RIMROCK
LEADING ADDICTION TREATMENT

Michel's House
&
Willow Way

APPLICATION FORM

Name:_____
Last First Maiden

Date of Birth:_____ Age:_____ Place of Birth:_____

Social Security Number:_____ Ethnicity:_____

Address:_____ Zip Code:_____

Telephone Number:_____ Email Address:_____

Who Referred You:_____ Phone #:_____Agency:_____

List a close family member or friend who knows how to contact you:

Name: _____ **Phone Number:** _____

Years of education completed:_____

Do you have a: High School Diploma ____ GED ____ College Degree_____

Employment: ___Full time ___Part time ___Unemployed

___Not in labor force ___Public assistance benefits depleted

Assistance (Current or Past): ____SSI/ SSDI ____TANF(Total Months:____) ____Medicaid ____SNAP

Any legal charges against you? ____Yes ____No If yes, are you on probation? ____Yes ____No

Name of PO (Please attach release):_____ PO phone number: _____

Please explain charges:_____

_____

Are you in a Drug Court? If so, where: _____

Number of prior chemical dependency treatments:_____ Where & when:_____

_____

Recent use in the past month: List drug/s, frequency and amounts:_____

_____

Last use:_____ How much?_____

Do you have any medical conditions that may interfere with treatment?_____

_____

List any medications you are prescribed:_____

Have you ever been treated for your mental health? __Yes ___No

If yes, where and when:_____

Diagnosis:_____ Doctor/Counselor:_____

Current marital status: ____Single ____Married ____Separated ____Divorced
____Widowed ____Living with someone ____Not in relationship

Current/Previous marriages/long-term partnerships:

Who/When: _____ Reason for break-up:_____

_____ _____

_____ _____

Pregnancies:____ # Miscarriages:____ # Abortions:____ # Adoptions:____

Are you currently pregnant? ___Yes ___No

Do you have DFS involvement? ___Yes ____No If yes – who is your caseworker? _____

How long have they been involved? _____

Caseworker's Phone Number (Please attach release): _____

Children:

Name	Age	Other Parent	Who has Custody

Will you bring all of your children? _____ (Up to 3)

Do any of your children have any special needs? ____Yes ____No If yes, please describe:

Child's Name	Special Needs

Are your children's' immunizations current? ____Yes ____No

If no, what is needed? _____

_____

_____

Why do you want to come to Michel's House/Willow Way? _____

_____

Are family members supportive of your treatment at this time? ____Yes ____No Please describe:

_____

I have read and understand this application and submit my request for admission into Michel's House or Willow Way

Signed:_____ Date:_____

"This project is funded (in part) under a contract with the Montana Department of Public Health and Human Services. The statements herein do not necessarily reflect the opinion of the Department".

RIMROCK
LEADING ADDICTION TREATMENT

Willow Way and Michel's House
Packing Guide

Clothing/Footwear
- Casual wear
- Nightwear
- Seasonal outerwear
- Recreation attire
- Swim suit
- Seasonal footwear
- Athletic shoes

Linens/bedding
- Sheets for a twin bed /crib/toddler bed
- Blankets
- Comforter for a twin bed/crib/toddler bed
- Pillows
- Towels
- Washcloths
- Alarm clock

Toiletries
- Soap/body wash
- Lotion
- Shampoo/conditioner
- Toothbrushes/Toothpaste
- Razor
- Makeup

Laundry supplies
- Detergent
- Softener/dryer sheets
- Laundry basket
- Hangers

Documentation
- Identification
- Proof of benefits TANF/SNAP/Medicaid
- Birth certificates
- Social security cards
- Shot records
- Parenting/custody paperwork

Infant/toddler care items
- Swing
- Baby bath
- Activity center
- Age appropriate toys
- Teething rings
- Car seat /booster
- Stroller
- Bottles/sippy cups

Food- it is helpful to bring a few days worth of necessities until benefits are approved.
- Formula
- Baby food
- Baby cereal
- Boxed/canned foods

Medications
- Bring all prescription medications you are currently taking
- Only ***UNOPENED*** medications Tylenol/orajel etc. can be brought into the house.

1231 N 29th St • Billings, MT 59101
P 406.248.3175 • T 800.227.3953 • F 406.248.3821

Rimrock
Authorization for Use or Disclosure of Protected Health Information

I, _____, date of birth: _____hereby authorize Rimrock, 1231 North 29th Street, Billings, MT 59101, and the following named agency, organization and/or persons, to communicate with and disclose to one another my protected health information as indicated below:

Name of Person or Organization: DPHHS - Child and Family Services Relationship:_____

Organization Contact Name: _____

Address:_____

City, State, Zip:_____

Phone:_____ Fax:_____ Email:_____

INFORMATION TO BE DISCLOSED

☑ Treatment Status	☐ Treatment Discharge Summary	☐ FMLA/Short-Term Disability
☐ Family Week Participation	☑ Progress Notes	☑ Drug & Alcohol Testing
☐ Court Referral	☐ Medical Assessment	☐ Cost of Treatment
☐ DUI Evaluation Report	☐ Psychiatric History & Treatment Summary	☐ Services Provided
☑ Progress/Compliance Reports	☐ Probation/Parole History & Reports	☐ Entire Treatment Record
☑ Assessment/Recommendations	☐ Employer Conference	☐ Education Records including IEP
☐ Visitation	☐ Return to Work Letter	☑ Admission/Completion Letter

☐ Minimum necessary medical, clinical and financial information to facilitate payment

☑ Other (specify): Copy of family care plan/permanency goal, mental health evaluation, supervised visit documentation, attendance

PURPOSE OF DISCLOSURE

☐ Facilitate Diagnosis/Treatment	☐ Facilitate Utilization Review	☑ Provide Follow-Up Information
☑ Coordinate Care	☑ Facilitate Admission	☐ Visitation
☐ Communicate with Family	☑ Provide Information for Legal Action	☐ Results of Drug & Alcohol Testing
☐ Comply with Probation/Parole Conditions	☑ Investigation of Child Abuse and Neglect Reports	

☐ Other (specify):_____

I understand that my drug and/or alcohol treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and my health information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Part 160 and 164. My information cannot be disclosed without my written authorization unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time by notifying Rimrock, except to the extent that action has been taken in reliance on it.

This authorization expires on: _____ (specify date, event, or condition upon which this authorization expires).

I understand that I might be denied services if I refuse to consent to disclosure for purposes of treatment, payment or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. I have read and understand this authorization and have received a copy of it.

Method of Disclosure: ☑phone ☑mail ☑email ☑fax ☑in person ☐other:_____

_____ _____

Client Signature Date Parent/Guardian Date

_____ _____

Witness Signature Date Personal Representative Date

Describe authority to sign on behalf of the client:

_____

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS
Section 2.32, Prohibition on Re-disclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). **The Federal rules prohibit you from making any further disclosure of this information** unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SUBMIT