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

- 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.

Eligibility:

- Ages 13-17, males and females
- 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

REFERRAL INFORMATION	
Name of the person filling out this application	
Relationship to the Youth or Self-Referral	Agency
Contact Phone Number	Contact Email Address
Signature	Date
Is the youth aware of this application?	Contact information for scheduling of assessment:

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

Section A: Priority Screen

1. Pregnancy
Is the youth currently pregnant? ☐ Yes ☐ No
If yes, please explain current prenatal care and length of pregnancy:

2a. IV Drug Use
Does the youth have a history of IV drug use? ☐ Yes ☐ No ☐ Unknown
If yes, please explain the type and frequency of IV drug use, and the last known date of IV drug use:

2b. Drug Use
What drugs is the youth using?
How often does the youth use?
How much does the youth use?
Has the youth ever overdosed? If so, how many times?

Section B: Demographic and Home Information

3. Demographics		
Applicant's Name		Gender ☐ Male ☐ Female ☐Transgender
Date of Birth	Age	Social Security Number
Race ☐Asian ☐Black/African American ☐Hispanic or Latino ☐Native Hawaiian/ Pacific Islander ☐White ☐American Indian/ Alaska Native (specify Tribal affiliation): ☐Other (specify):		

Mother's Name:	Mother's phone number:
Mother's Address	Mother's email:
Father's Name:	Father's phone number:
Father's Address:	Father's email:
Other Guardian/ Family Name and Relationship:	Phone Number:
Address:	Email:

4. Home Residence			
Current Residence Address or Other Placement Address and Information (If currently in a different setting)			
Address	City	State	Zip Code
Agency or Foster Home Name:			
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? ☐ Yes ☐ No ☐ Unknown If yes, please explain:
Does the youth have any disabilities? ☐ Yes ☐ No ☐ Unknown If yes, please explain:
Does the youth have any allergies? Include food, insects, etc. ☐ Yes ☐ No ☐ Unknown If yes, please explain:

7. Current Medications					
DRUG NAME	DOSAGE	PURPOSE	LENGTH OF USE	PRECAUTIONS	PRESCRIBER

Section E: Billing Information

8. Coverage Type
What type of health coverage does the youth have? ☐ Medicaid ☐ BCBS ☐ Sanford ☐ Other Insurance ☐ No coverage
Other Comments:

9. Coverage Information			
Primary Insurance			
Insurance Company Name:	Insurance Telephone Number (Back of Card):		
Insurance Address:	City	State	ZIP Code
Name of Policy Holder	Policy Holder Telephone Number		
Policy Holder Address	City	State	ZIP Code
Member Identification Number:	Group Number:		

Secondary Insurance			
Insurance Company Name:	Insurance Telephone Number (Back of Card):		
Insurance Address:	City	State	ZIP Code
Name of Policy Holder	Policy Holder Telephone Number		
Policy Holder Address	City	State	ZIP Code
Member Identification Number:	Group Number:		

END OF APPLICATION