



## Application for Adolescent Residential Substance Use Disorder Treatment Levels 3.1, 3.2, and 3.5

**Filling out the Application:**

Please complete each section of this application. Indicate “NA” or “Unknown” throughout as applicable. Complete applications will be processed quicker. Incomplete applications will require follow up phone calls from Eckert Staff. If you have any questions or need assistance regarding completing this application, please contact Eckert Staff at 701-572-6181.

**Submitting the Application:**

If you need help filling out this application, please contact Eckert Staff. This application and supporting documents may be submitted by email to [admissions@eckertyouth.com](mailto:admissions@eckertyouth.com)

- You are encouraged to follow-up via phone or email to confirm your information has been received and verify if any additional documents will be needed.
- You will receive a response acknowledging receipt of your application within 24 hours.

**Additional Documentation:**

Items required for Admission:

- Completed Eligibility Application
- Necessary Releases of Information
- Updated ASAM Criteria reflecting need for ASAM Level 3.1, 3.2, or 3.5 Level of Care (Eckert can assist in completing this via face to face or via tele-med appointment)
- Previous assessments are requested

If a referring agency is submitting this application, please include the necessary signed Release of Information with CFR 42 Part 2 requirements to allow for communication regarding this application. If no ROI is included, you will not be contacted. If available, please attach written documentation of applicant’s integrated mental health and substance abuse intake, diagnosis, and recommendations from a qualified mental health professional from within the last year.

NOTE: For youth ages 14 and above, a release of information must be signed by the youth only for release of drug and alcohol treatment records. Parents/guardians are not able to access the youth’s records without signed permission by the youth. Please attach release of information if applicable.

**Consent:**

By completing this application, I understand that its contents may be shared with Admissions Staff at Eckert Youth Homes. The information received in this application will be handled in accordance with State and Federal Regulatory Confidentiality laws including HIPAA and CFR 42 Part 2.

Name of the person filling out this application:		
Agency	Contact Phone Number	Contact Email Address
Relationship to the Youth (or indicate if the youth is filling out for self)		
Signature	Date	

*I hereby certify that the above statements are true and correct to the best of my knowledge.*

**Eligibility:**

- Ages 14-18, males and females
- North Dakota resident
- Preference given to pregnant youth and youth with IV drug use
- Meets diagnostic criteria for a substance use disorder as described in the DSM
- Meets specifications in each of the ASAM dimensions required for the recommended level of care.

**START OF THE APPLICATION**

**Section A: Priority Screen**

**1. Pregnancy**

Is the youth currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain current prenatal care and length of pregnancy:

**2. IV Drug Use**

Does the youth have a history of IV drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, please explain the type and frequency of IV drug use, and the last known date of IV drug use:

**Section B: Demographic and Home Information**

**3. Demographics**

Applicant's name		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender
Date of Birth	Age	Social Security Number

**4. Home Residence**

<b>Applicant's Other Placement Address and Information (If currently in a different setting)</b>			
Agency or foster home name		Telephone Number	Fax
Address		City	State      Zip
Agency of Foster home Contact Person and Information:			

**Section C: Referral Information**

**5. Referral Narrative**

Description of reason for referral:
What services has the youth received in the past year?

**Section D: Medical History**

**6. Medical History**

Are there any known current or past Medical Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, please explain:
Does the youth have any disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, please explain:
Does the youth have any allergies? Include food, insects, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, please explain:

**7. Current Medications**

DRUG NAME	DOSAGE	PURPOSE	LENGTH OF USE	PRECAUTIONS	PRESCRIBER

**Section D: Billing Information**

**8. Coverage Type**

What type of health coverage does the youth have? <input type="checkbox"/> Medicaid <input type="checkbox"/> BCBS <input type="checkbox"/> Sanford <input type="checkbox"/> Other Insurance <input type="checkbox"/> No coverage
Other Comments:

**9. Coverage Information**

**Primary Insurance**

Third Party Insurance Company Name	Telephone Number		
Address	City	State	ZIP Code
Name of Policy Holder	Telephone Number		
Address	City	State	ZIP Code
Policy Number:			

**Secondary Insurance**

Third Party Insurance Company Name	Telephone Number		
Address	City	State	ZIP Code
Name of Policy Holder	Telephone Number		
Address	City	State	ZIP Code
Policy Number			

**END OF APPLICATION**