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: ________________________________
Physical Address: ________________________________
City, State, Zip: ________________________________
Mailing Address: (if different from above) ________________
City, State, Zip: ________________________________
E-mail: ________________________________
Employer: ________________________________

Sex: ________ DOB: ___________ Age: ______
Race/Ethnicity: ________________________________
SS#: ________________________________
Home or Cell Phone: ________________________
Are you ok with receiving text messages? Yes No
Student Status: *Full time* *Part time* *Non-student*
Work Status: *Full time* *Part time* *Seasonal* *Retired* *Unemployed* *Disability*

Insurance information

Referred by: ________________________________
PMI#: ________________________________
Insurance: ________________________________
Policy Holder Name: ________________________________
Policy Holder DOB: ________________________________

Referral Phone Number: ______________________
Direct Access Approved: *yes* *no*
County: ________________________________
Insurance Phone: ________________________________
Policy Holder Employer: ______________________

Policy Holder Address: ____
Policy ID Number: ____________________________ Group Number: ____________________________
Patient Relationship to Insured: *self* *spouse* *child* *step-child* *significant other* *life partner*
For HOH Staff only: Insurance Verified: Yes No
If no insurance/eligible for Direct Access? Yes No Have you applied for MN Sure? Yes No

Request for services

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

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: Yes No
How long have you been medication compliant?____
Have you been diagnosed with a developmental disability? Yes No What?________________
Related conditions: Have you been diagnosed as having a severe, chronic disability that meets ALL of the following conditions:

Yes	**No**	**Attributable to cerebral palsy, epilepsy, autism, Prader-Willi syndrome or any other condition other than mental illness or an emotional disturbance**
Yes	**No**	**Manifested before the age of 22**
Yes	**No**	**Likely to continue indefinitely**
Yes	**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: ________________________
____

Are you currently prescribed any medication, including MAT (Buprenorphine, Methadone, Naltrexone) or have you been prescribed in the past? ________________________________
Have you experienced any withdrawal symptoms? ________________________________

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? Yes No
If yes:
Commitment worker:____________________ Phone Number:________________
County:____________________

Type of Commitment: Mark one- MI CD MI/CD

Legal Involvement

Are you currently on Probation: Mark one- Yes 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? Yes No Any Restraining orders/OFP/DANCO? Yes No

Details:______________________________________

Have you ever been convicted of a sexual offense? Yes No

Are you required to register? What level?______________________________________

Child Protection Involvement

Are you involved in a CHIPS case? Yes 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: ____
____