HOH CO-OCCURRING BEHAVIORAL HEALTH GROUP PROGRAM APPLICATION

Please fill out the following application and attach a copy of your:

- **Photo copy of the front and back of your insurance card**
- **Most recent Psychological Evaluation or Diagnostic Assessment**
- **Most recent Substance Use Assessment**
- **Most recent Medication Administration Record (MAR) or Medication list from your provider**
- **If you are currently in treatment: aftercare recommendations from counselor**
- **If you recently completed treatment: discharge summary**

Fax this application, along with the information requested above to, 507-345-1895. Attn: BHG admission team

Patient information

Legal Name: _____ Sex: _____ DOB: _____ Age: _____
Physical Address: _____ Race/Ethnicity:_____
City, State, Zip: _____ SS#: _____
Mailing Address: (if different from above) _____ Home or Cell Phone: _____
City, State, Zip: _____ Are you ok with receiving text messages? No
E-mail: _____ Student Status: Non-Student
Employer: _____ Work Status: Disability

Insurance information

Referred by: _____ **Referral Phone Number:**_____
PMI#: _____ **Direct Access Approved:** No
Insurance: _____ **County:** _____
Policy Holder Name: _____ **Insurance Phone**:_____
Policy Holder DOB: _____ Policy Holder Employer: _____
Policy Holder Address: _____
Policy ID Number: _____ Group Number: _____
Patient Relationship to Insured Life Partner
For HOH Staff only: InsurnaceVerified: No
If no insurance/eligible for Direct Access? No Have you applied for MN Sure? No

Request for services

Reason for requesting service: _____
_____
Drug of Choice/date of last use: _____
Do you have a Medical Marijuana card? No **Prescriber?** _____
Dosage?_____**Dispensary Used?**_____ **Have you ever used drugs intravenously (IV)?** No
Are you currently pregnant? N/A

Mental Health

Mental Health Diagnosis: _____
_____
Mental Health Case Manager:_____ Phone Number:_____
County:_____

Therapist:_____ Company/Clinic:_____
Address:_____ Phone Number:_____
City, State, Zip:_____

Psychiatrist:_____ Company/Clinic:_____
Address:_____ Phone Number:_____

City, State, Zip:_____
Current Medications:_____
_____
_____
Are you currently taking your medications as prescribed: No
How long have you been medication compliant?_____
Have you been diagnosed with a developmental disability? No **What?**_____
Related conditions: Have you been diagnosed as having a severe, chronic disability that meets ALL of the following conditions:

No **Attributable to cerebral palsy, epilepsy, autism, Prader-Willi syndrome or any other condition other than mental illness or an emotional disturbance**
No **Manifested before the age of 22**
No **Likely to continue indefinitely**
No **Results in substantial functional limitations in three or more of the following areas of major life activity**

- ☐**Self care**
- ☐**Understanding and use of language**
- ☐**Learning**
- ☐**Mobility**
- ☐**Self-direction**
- ☐**Capacity for independent living**

IF THE PATIENT ANSWERS "YES" TO HAVING A DEVELOPMENTAL DISABILITY OR RELATED CONDITION PLEASE COMPLETE THE PSR COLLATERAL CONTACT FORM PRIOR TO SCHEDULING.

Substance Use

Substance use diagnosis:_____

When and where was your most recent Substance use Assessment:_____
_____
When and where was your most recent Substance use treatment: _____
_____

LADC:_____ Company/Clinic:_____
Address:_____ Phone Number:_____
City, State, Zip:_____

List any previous treatment episodes, prior to your most recent, along with place, type of treatment (Residential, outpatient, etc) and dates:_____
_____
_____
_____

Commitment

Are you on a commitment? No
If yes:
Commitment worker:_____ Phone Number:_____
County:_____
Type of Commitment: MI/CD

Legal Involvement

Are you currently on Probation: No
If yes:
Probation Officer: _____ Phone Number:_____
County:_____

Reason for Probation/ Current Charges? _____
Any Upcoming Court dates? _____
Are you part of Drug Court? County?_____
Are you on Furlough/ISR? No **Any Restraining orders/OFP/DANCO?** No
Details:_____
Have you ever been convicted of a sexual offense? No
Are you required to register? What level?_____

Child Protection Involvement

Are you involved in a CHIPS case? No
If yes:
Child Protection worker:_____ Phone Number:_____
County:_____
Reason for CHIPS case? _____
_____

Supportive Person's Information

Write N/A if not applicable

Emergency Contact:
Name: _____ Phone Number: _____
Address: _____ City, State, Zip: _____

Spouse/Significant Other:
Name: _____ Phone Number: _____
Address: _____ City, State, Zip: _____

Any Other Social Workers not previously listed:
Name: _____ Phone Number: _____
Address: _____ City, State, Zip: _____
County: _____

Other Supportive People:
Name: _____ Phone Number: _____
Address: _____ City, State, Zip: _____
Relationship: _____

If needed, attach list with any other workers, family members or friends who are supportive.

To be completed by patient: What do you hope to gain/accomplish by being part of this group?
_____
_____
_____

To be completed by referral: Please provide rationale as to why the patient is appropriate for this program and what your goals are for the patient enrolling.

_____
_____
_____
_____

Patient Signature: _____ **Date:** _____

Form Completed By (If not patient) : _____ **Relationship to Patient:** _____

Signature:_____ **Date:** _____

Notes: _____
_____

Submit