

Residential Treatment Expansion Consortium

Applicant Information

Name: _____
Last First Middle Maiden

Address: _____
Street City State Zip Code County

Birth Date: _____ Age: _____ Sex: Female _____ Male _____

Phone Number: _____ Social Security Number: _____

Montana Resident? _____ Yes _____ No

Marital Status: _____ Married _____ Never Married _____ Divorced _____ Separated _____ Life Partner

Pregnant: _____ Yes _____ No Dependent Children: _____ Yes _____ No # in Household: _____

Homeless: _____ Yes _____ No Veteran: _____ Yes _____ No Religious Preference: _____

Race & Ethnic Background: _____ Tribal Affiliation: _____

Years of Education Completed: _____ GED? _____ Yes _____ No Degree/Certification: _____

Type of Referral: _____ Voluntary _____ Forced Voluntary _____ Court Ordered Judge: _____

Currently on Probation or Parole? _____ Yes _____ No Name of Officer? _____

Contact Information of Officer? _____

Has he/she had previous substance-related treatment admits? _____ Yes _____ No How many (lifetime)? _____

Substance Use Diagnoses (DSM): _____ Co-Occurring Diagnoses (if known): _____

Employer: _____ Current Position: _____

Address: _____ Phone Number: _____

Spouse's Name: _____ Social Security Number: _____

Employer (Spouse): _____ Phone Number (Spouse): _____

Primary Source of Income: _____ Wages _____ Public Assistance _____ Disability _____ Retirement _____ Other: _____

Annual Gross Income (combined): _____ Currently: _____ Employed Full-Time (35 hrs. or more per week)

Dependents (Including Referral): _____ _____ Employed Part-time
_____ Unemployed/Reasons: _____

Person to Notify in Case of Emergency: _____ Relationship to him/her: _____

Address: _____ Phone: _____

List any Current Medications: _____

Allergies: _____

Date Completed: _____ Completed By: _____