks, etc.
- Toiletries (no alcohol in first three ingredients & unopened): soap, comb, toothbrush/toothpaste, shampoo, deodorant, razor, blow dryer.
 - Females: makeup, sanitary items, etc.
- Linens: blanket, pillow/cases, twin sheets, towel/washcloth.
- Medications: 30 day supply of all prescription medications (excluding prescribed narcotics), non-prescription medications. Only three prescribed and 3 over the counter medications will be allowed (six total)

*Please note, due to space limitations students may only bring two suitcases worth of belongings.

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Employment/Work Therapy

Due to the nature and schedule of our program, students may not actively be employed throughout the duration of their recovery.

- Students are required to participate in work therapy assignments. All students will be required to participate in general housekeeping and clean-up assignments.
- Students will be scheduled to participate in *up to* 30 hours of work therapy activities per week.
- Students voluntarily participating in other work therapy assignments will allow them to learn new or refine existing skills.

Mail/Visitation

- Students may receive visits from their personal physician, religious advisor, county case manager, attorney, and parole/probation officer at any reasonable hour.
- Correspondence will be limited to those who have been approved. Mail from those who have not been approved will be returned to the sender.
- Students may temporarily lose phone, mail, or visitor privileges if they are caught manipulating the system.

Medical/Dental Care & Prescription Medications

Students are responsible for all their health care expenses.

- Students are required to obtain a summary of each medical and dental visit prior to leaving the place of treatment and must provide the information to their staff immediately upon return to Adult & Teen Challenge.
- Students should bring enough prescription medication to last at least **30 days**, and bring it in their original containers bearing appropriate labels. Only three prescribed and three over the counter medications will be allowed. (six total)
- Students are required to take prescription medication **exactly** the way their doctor prescribes it. If subsequent medical treatment or behavioral issues arise as a result of a refusal to take prescribed medications, the student may be discharged from the program.
- Resident students are not permitted to take narcotics and certain other medications. Please see the Prohibited Medications document in this packet.

If applicant does NOT have ND health insurance, please follow the following steps before being admitted to North Dakota Adult & Teen Challenge:

1. Go online to: dhsbenefits.dhs.nd.gov/access/jsp/access/Home.jsp
2. Click: Sign in/ Create Account
3. Click: Register now
4. You are applying for Morton County if you are applying for North Dakota Adult & Teen Challenge.

Possession/Use of Drugs, Alcohol, & Tobacco

Possession and/or use of drugs, alcohol, and tobacco are prohibited while enrolled in our program.

- Drug and/or alcohol tests may be administered at any time to students without prior notice. Students who test positive for drugs and/or alcohol use while in our program will face disciplinary action and possible discharge from Adult & Teen Challenge.
- Students, their rooms, and their personal property may be searched at any time without prior notice or approval.

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Program Fee Information

North Dakota Adult & Teen Challenge's average monthly cost per student is approximately \$4,000. Students will have a suggested \$500 per month room fee, however students who are not able to cover the \$500 per month are still eligible to participate in the program.

Daily Schedule

Students are required to participate in all daily scheduled programming and activities, with the exception of optional recreational activities. A typical week day at Adult & Teen Challenge would include devotions, chapel, classroom education, and group/individual discipleship.

- In addition to this schedule, students are expected to participate in group choir rehearsals and weekly evening church groups at different churches in the local community.
- Saturday's are less structured and include time in the afternoon for visits from approved family and friends as well as passes for upper level students.

Program Outline

The Adult & Teen Challenge program consists of four levels. Each level focuses on the recovery and spiritual and emotional wellness of the student. The paragraphs that follow give a general outline and approximate timeline of each level:

Level One (approximately 14 weeks)

In level one, students attend classes that promote life recovery in the areas of: chemical dependency, anger management, personal relationships, family dynamics, depression, self-acceptance, and maintaining a chemical-free lifestyle.

Level Two (approximately 12 weeks)

In level two, students attend a series of classes designed to assist in the development of personal character and in the facilitation of healthy relationships with others. Students also work independently on materials focusing on their specific personal and family issues. They continue receiving these materials throughout the remainder of the program as they address each major issue in their lives.

Level Three (approximately 12 weeks)

In level three, students learn how to deal with the pain and emotional suffering associated with their current and past issues. Students attend classes designed to provide healing for damaged emotions and confront the issues that have left them emotionally scarred. *Family therapy may be offered to students when they enter this level and may continue through level four if desired.

Level Four (approximately 12 weeks)

Throughout level four, students focus on transitioning back into their local community. They receive classroom instruction on marriage and home, financial management, how to be good citizens and solving life's problems. Level four students also receive assistance with obtaining affordable housing, finding adequate employment, and connecting with a mentor in the local community.

Application – Adult Life Care Program

Holiday Breaks

There are three scheduled holiday breaks in the program –Fourth of July, Thanksgiving, and Christmas. All normal student activities cease during these times. North Dakota Adult & Teen Challenge is not liable for the safety of students who are away from our facility on break.

Eligibility:

Students may go home during these breaks only if all of the following conditions are met:

1. They must be in our program at least 90 consecutive days prior to the start of the break.
2. They must have the approval of the Program Director.
3. If on parole/probation, they must have permission from their probation officer.

Transportation:

North Dakota Adult & Teen Challenge does not provide transportation for students who are going away on break. This includes transportation to/from airports, train stations, bus stations, or any other location.

Students remaining at North Dakota Adult & Teen Challenge during break:

Recreation and other activities will be scheduled for students who remain in our facility during these breaks. Family and friends desiring to visit students during scheduled breaks must contact the program director to arrange dates and times of visitation.

Break Schedule:

A schedule of when students may depart and when they must return will be provided to the student by the Program Director or the Assistant Program Director and will also be posted on the bulletin board in the student's living facility. Students who do not return from break on time may be discharged, set back in the program, and/or lose future opportunities to go home during scheduled breaks.

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Prohibited Medications

The following medications are prohibited at North Dakota Adult & Teen Challenge due to their interference with the recovery process. Prospective students that are currently taking any of the listed medications need to check with their health care provider prior to admission to determine if an appropriate alternate medication is available. In the rare circumstance that an alternate is not available North Dakota Adult & Teen Challenge is not an appropriate recovery option and a referral list of treatment programs in the area will be provided.

Examples of addictive medications include but are not limited to the following and are subject to change as deemed necessary:

All Narcotic pain relievers and pain relievers with potential for dependence and abuse

- Vicodin- (hydrocodone with acetaminophen)
- OxyContin- (oxycodone)
- Percocet- (oxycodone with acetaminophen)
- Dilaudid
- Morphine
- Tramadol-Ultram
- Darvocet-Darvocet N (propoxyphene)
- Tylenol with Codeine (acetaminophen with codeine)
- Cough medicine containing codeine
- Demerol (meperidine)
- Morphine
- Zantac
- Gabapentin

All medications used for the treatment of opiate dependence, e.g. Methadone, Suboxone, Subutex, Naltrexone

All Benzodiazepines

Most commonly prescribed

- | | |
|-------------------------|------------------------|
| ▪ Xanax (Alprazolam) | Dalamine (Flurazepam) |
| ▪ Klonopin (Clonazepam) | Halcion (Triazolam) |
| ▪ Valium (Diazepam) | Tranxene (Chorazepate) |
| ▪ Ativan (Lorazepam) | Serax (Oxazepam) |
| ▪ Restoril (Temazepam) | |
| ▪ Librium | |

All Stimulant medications used to treat Attention Deficit Disorder & Attention Deficit/Hyperactivity

- | | |
|--------------------------------------|----------------------------------|
| ▪ Adderall (amphetamine mixed salts) | Methylin (Methylphenidate HCL) |
| ▪ Adderall XR | Daytrana (Methylphenidate HCL) |
| ▪ Concentra (Methylphenidate HCL) | Metadate (Methylphenidate HCL) |
| ▪ Ritalin (Methylphenidate HCL) | Desedrine |
| ▪ Ritalin SR | Focalin (Dexmethylphenidate HCL) |
| ▪ Vyvanse | Lisdexamfetamine |

All Sleep Agents Ambien, Ambien CR (zolpidem), all over the counter PM medications (with the exclusion of Melatonin)

All Muscle Relaxants Soma (Carisoprodol)

Smoking Cessation Medication Bupropion (Wellbutrin), Chantix (Vareniclin), patches, gum, etc...

Others: Trazadone, Robitussin, any medication with Dextromethorphan

(Please keep pages 1-6 for your records and return only pages 7-15 to the Admissions Office.)



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First Name: _____ SSN: _____

Sex:

Middle Name: _____ Email: _____

Male

Last Name: _____ DOB: ___/___/___ Age: _____

Female

Current Address:

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____

Email: _____

Legal Resident Of:

State: _____

County: _____

Do You Have Any Relatives Or Friends Currently In Our Program? Yes No

Have You Previously Been In Our Program? Yes No How Many Years Ago? _____

Marital Status: Single Married Divorced Engaged Separated

Citizenship: United States Other

Race: American Indian Asian Black Hispanic Multi Racial White Other

Do You Read And Write At A 5th Grade Level or Above? Yes No

Do You Have A High School Diploma? Yes No If No, Do You Have A GED? Yes No

I Mainly Need Help With: (Check All That Apply) Alcohol Addiction Drug Addiction Other: _____

Do You Use Tobacco? Yes No (Tobacco use is not permitted any time while enrolled in the program)

Have You Ever Been Treated For Chemical Addiction? Yes No How many times? _____

Prior Treatment Facility: (list the most recent treatment program you have been

in) Name of Facility: _____

Address: _____

City: _____ State: _____

Dates of Treatment: ___/___/___ to ___/___/___

Reason for Treatment: _____

Did you complete the program? Yes No

How Did You Hear About Our Program? Church Radio Family/Friends Other _____

In your own words, tell us why you want to come to North Dakota Adult & Teen Challenge and the main issues you believe you need to deal with while in the program: (please print clearly)

Application – Adult Life Care Program

PHYSICAL HEALTH

Do you have ND Health Insurance? Y___ N___ (if not, see page 3)

Medical History: (Check all that apply to your current and past conditions)

- | | | |
|----------------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Trauma/TBI | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> STI/STD |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> HIV/Aids | |

Do you have any current medical concerns? If yes, please be specific: _____

Are you currently being treated by a doctor? Yes No

Name of Primary Doctor: _____

Address: _____

City: _____ State: _____

Phone: _____ Fax: _____

Dates of Treatment: ____/____/____ to ____/____/____

Reason for Treatment: _____

Are you pregnant? Yes No Due Date: ____/____/____

Are you allergic to any medications? Yes No If yes, what medications? _____

Are you being treated with prescribed narcotics? (Applicants on prescribed narcotics will need to complete the regimen prior to admission or switch to non-narcotic pain medications.) Yes No

If Yes, what medications? _____

Non-Psychiatric Medications:

List all current non-psychiatric medications:

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

Special Needs: (Please explain if checked "yes")

- | | | |
|----------------------------------------------|----------------------------------------------------------|-------|
| Do you have any type of disability? | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Do you have any chronic conditions? | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Do you have any medical restrictions? | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Do you have any other type of special needs? | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Do you have any allergies? | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| Do you require a special diet? | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |

Application – Adult Life Care Program

MENTAL HEALTH

Have you ever been treated for mental disorders? Yes No When: ___/___/___
Have you ever been treated by a psychiatrist/psychologist? Yes No Last Visit: ___/___/___

Mental Health History: (Check all that apply to your current and past conditions)

- | | | |
|-------------------------------------------|--------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hearing Voices | <input type="checkbox"/> Rape |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Homicidal Tendencies/Thoughts | <input type="checkbox"/> Schizoaffective Disorder |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Multiple Personalities | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Suicide Attempts |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Personality Disorder | <input type="checkbox"/> Suicide Thoughts |

Have you thought about, or attempted suicide in the past 3 months? Yes No If yes, how long ago? _____

Name of Primary Psychiatrist/Psychologist: _____

Address: _____

City: _____ State: _____

Phone: _____ Fax: _____

Dates of Treatment: ___/___/___ to ___/___/___

Reason for Treatment: _____

Mental Health Medications Currently Taking:

ONLY three prescription medications allowed

Medication Name	Dosage	Reason
1.		
2.		
3.		

FINANCIAL INFORMATION

Are you presently employed? Yes No If yes, what is your monthly income? _____

Do you receive any other income (SSI, disability, etc)? Yes No If yes, what is the monthly amount? _____

Do you currently receive government assistance? Yes No What type? _____

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LEGAL ISSUES

Are you currently on probation? Yes No State/County: _____

Are you currently on parole? Yes No State/County: _____

Do you currently have court cases pending? Yes No State/County: _____

Please list any pending charges and court dates: _____

Are you currently under investigation for anything? Yes No State/County: _____

Do you currently have any outstanding warrants? Yes No State/County: _____

Have you ever been convicted of a violent crime: Yes No If yes, please list each conviction and date:

Are you currently facing charges for a violent or sex related crime? Yes No If yes, please describe fully:

Are you required to register as a sexual or predatory offender? Yes No

Probation Officer's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Attorney's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

LEGAL HISTORY: (Check all that you have been involved with)

- | | | |
|-----------------------------------------------------|----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Murder | <input type="checkbox"/> Battery | <input type="checkbox"/> Prostitution |
| <input type="checkbox"/> Attempted Murder | <input type="checkbox"/> Drug Distribution | <input type="checkbox"/> Soliciting Prostitutes |
| <input type="checkbox"/> Manslaughter | <input type="checkbox"/> Drug Possession | <input type="checkbox"/> Incest |
| <input type="checkbox"/> Vehicular Homicide | <input type="checkbox"/> Theft | <input type="checkbox"/> Armed Robbery |
| <input type="checkbox"/> Rape/Attempted Murder | <input type="checkbox"/> Attempted Theft | <input type="checkbox"/> Attempted Robbery |
| <input type="checkbox"/> Sex with a minor | <input type="checkbox"/> Larceny | <input type="checkbox"/> Shoplifting |
| <input type="checkbox"/> Criminal Sexual Conduct | <input type="checkbox"/> Embezzlement | <input type="checkbox"/> Underage Drinking |
| <input type="checkbox"/> Child Molestation | <input type="checkbox"/> Arson | <input type="checkbox"/> Disorderly Conduct |
| <input type="checkbox"/> Child Abuse/Neglect | <input type="checkbox"/> Probation Violation | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Child Endangerment | <input type="checkbox"/> Parole Violation | <input type="checkbox"/> DWI |
| <input type="checkbox"/> Possession stolen property | <input type="checkbox"/> Aiding & Abetting | <input type="checkbox"/> DUI |
| <input type="checkbox"/> Concealed Weapon | <input type="checkbox"/> Fraud | <input type="checkbox"/> Vandalism |
| <input type="checkbox"/> Fleeing and Eluding | <input type="checkbox"/> Assault | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Leaving Scene of Accident | <input type="checkbox"/> Attempted Assault | <input type="checkbox"/> Stalking |
| <input type="checkbox"/> Other: _____ | | |

EMERGENCY CONTACT

Name: _____ **Relationship:** _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____



Application – Adult Life Care Program

RELEASE OF INFORMATION FORM

Applicant's Full Legal Name: _____ Birth Date: ____/____/____
First Middle Last

SSN: _____ - _____ - _____ Gender (circle one): Male Female

I Am Currently Incarcerated In: Location of Facility Where Incarcerated: Date of Upcoming Sentencing:

- County Jail City: _____ Date: ____/____/____
Federal Prison County: _____
State Prison State: _____

I understand that North Dakota Adult & Teen Challenge is a faith-based, Christian drug and alcohol program that is at least twelve months long, and that if I am accepted, I may be ordered by the court to complete the entire program. Clients in the program must participate in daily devotions, bible reading, church attendance, and other religious activities. I further understand that other faith-based and secular treatment programs are available to me. My signature indicates that I am voluntarily choosing to seek admittance to the program and that if accepted, I agree to participate in all program requirements.

I authorize North Dakota Adult & Teen Challenge to speak with these individuals and/or agencies regarding my application to the program. I also authorize the following agencies to release all information (including, but not limited to, past arrests and convictions, current and pending charges, plea agreements, mental health notes, etc.), requested by North Dakota Adult & Teen Challenge as soon as possible.

Attorney: Probation/Parole Officer/Case Worker: Medical (Doctor, psychiatrist, counselor, etc.)

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

- I also authorize North Dakota Adult & Teen Challenge to speak to the State's Attorney's Office in the county/counties where I have current charges pending, regarding my application to the program.

I understand that:

- 1. My health information is protected by Federal Confidentiality Rules (42 CFR Part 2; and/or HIPAA, 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances as outlined in Adult & Teen Challenge policies. I understand that I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
2. I can revoke this authorization in writing at any time by providing a written notification to Adult & Teen Challenge, except to the extent that action has been taken in reliance on it. This authorization will expire one year from the date I sign, unless I request an earlier revocation in writing.
3. For disclosures other than treatment, payment, and healthcare operations purposes, treatment may not be conditioned on my agreement to sign an authorization, unless I am receiving care solely to create protected health information for disclosure to a third party.
4. Communications resulting from this authorization will reveal that I have received, or attempted to receive services at North Dakota Adult & Teen Challenge.
5. Federal confidentiality regulations prohibit re-disclosure of information.

Applicant's Signature: _____ Date: ____/____/____

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PROGRAM FEE INFORMATION

North Dakota Adult & Teen Challenge average monthly cost per student is \$4,000. All residents will be asked to pay a suggested payment of \$500 per month. All students will have the opportunity for scholarship, whether the student is coming from DOC/jail/prison/streets/ etc.

An available funding through Adult & Teen Challenge is from the Department of Corrections and Rehabilitation. In order to be eligible, one of the following must apply:

- You must be on parole or supervised probation.
- Be court ordered to NDTC with supervised probation.
- Be approved for funding through the Department of Corrections and Rehabilitation.

How much can you afford of the approximate \$4,000.00 monthly program cost? \$ _____/month (12-months)

Do you have any of the following personal assets/income?

Vehicles	Yes <input type="checkbox"/> No <input type="checkbox"/>	Value _____	Checking Account	Yes <input type="checkbox"/> No <input type="checkbox"/>	Value _____
Property	Yes <input type="checkbox"/> No <input type="checkbox"/>	Value _____	Savings Account	Yes <input type="checkbox"/> No <input type="checkbox"/>	Value _____
401K	Yes <input type="checkbox"/> No <input type="checkbox"/>	Value _____	Child Support	Yes <input type="checkbox"/> No <input type="checkbox"/>	Value _____
SSI	Yes <input type="checkbox"/> No <input type="checkbox"/>	Value _____	Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>	Value _____

Please list all parties contacted and responsible for payment toward your recovery:

Mother's name _____ Address _____ Phone number _____ Monthly payment amount _____	Father's name _____ Address _____ Phone number _____ Monthly payment amount _____
Grandparent's name _____ Address _____ Phone number _____ Monthly payment amount _____	Grandparent's name _____ Address _____ Phone number _____ Monthly payment amount _____
Church name _____ Address _____ Phone number _____ Monthly payment amount _____	Name _____ Address _____ Phone number _____ Monthly payment amount _____

By my signature below, I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that should an investigation disclose untruthful or misleading answers, I may be discharged from the North Dakota Teen Challenge program. Furthermore, I understand that North Dakota Teen Challenge is a Christian, faith-based program.

Please initial indicating you have received, read, and agree to abide by the following documents:

_____ Program Policies and General Information	_____ Prohibited Medication
_____ Holiday Breaks	_____ Room Fee Information
Applicant's Signature: _____	Date _____ / _____ / _____

Application – Adult Life Care Program Voluntary Compliance with Faith Based Activities

North Dakota Adult & Teen Challenge is a faith-based program that is based upon Christian principles and practices. As such, North Dakota Adult & Teen Challenge is only an appropriate option for people desiring such a program and who are willing to commit to fully participate in it. If you do not want to participate in this program and follow the requirements listed below, please contact our admissions department and we will provide a referral list of other programs that may better meet your needs.

No provider of substance abuse services receiving federal funds from the U.S. Substance Abuse and Mental Health Services administration, including this organization, may discriminate against on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in religious practice. **If you object** to the spiritual education model utilized by North Dakota Adult & Teen Challenge and object to the religious character of this organization, federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization.

Please read each item carefully and initial your acceptance to each program requirement.

Upon admittance to North Dakota Adult & Teen Challenge, I agree to the following:

_____ I will participate in daily devotions, Bible reading, and prayer.

_____ I will participate in the Teen Challenge choir which performs Christian songs at weekly church services and special events.

_____ I will participate in lecture classes, individualized study courses, group discipleship, individual discipleship, and other program components that are based on Christian principles.

_____ I will attend church services when scheduled.

_____ If offered the opportunity to partake in communion or water baptism, my participation is voluntary.

_____ If I object to the religious nature of this program and its requirements, I will notify the Program Director and receive a referral to another program of my choosing.

My signature below indicates that I have carefully considered the Christian nature of the program and have made a free and independent choice to participate in the North Dakota Adult & Teen Challenge program. I also acknowledge that I have been given the opportunity to ask for a referral list of other faith-based and secular programs.

Applicants Signature

____/____/____
Date

(This page must be returned with the application.)



**Application – Adult Life Care Program
Authorization for Release of Confidential Information**

Student/Applicants Full Legal Name: _____

First Middle Last

Date of Birth ____/____/____

**I authorize the disclosure of records and information about me between:
(ex: parents, lawyer, pastor, etc.)**

North Dakota Adult & Teen Challenge 1406 2 nd St NW Mandan, ND 58554 Phone: 701-667-2131 Fax: 701-663-3494	and	Name: _____ Address: _____ City: _____ State/Zip: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____ Contact Person: _____
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“At the Request of the Individual,” I Authorize the Release of the Following Information:

Disclose to the above party _____ _____ _____ _____ _____	Obtain from the above party ____ Progress Review ____ Follow-up/Aftercare ____ Treatment/Discharge Summary ____ Educational ____ Employment ____ Psychological	Disclose to the above party _____ _____ _____ _____ _____	Obtain from the above party ____ Medical ____ Financial ____ Social/Collaboration ____ Legal Consultation ____ Phone Conversations ____ Other (specify):
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- I understand that:
1. My health information is protected by Federal Confidentiality Rules (42 CFR Part 2; and/or HIPAA, 45 CFR) and state privacy laws and disclosure is allowed only with my authorization except in limited circumstances as outlined in Adult & Teen Challenge policies. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
 2. I can revoke this authorization in writing at any time by providing a written notification to Adult & Teen Challenge, except to the extent that action has been taken in reliance on it. This authorization will expire one year from the date I sign, unless I request an earlier revocation in writing.
 3. For disclosures other than treatment, payment, and healthcare operations purposes. Treatment may not be conditioned on my agreement to sign an authorization, unless I am receiving care solely to create protected health information for disclosure to a third party.
 4. Communications resulting from this authorization will reveal that I have received services at North Dakota Adult & Teen Challenge.
 5. Federal confidentiality regulations prohibit re-disclosure of information.

Applicant/Student Signature

Date

Staff Signature

Date



Application – Adult Life Care Program

North Dakota Teen Challenge

Physical Examination Form * **BRING TO DOCTORS APPOINTMENT**

Patient's Name: _____ SSN ----- _____ D.O.B ----- _____

Sex: ___Male___Female Height: _____ Weight: _____

I authorize the release of the physical examination information contained on this form to North Dakota Teen Challenge for the purpose of determining my eligibility for admission. I also authorize the physician who provided the physical examination and/or his/her staff to discuss my medical condition with North Dakota Teen Challenge to whatever extent necessary to determine admission eligibility.

Patients Signature: _____ Date: ___/___/___

*If this form is not completed and returned to Adult & Teen Challenge, there will be a \$200 physical fee due at the time of admission.

THIS PORTION OF FORM TO BE COMPLETED BY YOUR **PHYSICIAN**

Send completed form to:

Admissions Department
North Dakota Adult & Teen Challenge
1406 2nd Street NW
Mandan, ND 58554
Fax: 701-663-3494

Medications: (List all medications applicant is currently taking)

- 1. _____ Reason: _____
2. _____ Reason: _____
3. _____ Reason: _____
4. _____ Reason: _____

Please Circle All That Require Further Medical Treatment:

- Ears Nose Throat Eyes Neck Back Neurological
Skin Rectal Pelvic Genitals Thyroid Abdomen
Heart Lungs Bones Joints Extremities Lymph Gland

Required Medical Information and Tests:

HEPATITIS B Y__N__ HEPATITIS C Y__N__ HIV Y__N__ TUBERCULOUS Y__N__
PREGNANCY Y__N__

Adult & Teen Challenge needs test results indicating if blood tests are 'reactive' or 'nonreactive'

Is there any medical condition that may endanger the health of our staff or students while in the program?

YES ___NO___ Condition: _____
Condition: _____
Condition: _____

Is there any reason why this applicant should not assist in the preparation of food or medical services?

YES ___NO___ Reason: _____

Physician's Printed Name: _____ Date of Exam: ___/___/___

Physician's Signature: _____ Phone: (____)____-_____