APPLICATION FOR ADMISSION TO A PROGRAMS AND FACILITIES BUREAU PROGRAM

NAME: _____

DOC #: _____ **DATE:** _____ **CURRENT LOCATION:** _____

Please complete all 9 pages of this application, including the Release of Information on pages 8 and 9. Once you have completed the application, return it to the person referring you. The application may be returned to you for corrections if it is determined that your answers are incomplete, missing, unclear, false, or misleading.

Do you need help with this application? ☐ Yes ☐ No

Please return this form to the person who gave it to you and ask for any help you need.

Choose the program(s) you are applying to and initial that you understand the specific requirements.

☐ Prerelease: start my application at _____
Prerelease name

1. I understand I am responsible for all medical and treatment costs unless I am an inmate worker. Initial _____
2. I understand I am responsible for all debts incurred to the prerelease center and any community treatment providers while I am a resident. Initial _____

☐ Substance Use Treatment _____
Program name

1. If I am applying for placement at Elkhorn or Nexus, I understand that Administrative Rules of Montana require offenders to attend and complete a prerelease aftercare program that is approximately 6 months long, following a 9-month methamphetamine treatment program. Initial _____

☐ Culinary Arts Program (CAP): CAP ➔ Inmate Worker ➔ Prerelease

Please initial that you understand the general requirements for PFB programs.

1. I understand my application will be screened by one or more facility screening committee(s) and may be denied for specific reasons. Initial _____
2. I agree to authorize the release of all medical, psychological, substance use, and criminal history information to the program(s) for screening of my application. Initial _____
3. I understand the demanding schedule and structure of PFB programs, and the costs involved, and I am willing to make a commitment to participate fully. I will abide by all terms of the placement. Initial _____
4. I understand I must be able to complete the program's objectives and that reasonable accommodations may be made as appropriate. Initial _____
5. I understand I may be placed at a higher level of custody if I am removed from the program for disciplinary reasons. Initial _____
6. I understand if I am not placed in the facility as a condition of my supervision (probation, parole, conditional release), I may be charged with Felony Escape if I leave the program without permission Initial _____
7. I understand I may be required to wear an electronic bracelet while in some programs. Initial _____
8. I understand I may be required to pay for room and board costs, and the amount depends on the program. Information on room and board costs will be provided to me during the program orientation. Initial _____
9. I understand Montana statutes prohibit the use of medical marijuana while in PFB program(s). Initial _____
10. I understand that additional rules, costs, and length of stay may be required at some programs for people who are convicted of sexual offenses or who are on the sex offender registry. Initial _____
11. I understand I am responsible for making regular restitution payments if restitution is owed. Initial _____
12. I understand some program(s) include vocational training, life skills, and/or adult basic skills (HiSET) which I will be required to participate in during the entire length of the program. Initial _____
13. I understand juvenile offenders may be located at some facilities and I will have no contact with the juveniles at any time. If I initiate contact with a juvenile at any time, I will be dismissed from the program. Initial _____

GENERAL INFORMATION

Legal Information

Please provide a description of your current felony charges (include charge, date/year, and state):

Are you in the process of having a Suspended, Deferred sentence(s) or Conditional Release revoked?
☐ Yes ☐ No

Education

☐ Did not finish high school ☐ completed high school/Hi-Set ☐ Some college ☐ College degree

Give details of any education beyond high school equivalency level (if any) including vocational training:

Name of Program or Training	Completed?	Approximate Dates Attended
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Employment

Do you have a job offer or prospects once you are released? ☐ Yes ☐ No If Yes, give details (include names, phone numbers, and if it's in the same community as the Prerelease you are applying to):

Describe your past employment (include length of the employment and reason for leaving):

Family & Community Relationships

I am: ☐ Single ☐ Living with significant other ☐ Married ☐ Separated ☐ Divorced # of Previous Marriages: ____

List parents, brothers, sisters, spouse or significant other, and children:

Name (First, Last)	Relationship	City/State	Incarcerated?	On Supervision?

Are you an enrolled tribal member? ☐ Yes ☐ No Name of Tribe: _____

Do you own your own home? ☐ Yes ☐ No If Yes, where? _____

If No, where do you plan to live after this program? _____

Gangs

Have you ever been involved in gang activities? ☐ Yes ☐ No

If Yes, which gang are you or were you affiliated with? _____

How you are involved now, were involved in the past, if you have been validated and when:

_____

_____

PRIOR PLACEMENTS AND TREATMENT

Prior Programs

Have you ever attended a DOC program before? ☐ Yes ☐ No

If Yes, please list the programs:

If you were previously revoked from a program, please describe the reason(s) why. Please be specific:

_____

_____

_____

_____

Drug and/or Alcohol Use Information

Rank your top three drugs of choice:

____Alcohol ____Marijuana ____Cocaine ____Pain Medication ____Amphetamines

____Heroin ____Inhalant/huffing ____Ecstasy ____PCP ____Benzodiazepine

____Barbiturate ____Methadone ____Meth ____Other (list): _____

____Synthetic Drugs (list): _____

____Prescription Drugs (list): _____

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

_____

How do you use? (check all that apply) ☐ Drink ☐ Snort ☐ Drop ☐ Smoke ☐ Inject

Which drugs and/or alcohol did you use last and when? _____

_____

_____

Why did you use them? _____

_____

Have you ever overdosed on drugs and/or alcohol? ☐ Yes ☐ No If Yes, when?

_____

_____

Has your drug/alcohol use affected your ability to function, or work, or interact with other people?

☐ Yes ☐ No

If Yes, please explain how: _____

_____

_____

Have you ever been assessed for a drug/alcohol problem? ☐ Yes ☐ No If Yes, list by who, where and when:

_____

_____

Have you ever been told by a professional that you should go to treatment for drugs/alcohol? ☐ Yes ☐ No

Self -Help

Do you have any past self-help experience (i.e., AA, NA, GA or SA)? ☐ Yes ☐ No

If Yes, did you have a sponsor? ☐ Yes ☐ No Did you work the steps? ☐ Yes ☐ No

What type of support system do you have (friends, family, treatment)? Include names and phone numbers:

Gangs

Do you have a problem with gambling or sometimes wonder if you have a problem with gambling?
☐ Yes ☐ No

If Yes, do you think your gambling problem is as severe as your drug/alcohol usage? ☐ Yes ☐ No

Have you ever been treated for a gambling addiction or talked to someone about your gambling? ☐ Yes ☐ No

Do you gamble while you are high or drinking, and don't consider it a problem? ☐ Yes ☐ No

Prior Chemical Dependency Treatment

Have you ever been to any inpatient (like MCDC) or community outpatient treatment (like IOP) not provided by a DOC facility? ☐ Yes ☐ No If Yes, list:

Community Provider	Completed?	Approximate Date Discharged
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

How long after your last treatment did you stay clean/sober?

How were you able to stay clean/sober?

What was your longest period of staying away from drugs/alcohol?

What do you see as the main cause(s) of why you cannot stay clean/sober?

HEALTH INFORMATION

Mental Health Information

Have you ever received a diagnosis or treatment from a mental health professional or physician and/or therapist or counselor? ☐ Yes ☐ No

Please describe any mental health issues that contributed to your crime or your ability to be stable in your life?

Do you have or think you may have an eating disorder? ☐ Yes ☐ No

Do you currently have thoughts of self-harm? ☐ Yes ☐ No

Have you ever caused harm to yourself? ☐ Yes ☐ No If Yes, when?

Are you currently experiencing or have you ever experienced trauma, abuse or grief in your life? ☐ Yes ☐ No
Are you currently participating or have you ever participated in treatment for trauma, abuse or grief, either in a group or individually? ☐ Yes ☐ No If Yes, when, where and therapist's name?

Medical Information

Do you have any medical issues that might impact your daily life or require immediate attention? ☐ Yes ☐ No
If yes, please describe the medical issues:

Did your mother use alcohol or drugs while she was pregnant with you? ☐ Yes ☐ No ☐ Don't know
List the name and location of the doctor or provider you last saw:

Are you waiting to be seen for a medical or dental reason? ☐ Yes ☐ No If Yes, describe the reason:

Have you ever received Medicaid, Medicare, or Disability benefits before your incarceration? ☐ Yes ☐ No
Do you use any special equipment to help with your everyday activities (cane, walker, hearing aid)?
☐ Yes ☐ No
If Yes, explain:

Are you allergic to or have you reacted to the following?

Local anesthetics	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No
Barbiturates, sedatives or sleeping pills	☐ Yes ☐ No	Other antibiotics	☐ Yes ☐ No

Food Allergy? ☐ Yes ☐ No Please list:
Other Allergy? ☐ Yes ☐ No Please list:

Do you now or have you ever followed any special diets? ☐ Yes ☐ No If Yes, what kind and why?

List the name of all medication you are currently taking and how often you take it:

Name of Medication	How Often?

If you arrive at the program and are taking certain prescribed medications, medical staff may complete a review of the medications to assess if alternatives may be substituted.

Writing a personal note to the Screening Committee can accomplish several things:

Tell us what you want to gain or accomplish while in the program:

Tell us the skills you want to learn/develop/use while you are in treatment:

Tell us what you want us to know about any negative parts of your application:

Tell us about your strengths that were not covered in the application questions:

Tell us what you want to accomplish in the next year (your personal goals):

Is there anything else you would like the screening committee to know about you?

DISCLAIMER

Read and initial each statement. If you don't understand a statement, ask for an explanation before you initial.

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

I understand that not telling about any medical information may affect my placement. Initial _____

I understand that if I choose to not answer the above questions honestly, the state of Montana and/or the Department of Corrections cannot be held responsible. Initial _____

By signing this application for admission, you are saying that you answered all the questions and provided the information honestly to the best of your ability, and that you understand the contents. Providing false or misleading information in this application may result in denial of acceptance or revocation from the program.

Signature

Date

State of Montana
DEPARTMENT OF CORRECTIONS
AUTHORIZATION FOR THE RELEASE OF INFORMATION

Offender's Full Name | Address or Location

DOC I.D. # | Soc. Sec. # | Date of Birth

Complete appropriate section and include all information and signatures.

☒ **SECTION I**: **Release of information contained in offender's case record**.

I, _____ , authorize the Department of Corrections to release
Offender Name
information from my case file to the following program(s) for the purpose of screening for placement:

	Male Programs	**Female Programs**
☐ Prerelease Centers	Butte, Helena, Great Falls, Billings, Missoula, Bozeman	Butte, Great Falls, Missoula, Passages
☐ Treatment Centers	CCP East & West, WATCh West, Pine Hills ATTP	ADT, WATCh East, Riverside
☐ Meth Treatment Center	Nexus	Elkhorn

Offender's Signature | Date

☒ **SECTION II**: **Release of health care, treatment, or other types of information and/or records**.

I, _____ , further authorize the exchange of information between the
Offender Name
Facility(s)/agency(s) indicated above and the Department for the purpose of: Screening for placement.

Authorization expires: 4 months from the signature date on page 2.

Check all that are specifically authorized:

☐ **Health Care Information**:
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation Reports
- ☐ Immunization Record
- ☐ Other: _____
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ Emergency Room Report
- ☐ Complete Health Record
- ☐ Operative Notes
- ☐ Pathology Report
- ☐ X-ray/Imaging Reports

☐ **Treatment Information**:
- ☐ CD Evaluation results/recommendations
- ☐ Discharge Summary
- ☐ Mental Health/Psychological Evaluation/Diagnosis
- ☐ Other: _____

☐ **OTHER**: _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or Hepatitis A, B or C. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

2. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on this authorization. The revocation is effective from the time it is communicated to the provider. Unless otherwise revoked, this authorization is valid for up to 30 months from the date of execution below. If no expiration is specified, this authorization will automatically expire six (6) months from the date of signing. This authorization does not permit the release of health care information relating to health care that the patient receives more than six (6) months from the date of execution below. (§50-16-527, MCA)

3. The Montana Department of Corrections, Montana State Prison, Montana Women's Prison, its health care providers, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information pursuant to the Uniform Health Care Information Act, §50-16-501 through §50-16-553, MCA, or the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d.

4. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Offender or Offender's Representative Date

Relationship to the offender _____

Signature of Witness Date

Signature of DOC Representative Requesting Information Date

Printed Name Printed Title

Address Fax # Email Address

cc: Offender File