



Thank you for your interest in **Adult and Teen Challenge New Mexico (ATCNM), Adult Substance Abuse Recovery Program**. Our program is designed to help those who are struggling with life-controlling chemical dependency issues and desire a faith-based approach to recovery.

To complete the admissions process you must complete the following steps:

- Complete the attached application and mail or email it to the appropriate **Intake Coordinator** listed below
- Specify What Length Of Treatment You Need: 90 Days/ 3Months____180 Days/6 Months____12 Months____
- Phone Interview with Intake Coordinator
- Fill out Krossroads Behavioral Health referral form at this link: (Any questions contact Intake Coordinator)
<https://www.cognitofirms.com/KrossroadsBehavioralHealth/KrossroadsBehavioralHealthReferralForm>
- Physical & Required lab work: Hepatitis Panel, Urinalysis, HIV, STD's, T.B Skin Test (If T.B is positive a Chest X-Ray is required)
- Negative Covid 19 Test (Done at a physician's office or contact our local Duke City Urgent Care)
- Based on your current mental health you may be required to have a Psychiatric Evaluation done from a Behavioral Health Specialist
- Financial screening and agreement has to be reviewed and approved by ATCNM Financial Dept.

Men's Intake Coordinator

Juan Muro
505-270-1810
juan@atcnm.org

Adult & Teen Challenge of New Mexico

P.O. Box 20610
Albuquerque, NM 87154-0610
teenchallengeofnewmexico@mytcnm.net

Women's Intake Coordinator

Brittanie Aguirre
505-259-9504
intake@atcnm.org

Upon receipt of your application, an intake coordinator will contact you and begin processing your application. In processing applications a number of things are taken into consideration including: mental health, medical condition, past and present legal status, funding eligibility, and level of care required. The length of the application process can vary from one day to two weeks depending on the need for notes and funding confirmation.

ATCNM is a voluntary program. Please carefully review all of the information in this packet to determine if our program is right for you. If not, please contact our admissions office to request a referral list of other programs.

It's important that your contact information is current. If you are submitting an application and have relocated please be sure to notify our admissions department of your current contact information. If you have a friend or family member assisting you in the application process, please complete the **Release of Confidential Information** form.

Important Applicant Information:

- Applicants who enroll in the recovery program will also be assessed for Behavioral Health treatment services.
- Applicants requiring detoxification must do so prior to entry. You may not detox on our campus.
- Applicants are strongly encouraged to enter the program with at least a 30 day supply of all currently prescribed medications (with the exclusion of prohibited medication) or an active prescription and open insurance coverage.
- A physical examination is required prior to admission
 - Tests for HIV, STD's, Tuberculosis and Hepatitis are required as part of the physical exam.
- NM applicants may be approved for admission prior to having a physical examination, provided they agree to have a physical immediately upon entering our program.
 - Tests for HIV, STD's, Tuberculosis and Hepatitis are required as part of the physical exam.

Please return only the Application, Voluntary Compliance with Faith Based Activities document, and Release of Information form to the admissions office by either mail or email.

Please **Print** Clearly:

First Name: _____

Middle Name: _____

Last Name: _____

DOB: ____/____/____

Age: _____

Sex:

Male

Female

Current Address:

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____ Email: _____

Height: _____ **Weight:** _____

Legal Resident Of:

State: _____

County: _____

Do You Have Any Relatives Or Friends Currently In Our Program? Yes Who? _____ No

Have You Previously Been In Our Program? Yes No **If yes, How Many Years Ago?** _____

Marital Status: Single Married Divorced Engaged Separated

Citizenship: United States Other (If Other) **Do you have a Green Card or verifying document?** Yes No

Race: Native American Asian Black Hispanic Multi Racial White Other _____

Do You Read And Write English At A 5th Grade Level or Above: Yes No

Do You Have A High School Diploma? Yes No **If No, Do You Have A GED?** Yes No

I Mainly Need Help With: (Check All That Apply) Alcohol Addiction Drug Addiction Other: _____

Last date of use? _____ **Substance used:** _____

Do You Use Tobacco? Yes No (Tobacco use is not permitted at any time while enrolled in the program)

Have You Ever Been Treated For Chemical Addiction? Yes No **How many times?** _____

Prior Treatment Facility: (list the most recent treatment program you have been in)

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Treatment: ____/____/____ to ____/____/____

Reason for Treatment: _____

Did you complete the program? Yes No

For Admission Use only:

In your own words, tell us why you want to come to Adult and Teen Challenge New Mexico and the main issues you believe you need to deal with while in the program: (Please **print** clearly)

PHYSICAL HEALTH

Please be advised that ATCNM is NOT a Hospital Based Setting

If it is determined your needs exceed our care ability; you will be referred to a more suitable placement.

Medical History: (Check all that apply to your current and past conditions)

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Gastric Bypass Surgery | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Head Trauma/TBI | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Attack/Stroke/Condition | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Crohns Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> STI/STD |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |

Do you have any current medical concerns? If yes, please be specific: _____

Are you currently being treated by a doctor? Yes No

Primary Physician Clinic: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Treatment: ____/____/____ to ____/____/____

Reason for Treatment: _____

For Admission Use Only:

Are you pregnant? Yes No Due Date: ____/____/____

Are you allergic to any medications? Yes No If Yes, what medications? _____

Are you being treated with prescribed narcotics/benzodiazepine/opiate/prohibited medications? Yes No

If Yes, what medications? _____

(Applicants on these types of medications or ingesting any of the above will need to complete the taper regimen prior to admission or switch to approved medications under doctor supervision.)

Non-Psychiatric Medications:

Medication Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		

Special Needs:

Do you have any type of disability? Yes No Type: _____

- Do you have any chronic conditions? Yes No Type: _____
- Do you have any medical restrictions? Yes No Type: _____
- Do you have any other type of special needs? Yes No Type: _____
- Do you have any food or environmental allergies? Yes No Type: _____
- Do you require a special diet? Yes No Type: _____

ATCNM is NOT a hospital based setting; therefore, any special dietary accommodations or substitute meal requests are unable to be accommodated. Please speak to your admissions representative to discuss your needs.

MENTAL HEALTH

Mental Health History: (Check all that apply to your current and past conditions)

- | | | |
|---|--|---|
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Dissociative Identity Disorder | <input type="checkbox"/> Personality Disorder _____ |
| <input type="checkbox"/> Anti-Social Personality Disorder | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Anxiety Disorder/Panic Attacks | <input type="checkbox"/> Hearing Voices | <input type="checkbox"/> PTSD/Trauma _____ |
| <input type="checkbox"/> Autism/Aspergers | <input type="checkbox"/> Homicidal Tendencies/Thoughts | <input type="checkbox"/> Rape |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Schizoaffective Disorder |
| <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> Narcissistic Personality Disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Sexual Abuse |
| | | <input type="checkbox"/> Suicide Thoughts/Attempts |

Have you thought about, or attempted suicide in the past 3 months? Yes No If yes, how long ago: _____

Primary Psychiatrist/Psychologist Clinic: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Treatment: ____ / ____ / ____ to ____ / ____ / ____

Reason for Treatment: _____

For Admission Use Only:

Mental Health Medications Currently Taking:

Medication Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

FINANCIAL INFORMATION (to be used to help determine eligibility for our financial sliding scale or scholarship)

Are you presently employed? Yes No If yes: What is your monthly income? _____

Do you receive any other income (VA, Pension, Settlement, etc)? Yes No If yes: Monthly amount? _____

Is your family willing to financially support you during your stay at ATCNM i.e Intake Fee: Yes \$ _____ No;

Monthly Tuition: Yes \$ _____ No ; Monthly Personal Hygiene: Yes \$25 - \$50 No

Do you have assets titled in your name (house, vehicles, land, trailer)? Yes No If yes: Is their an an outstanding loan? Yes No If yes: Balance Due? _____ Co-Signer?: _____
If yes: Balance Due? _____ Co-Signer?: _____

Do you currently receive any government assistance Please circle (SSI, Disability, MA/GA, Other: _____)?
 Yes No If yes: Monthly amount? _____

Do you currently receive EBT benefits? Yes No If Yes: Which state? _____ Amount? _____

Do you have New Mexico Medicaid? Yes No If yes, please provide the following information:

Insurance Provider: _____ Member ID Number: _____
Address: _____ Group Number: _____
City: _____ State: _____ Zip: _____ Provide Phone: () _____ - _____

Do you have a county case worker: Yes No If yes, please provide the following information:

Case Worker's Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

For Admission Use Only:

LEGAL ISSUES

Are you currently on probation? Yes No State/County: _____
Are you currently on parole? Yes No State/County: _____
Do you currently have any court cases pending? Yes No State/County: _____
Are you currently under investigation for anything? Yes No State/County: _____
Do you currently have any outstanding warrants? Yes No State/County: _____

Have you ever been convicted of a violent crime? Yes No If yes, please list each conviction and date:

Have you ever been convicted of a sex related crime: Yes No If yes, please list each conviction and date:

Are you currently facing charges for a violent or sex related crime? Yes No If yes, please describe fully:

Are you required to register as a sexual or predatory offender? Yes No
If yes, what Level? 1 2 3 Are you required to "Notify the Community" or police department? (please circle)

Probation Officer's Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

For Admission Use Only:

Attorney's Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

For Admission Use Only:

EMERGENCY CONTACTS

Primary Contact Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____ Email: _____

Secondary Contact Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____ Email: _____

By my signature below, I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that should an investigation disclose untruthful or misleading answers, I may be discharged from the Adult & Teen Challenge New Mexico program. Furthermore, I understand that Adult & Teen Challenge New Mexico is a Christian, faith-based program and that I have made a free and independent choice to enroll. I understand that other program options are available to me and I have had an opportunity to request a referral.

Please initial indicating that you have received, read and agree to abide by the following documents:

- _____ Program Policies and General Information
- _____ Prohibited Medication
- _____ Break Policy
- _____ Intake Fee & Tuition Information

Applicant's Signature Date

Voluntary Compliance with Faith Based Activities

Adult & Teen Challenge New Mexico's Program is a faith-based program that is based upon Christian principles and practices. As such, ATCNM is only an appropriate option for people desiring such a program and who are willing to commit to fully participate in it. If you do not want to participate in this program and follow the requirements listed below, please contact our admissions department and we will provide a referral list of other programs that may better meet your needs.

Please read each item carefully and initial your acceptance to each program requirement.

Upon admittance to Adult & Teen Challenge New Mexico, I agree to the following:

- I will participate in daily devotions, Bible reading, and prayer.
- I will participate in the Teen Challenge choir which performs Christian songs at weekly church services and special events.
- I will participate in lecture classes, individualized study courses, group counseling, individual counseling, and other program components that are based on Christian principles.
- I will attend church services when scheduled.
- If offered, the opportunity to partake in communion or water baptism participation is voluntary.
- If I object to the religious nature of this program and its requirements, I will notify my Program Manager and receive a referral to another program of my choosing.

My signature below indicates that I have carefully considered the Christian nature of the program and have made a free and independent choice to participate in the Adult & Teen Challenge New Mexico program. I also acknowledge that I have been given the opportunity to ask for a referral list of other faith-based and secular programs.

Applicant's Signature

____/____/____
Date

(THIS PAGE MUST BE RETURNED WITH THE APPLICATION)

THIS PAGE MUST BE RETURNED WITH THE APPLICATION IF YOU WANT US TO TALK TO SOMEONE ELSE ABOUT YOUR ENROLLMENT
Adult & Teen Challenge New Mexico Authorization to Release & Disclose Client Information

Instruction: If any section is incomplete this form may be invalid and the request may not be processed.

Client Information	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____
Health Care Provider/ Individual: "Disclosing Party" (<i>Who</i> has the information you want released) Be specific.	Physician/Mental Health Provider or Prior Treatment Center within the past year: <input type="checkbox"/> Other: Facility/Name: _____ Attention: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____
Receiving Party: (<i>Where</i> do you want the information sent?) Be specific.	<input type="checkbox"/> Adult and Teen Challenge Women's Center, Attention: _____ <input type="checkbox"/> Adult and Teen Challenge Men's Center, Attention: _____ <div style="text-align: center;"> Adult & Teen Challenge of New Mexico P.O. Box 20610 Albuquerque, NM 87154-0610 teenchallengeofnewmexico@mytcnm.net </div>
Information to be Released: (<i>What</i> do you want sent or released?)	<input type="checkbox"/> Any and All Records (including those specified below) <input type="checkbox"/> I authorize the Disclosing Party and Receiving Party to exchange information necessary for my ongoing treatment, coordination of care and/or for payment purposes. (Check if Applicable) <u>Only Records Checked Below:</u> <input type="checkbox"/> Discharge Summary/Notes <input type="checkbox"/> Personal* <input type="checkbox"/> Progress/Clinic Notes <input type="checkbox"/> Legal* <input type="checkbox"/> Medical History/Physical Exam <input type="checkbox"/> Financial Records <input type="checkbox"/> Mental Health Records <input type="checkbox"/> Rule 25 <input type="checkbox"/> Chemical Dependency/Substance Abuse Records <input type="checkbox"/> Other (<i>Specify</i>): _____ <u>Optional Limits:</u> Disclose Records Only Related to the Following: <input type="checkbox"/> Date(s) of Service: _____ <input type="checkbox"/> Injury or Illness: _____
Release Instructions: (<i>How</i> and <i>When</i> do you want the information?)	Date the information is needed (please allow 7-10 days for processing): _____ Release Method format requested: (check one) <input type="checkbox"/> Paper <input type="checkbox"/> Email <input type="checkbox"/> Verbal <input type="checkbox"/> Other (<i>specify</i>): _____
Purpose of Release: (<i>Why</i> is the information needed?)	<input type="checkbox"/> Treatment/Continued Care <input type="checkbox"/> Personal* <input type="checkbox"/> Progress Notes <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Financial/Insurance <input type="checkbox"/> Legal* <input type="checkbox"/> Other (<i>Specify</i>): _____
<p>I agree that: (i) this Authorization is effective for one year from the date I sign below (or such later expiration date as provided here: _____ unless earlier revoked; (ii) my information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse; (iii) I can revoke this Authorization, in writing, at any time, but my revocation will not apply to any information to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; (iv) I can send a request for revocation or questions about disclosures to the Medical Record Department at the ATCNM address listed above; (v) once my information is disclosed it may be re-disclosed and not be protected by federal privacy rules, and the facility cannot prevent the re-disclosure; (vi) I can refuse to sign this Authorization and still be assured treatment; (vii) I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. §164.524; (viii) a photocopy/fax of this Authorization will be treated in the same manner as the original; and (ix) ATCNM records may include records that it received from other organizations. If these records have been used by ATCNM and filed in the record ATCNM maintains about me, these records may be released with my ATCNM records. By signing below I acknowledge that I have read and understand this form, and authorize release of the information as described above.</p>	

Client Signature

Date

Parent/Legal Guardian Signature (when applicable)

Date

Authority: Parent Legal Guardian Personal Rep (*specify*): _____ Print Name: _____

The information disclosed pursuant to this Authorization includes records protected by Federal confidentiality rules (42 C.F.R. part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.