RECOVERY CENTERS OF MONTANA
APPLICATION FOR SERVICES & PRE-ADMISSION SCREENING
This application is used to determine eligibility, funding source, and safe placement prior to admission.

A comprehensive biopsychosocial assessment meeting ARM 37.106.1413 standards is required prior to residential admission consideration.

IDENTIFYING INFORMATION
Full Legal Name: _____
Date of Birth: _____ Age: _____
Physical Address: _____
City/State/Zip: _____
Mailing Address (if different): _____
County of Residence: _____
Cell Phone: _____
Alternate Phone: _____
Emergency Contact Name: _____
Relationship: _____ Phone: _____
Are you a Veteran?☐ Yes ☐ No
Are you currently homeless? ☐ Yes ☐ No

INSURANCE & ELIGIBILITY INFORMATION
(Used solely for insurance verification and billing purposes)
Primary Coverage:
☐ Medicaid
☐ Private Insurance
☐ None
☐ Other: _____
Insurance ID Number: _____
Name of Insured (if different): _____
Relationship to Insured: _____
Social Security Number (Required for Medicaid eligibility verification):
_____ – _____ – _____
This information is required only for Medicaid eligibility verification and is not used for clinical decision-making.
Employer (if applicable): _____
This information is accessed only by authorized admissions and billing personnel for eligibility verification and payment determination.

SAFETY & MEDICAL SCREENING
(Used to determine appropriate level of care and safe admission)
Primary substance(s) used in the past 30 days:

Date of last use: _____
Are you currently experiencing withdrawal symptoms?
☐ Yes ☐ No
If yes, describe briefly: _____
Have you **ever** experienced any of the following related to substance use:
Seizures? ☐ Yes ☐ No
Delirium Tremens (DTs)? ☐ Yes ☐ No
Severe withdrawal requiring hospitalization? ☐ Yes ☐ No
Are you currently taking prescribed medications? ☐ Yes ☐ No
If yes, list: _____
Are you currently receiving Medication Assisted Treatment (MAT)?
☐ Yes ☐ No
If yes, medication: _____
Do you have any serious medical conditions that may affect participation?
☐ Yes ☐ No
If yes, describe: _____
Allergies: _____
Are you pregnant or possibly pregnant? ☐ Yes ☐ No ☐ Unsure
Do you require mobility, hearing, vision, or other accommodations?
☐ Yes ☐ No
If yes, describe: _____

PRIORITY & SPECIAL POPULATION SCREENING
Recovery Centers of Montana is required under state and federal regulations to identify certain priority and special populations for admission prioritization and reporting purposes.
The information below is used to support coordination of care, regulatory reporting, and determination of appropriate level of care within the scope of services offered.
Individuals who meet federally defined priority criteria may qualify for expedited placement in accordance with applicable regulations.

Pregnancy & Substance Use
Are you currently pregnant?
☐ Yes ☐ No ☐ Unsure

If pregnant, are you currently using alcohol or drugs?
☐ Yes ☐ No
If pregnant, have you injected drugs at any time during this pregnancy?
☐ Yes ☐ No

Injection Drug Use
Have you injected drugs in the past 12 months?
☐ Yes ☐ No
Have you injected drugs in the past 30 days?
☐ Yes ☐ No

Women With Dependent Children (Reporting category)
Are you a woman with dependent children under the age of 18?
☐ Yes ☐ No ☐ Not Applicable
If yes, number of dependent children: _____

Infectious Disease Status (For coordination of care and reporting purposes)
Have you ever been diagnosed with active Tuberculosis (TB)?
☐ Yes ☐ No
Have you ever been diagnosed with HIV?
☐ Yes ☐ No ☐ Prefer not to answer
Have you ever been diagnosed with Viral Hepatitis (Hepatitis B or C)?
☐ Yes ☐ No ☐ Prefer not to answer
Have you ever been diagnosed with a sexually transmitted infection within the past 12 months?
☐ Yes ☐ No ☐ Prefer not to answer

LEGAL STATUS IMPACTING ADMISSION
Are you currently on probation or parole? ☐ Yes ☐ No
If yes, supervising county/name: _____
Do you have court dates within the next 30 days? ☐ Yes ☐ No
Are you required to register as a violent or sexual offender?
☐ Yes ☐ No
Are you involved in an active DFS case? ☐ Yes ☐ No

MENTAL HEALTH SAFETY SCREEN
Have you been hospitalized for mental health concerns within the past 12 months?
☐ Yes ☐ No
Do you have a history of suicidal behavior or attempts? ☐ Yes ☐ No
Are you currently experiencing thoughts of harming yourself or others? ☐ Yes ☐ No

If yes to any above, explain briefly:

SECTION 7: OPTIONAL DEMOGRAPHIC INFORMATION

(Voluntary – Used for State and Federal Reporting Only)

Providing this information is voluntary and will not affect eligibility for services.

Race (Select all that apply):

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

☐ Other: _____

☐ Prefer not to answer

Ethnicity:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Prefer not to answer

Are you an enrolled member of a federally recognized tribe?

☐Yes ☐ No ☐ Prefer not to answer

If yes, tribe (optional): _____

IMPORTANT ADMISSION NOTICE

On the day of admission, you must arrive sober and not intoxicated.

If you arrive under the influence, admission may be delayed and you may be referred for medical evaluation.

CONFIDENTIALITY NOTICE

Recovery Centers of Montana is a federally assisted substance use disorder treatment program and complies with:

• 42 CFR Part 2

• HIPAA (45 CFR Parts 160 & 164)

• Applicable Montana Administrative Rules

Information provided in this application is used to determine eligibility, safety for admission, level of care, and payment verification.

Substance use disorder records are protected by federal law
(42 CFR Part 2) and may not be disclosed without written consent except as permitted by law.
Redisclosure of this information is prohibited unless expressly permitted under 42 CFR Part 2.

Please indicate:
☐ Application completed independently by applicant
☐ Application completed with assistance

Applicant Signature: _____
Date: _____

If assistance was provided:
Name of staff assisting: _____
Title: _____
Signature of staff assisting: _____

☐ Interpreter used
Language: _____
Interpreter Name: _____

Policy Reference: 3.1 – Admission Eligibility, Screening & Acceptance Criteria
Form Name: ASAM 3.5 Residential Application & Pre-Admission Screening
Version: 2.0
Effective Date: 02/24/2026
Supersedes: "New CCIH–RCM Application" (last modified 7/19/2024 and created 6/30/2024)