

Eastern Montana Community Mental Health Center

Recovery Home Application

PO Box 1530 • 2508 Wilson Street, Miles City, MT 59301

Ph: 406-234-1687 Fax: 406-234-1698

Name: _____ DOB: _____ SSN #: _____

Why are you seeking residential care at this time? _____

Please mark the number that best describes your readiness to change your life?

1-I don't want to change 2-Maybe 3-I will do whatever it takes

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

What substances are you using now: _____

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

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

Physical Health: Excellent Good Fair Poor Why: _____

Height: _____ Weight: _____

Current Medical Issues (diabetes, heart disease, liver disease, etc.): _____

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

Current diagnosis:

Substance Use Disorder _____ Mental Health: _____

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

If you did have treatment, where: _____ When: _____

Longest period of abstinence following any treatment episode: _____

Have you ever used drugs by injection?

Never Currently Using Last 1-12 Months More than a year ago

Have you been involved with AA or NA groups: Yes No Sponsor: _____

Have you been incarcerated in the last 30 days? Yes No If so, how many days? _____

Are you: On Probation Incarcerated Mandatory Monitoring
On Parole DUI Offender On Pre-Release

Name of probation officer: _____ Ph: _____

Name of attorney: _____ Ph: _____

Failure to disclose pertinent information to these questions may result in denial or immediate discharge from program!

Signature of Applicant: _____ Contact Ph. Number: _____

Referring Agency: _____
Address: _____
City, State, Zip: _____

Printed Name of Counselor: _____

Signature of Counselor: _____ Date: _____

What phone number should the residential program call to conduct a phone interview or set up a visit with the applicant and facility? _____

NOTE: You may also submit a copy of your own completed Biopsychosocial that includes the ASAM Assessment.

RELEASES OF INFORMATION MUST BE INCLUDED WITH APPLICATION

1. **Medical Issues:** If the patient has any medical issues we need Medical Records to complete this application.
 - Include releases for all medical providers and pharmacies the patient uses.
2. **Mental Health History:** If this patient has a history of Mental Health Counseling we will need Records from the provider.
 - Include releases for all mental health providers.
3. **Legal Involvement:** Include releases for probation officers, attorneys, judges, etc.

Application for Services: A phone interview will be conducted with the applicant and with other parties involved in supporting applicant in treatment and recovery before a final determination is made. Please attach a recent (within past 6 months) Chemical Dependency Evaluation.

Recovery Home 406-234-3517; Recovery Home Mgr. 406-951-0266