# APPLICATION - Adolescent Life Care Program

Dear Parent(s),

We are delighted that you are interested in this application. The Minnesota Teen Challenge Life Care program is a Christian residential rehabilitative program that is part of a network of over 250 Teen Challenge centers worldwide. We are accredited by Teen Challenge International, USA.

Our adolescent Life Care program is designed to help "at risk" teenagers who are struggling with drugs, alcohol, emotional instability, and delinquent behaviors. Our goal is to help you overcome these struggles by establishing a sober and substance free lifestyle, enhancing your social skills, building supportive relationships, and developing a personal relationship with Jesus Christ. Studies have shown that faith based programs like Minnesota Teen Challenge have the highest rates of recovery in the nation.

As you and your child complete the application, it is important to answer all the questions on the application truthfully. This is the only way we can accurately determine how best to serve you. Some things in your child's past may be difficult or painful to share, but doing so is essential to his/her healing and **complete recovery.**

Please return the completed application to our main office using one of the following methods:

**Mail:**
Minnesota Teen Challenge Inc.
1619 Portland Ave S.
Minneapolis, MN 55404
Attention: Admissions Department

**Fax:**
(612) 333-7678
Attention: Admissions Department

Upon receipt of your application, one of our admission representatives will immediately contact you and begin processing the application. Our admission office is open Monday through Friday. When applications are received on weekends or holidays, our admissions staff will contact you and begin processing the application on the next business day.

If you have any questions regarding our program or the status of your application, please contact the admissions department at (612) 373-3366

A large number of our graduates have experienced **complete recovery** from drug and alcohol addiction, emotional instability, and delinquent behavior. They have told us that the key to their success was developing a personal relationship with God and putting into practice all that they learned in our program. We are here to help your son/daughter do the same. We believe that God has a great purpose for his/her life. We are thankful for every opportunity to help him/her discover that purpose and live it to the very fullest.

Sincerely,

Cheryl Borkenhagen

Cheryl Borkenhagen
Admissions Director

# APPLICATION - Adolescent Life Care Program

## General Information:

**First Name:**____________________ **SSN:** _______-_____-_______ **Sex:**
**Middle Name:**__________________ ☐ Male
**Last Name:**____________________ **DOB:** ____/____/____ **Age:** ________ ☐ Female

**Current Address:** **Height:** _____ **Weight:** _____

Street: ____________________________________
City: ____________________________________
State: ____________ Zip: ______________
Phone: __________________ Email: __________________

**Legal Resident Of:**
State: ____________________
County: __________________

**Prior Military Service:** ☐ Yes ☐ No Branch: ______ # Years: ____ Discharge Date: ____/____/____

**Have You Ever Been Adopted?** ☐ Yes ☐ No

**Have You Ever Been In Foster Care?** ☐ Yes ☐ No

**How Many Children Do You Have?** ________

**Do You Have Any Relatives Or Friends Currently In Our Program?** ☐ Yes ☐ No

**Have You Previously Been In Our Program?** ☐ Yes ☐ No **How Many Years Ago?** _________

**Education:**
- ☐ 4 + Years of college
- ☐ 1-3 Years of College
- ☐ 1 + Years of Trade School
- ☐ H.S. Diploma
- ☐ GED
- ☐ Dropped out of H.S.
- ☐ Still Attending School
- ☐ Current Grade ______

**Housing Situation:**
- ☐ Live with Spouse
- ☐ Live with Parents
- ☐ Live with Relatives
- ☐ Live with Friends
- ☐ Incarcerated
- ☐ Homeless
- ☐ Live Alone
- ☐ Other

**Marital Status:**
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Engaged
- ☐ Separated
- ☐ Widowed
- ☐ Other

**Citizenship:**
- ☐ United States
- ☐ Other

**English Skills:**
- ☐ I Read English
- ☐ I Write English
- ☐ I Speak English

**Race:**
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ American Indian
- ☐ Asian
- ☐ Middle Eastern
- ☐ Other

**Religion:**
- ☐ Protestant
- ☐ Catholic
- ☐ Other

**Denominational Preference:** (If Religion is Protestant)
- ☐ Assemblies of God
- ☐ Baptist
- ☐ Church of God
- ☐ Evangelical Covenant
- ☐ Evangelical Free
- ☐ Lutheran
- ☐ Inter-Denominational
- ☐ Methodist
- ☐ Missionary Alliance
- ☐ Non-Denominational
- ☐ Presbyterian
- ☐ Other

**I Need Help With The Following:** (Check All That Apply)
- ☐ Alcohol Addiction
- ☐ Drug Addiction
- ☐ Tobacco Addiction
- ☐ Gambling
- ☐ Pornography
- ☐ Same Sex Attraction
- ☐ Anxiety
- ☐ Anger
- ☐ Depression
- ☐ Grief
- ☐ Fear
- ☐ Guilt
- ☐ Aggression
- ☐ Abandonment
- ☐ Eating Disorders
- ☐ Forgiveness
- ☐ Emotional Stress
- ☐ Self Esteem
- ☐ Self Mutilation
- ☐ Terminal Illness
- ☐ Suicidal Thoughts
- ☐ Death of A Loved One
- ☐ Family Relationships
- ☐ Parenting

Applicant's Signature: ________________________________ Date: ____/____/____

# APPLICATION - Adolescent Life Care Program

## Medical Information:

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

| | | | |
|---|---|---|---|
| ☐ ADD | ☐ Diabetes | ☐ High Blood Pressure | ☐ Physical Abuse |
| ☐ ADHD | ☐ Drug Abuse | ☐ HIV Virus | ☐ Rape |
| ☐ Alcohol Abuse | ☐ Eating Disorder | ☐ Homicidal Tendencies | ☐ Respiratory Problems |
| ☐ Anorexia | ☐ Flashbacks | ☐ Homicidal Thoughts | ☐ Schizophrenia |
| ☐ Asthma | ☐ Hallucinations | ☐ Insomnia | ☐ Seizures |
| ☐ Back Problems | ☐ Head Trauma | ☐ Mental Illness | ☐ Sexual Abuse |
| ☐ Bipolar | ☐ Hearing Voices | ☐ Multiple Personalities | ☐ Suicide Attempts |
| ☐ Bulimia | ☐ Heart Condition | ☐ Nervous Condition | ☐ Suicide Thoughts |
| ☐ Depression | ☐ Hepatitis | ☐ Paranoia | ☐ Tuberculosis |
| | | | ☐ Venereal Disease |

**Substance Abuse:** (Check all that you have used)

| | | | |
|---|---|---|---|
| ☐ Alcohol | ☐ Crack | ☐ Huffing/Sniffing | ☐ Mushrooms |
| ☐ Amphetamines (uppers) | ☐ Ecstasy | ☐ LSD | ☐ PCP |
| ☐ Barbiturates (downers) | ☐ GHB/MDMA | ☐ Marijuana | ☐ Over the Counter Drugs |
| ☐ Cocaine | ☐ Heroin | ☐ Meth | ☐ Prescription Drugs |
| | | | ☐ Other: __________________ |

What was the date you last used **any** of the above substances? _______________

Drug of Choice: ___________________ Method of Use: ☐ Inject ☐ Snort ☐ Smoke ☐ Oral ☐ Other

Do you use tobacco? ☐ Yes ☐ No If yes, check all that apply: ☐ Cigarettes/Cigars ☐ Chew/Snuff

**Treatment History:**

| | | | |
|---|---|---|---|
| Have you ever been in a residential treatment facility? | ☐ Yes | ☐ No | How Many? ________ |
| Have you ever been treated for chemical dependency? | ☐ Yes | ☐ No | |
| Have you ever been treated for mental disorders? | ☐ Yes | ☐ No | |
| Have you ever been treated for eating disorders? | ☐ Yes | ☐ No | |
| Have you ever been treated for sleep disorders? | ☐ Yes | ☐ No | |
| Have you ever been treated by a psychiatrist? | ☐ Yes | ☐ No | Last Visit: ____/____/____ |
| Have you ever been treated by a psychologist? | ☐ Yes | ☐ No | Last Visit: ____/____/____ |

**Medications:**

List all current medications:
1. _________________________
2. _________________________
3. _________________________
4. _________________________
5. _________________________

List any additional medications taken in the past 5 years:
1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________

**Special Needs:**

| | | | |
|---|---|---|---|
| Do you have any type of disability? | ☐ Yes | ☐ No | Type: ____________________________ |
| Do you require a special diet? | ☐ Yes | ☐ No | Type: ____________________________ |
| Do you have any medical restrictions? | ☐ Yes | ☐ No | Type: ____________________________ |
| Do you have any allergies? | ☐ Yes | ☐ No | Type: ____________________________ |
| Do you have any chronic conditions? | ☐ Yes | ☐ No | Type: ____________________________ |
| Do you have any other type of special needs? | ☐ Yes | ☐ No | Type: ____________________________ |

Applicant's Signature: __________________________________ Date: ____/____/____

# APPLICATION - Adolescent Life Care Program

## Medical Information:

**Insurance Provider:** ID Number: ____________________
Name: ____________________________________________________________
City: ___________________________ State: _______ Zip: _________
Phone: __________________________ Fax: ___________________________

**Prior Treatment Facilities:** (list the 2 most recent treatment programs you have been in)

Name of Facility: ___________________________________
City: ___________________________ State: _______
Dates of Treatment: ____/____/____ to ____/____/____
Reason for Treatment: ________________________________
Did you complete the program? ☐ Yes ☐ No

For Admission Use only:

Name of Facility: ___________________________________
City: ___________________________ State: _______
Dates of Treatment: ____/____/____ to ____/____/____
Reason for Treatment: ________________________________
Did you complete the program? ☐ Yes ☐ No

For Admission Use only:

**Doctor Information:**

Name of Doctor: ____________________________________
City: ___________________________ State: _______
Phone: ___________________ Fax: _______________
Dates of Treatment: ____/____/____ to ____/____/____
Reason for Treatment: ________________________________

For Admission Use Only:

Name of Psychiatrist: ________________________________
City: ___________________________ State: _______
Phone: ___________________ Fax: _______________
Dates of Treatment: ____/____/____ to ____/____/____
Reason for Treatment: ________________________________

For Admission Use Only:

Name of Psychologist: _______________________________
City: ___________________________ State: _______
Phone: ___________________ Fax: _______________
Dates of Treatment: ____/____/____ to ____/____/____
Reason for Treatment: ________________________________

For Admission Use Only:

Applicant's Signature: ______________________________________ Date: ____/____/____

# APPLICATION - Adolescent Life Care Program

## Legal Information:

**Current Legal Status:**

| Question | Yes | No | State/County |
|---|---|---|---|
| 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: ______________ |
| Are you currently involved in any type of lawsuit? | ☐ Yes | ☐ No | State/County: ______________ |
| Do you currently have any unpaid fines? | ☐ Yes | ☐ No | State/County: ______________ |
| Are you currently required to pay any restitution? | ☐ Yes | ☐ No | State/County: ______________ |
| Are you currently ordered to do any community service? | ☐ Yes | ☐ No | State/County: ______________ |
| Are you currently required to pay child support? | ☐ Yes | ☐ No | State/County: ______________ |
| Are you currently behind in child support payments? | ☐ Yes | ☐ No | State/County: ______________ |

**Past Legal Status:**

| Question | Yes | No | State/County |
|---|---|---|---|
| Have you ever been arrested? | ☐ Yes | ☐ No | State/County: ______________ |
| Have you ever been in a juvenile detention center? | ☐ Yes | ☐ No | State/County: ______________ |
| Have you ever been sentenced to jail? | ☐ Yes | ☐ No | State/County: ______________ |
| Have you ever been in prison? | ☐ Yes | ☐ No | State/County: ______________ |
| Have you ever been on probation? | ☐ Yes | ☐ No | State/County: ______________ |

**Criminal Activity:** (Check all that you have been involved with)

- ☐ Aiding & Abetting
- ☐ Armed Robbery
- ☐ Arson
- ☐ Assault
- ☐ Attempted Assault
- ☐ Attempted Burglary
- ☐ Attempted Rape
- ☐ Attempted Robbery
- ☐ Attempted Murder
- ☐ Attempted Theft
- ☐ Battery
- ☐ Burglary
- ☐ Car Jacking
- ☐ Child Abuse/Neglect
- ☐ Child Molestation
- ☐ Child Endangerment
- ☐ Child Pornography
- ☐ Concealed Weapon
- ☐ Criminal Sexual Conduct
- ☐ Disorderly Conduct
- ☐ Domestic Violence
- ☐ Driving Without A License
- ☐ Drug Manufacturing
- ☐ Drug Possession
- ☐ DUI
- ☐ DWI
- ☐ Embezzlement
- ☐ Escape from Custody
- ☐ Felony Conviction
- ☐ Fleeing or Eluding Police
- ☐ Fraud
- ☐ Harassment
- ☐ Incest
- ☐ Kidnapping
- ☐ Larceny
- ☐ Leaving Scene of Accident
- ☐ Manslaughter
- ☐ Murder
- ☐ No Contact Order
- ☐ Order of Protection
- ☐ Parole Violation
- ☐ Possession of Stolen Property
- ☐ Probation Violation
- ☐ Prostitution
- ☐ Rape
- ☐ Restraining Order
- ☐ Robbery
- ☐ Sex With A Minor
- ☐ Shoplifting
- ☐ Solicitation of Prostitution
- ☐ Stalking
- ☐ Terroristic Threats
- ☐ Theft
- ☐ Truancy
- ☐ Underage Drinking
- ☐ Use of Firearm in a crime
- ☐ Vandalism
- ☐ Vehicular Homicide
- ☐ Violation of No Contact Order
- ☐ Violation of Order of Protection
- ☐ Violation of Restraining Order
- ☐ Other: ______________________
- ☐ Other: ______________________

Applicant's Signature: ____________________________________ Date: ____/____/____

# APPLICATION - Adolescent Life Care Program

## Legal Information: (Continued)

**Probation Information:**
Probation Officer's Name: ______________________________________________
Street: _________________________________________________________
City: ____________________ State: _______ Zip Code: __________
Phone: _________________________ Fax: _________________________

For Admission Use Only:

**Attorney Information:**
Attorney's Name: ______________________________________________
Street: _________________________________________________________
City: ____________________ State: _______ Zip Code: __________
Phone: _________________________ Fax: _________________________

For Admission Use Only:

**Case Worker:**
Case Worker's Name: ______________________________________________
Street: _________________________________________________________
City: ____________________ State: _______ Zip Code: __________
Phone: _________________________ Fax: _________________________

For Admission Use Only:

**For Admission Use Only:** If the applicant is court ordered to our program, provide the following information:

**Program:**
___ Life Care
___ Extended Care
___ Outpatient

**Court Information:**
Name of Court: ______________________________________________
Street: _________________________________________________________
City: ____________________ State: ____ Zip Code: __________
County: __________________
Judge's Name: ______________________________________________

___ Copy of Court Order Received
___ Copy of Probation Requirements Received
___ Copy of Rule 25 Assessment Received

**Referral Information:** (If entering Ext. Care Program)
Referral's Name: _________________________________________
Agency Name: __________________________________________
Street: _________________________________________________________
City: _______________________________________ State: ____ Zip Code: __________
County: _______________________________
Phone: _______________________________ Fax: ___________________________

Applicant's Signature: _____________________________________ Date: ____/____/____

# APPLICATION - Adolescent Life Care Program

## Family Information:

**Primary Emergency Contact:**
Name: ______________________________
Relationship: ________________________
Street: ______________________________
City: ________________________________
State: _______ Zip Code: _________
Home Phone: _________________________
Work Phone: _________________________
Cell Phone: __________________________
Email: ______________________________

**Secondary Emergency Contact:**
Name: ______________________________
Relationship: ________________________
Street: ______________________________
City: ________________________________
State: _______ Zip Code: _________
Home Phone: __________________
Work Phone: _________________________
Cell Phone: __________________________
Email: ______________________________

**Mother's Information:**
Name: ______________________________
Street: ______________________________
City: ________________________________
State: _______ Zip Code: _________
Phone: ______________________________

**Father's Information:**
Name: ______________________________
Street: ______________________________
City: ________________________________
State: _______ Zip Code: _________
Phone: ______________________________

**Spouse's Information:**
Name: ______________________________
Street: ______________________________
City: ________________________________
State: _______ Zip Code: _________
Phone: ______________________________

**Legal Guardian's Information:**
Name: ______________________________
Street: ______________________________
City: ________________________________
State: _______ Zip Code: _________
Phone: ______________________________

**Children's Information:**
Name: _________________________ Sex: _____ Age: _______ DOB: ____/____/____
Name: _________________________ Sex: _____ Age: _______ DOB: ____/____/____
Name: _________________________ Sex: _____ Age: _______ DOB: ____/____/____
Name: _________________________ Sex: _____ Age: _______ DOB: ____/____/____
Name: _________________________ Sex: _____ Age: _______ DOB: ____/____/____
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Name: _________________________ Sex: _____ Age: _______ DOB: ____/____/____
Name: _________________________ Sex: _____ Age: _______ DOB: ____/____/____
Name: _________________________ Sex: _____ Age: _______ DOB: ____/____/____

**Siblings:**
Name: ____________________________________ Sex: _____ Phone: __________________
Name: ____________________________________ Sex: _____ Phone: __________________
Name: ____________________________________ Sex: _____ Phone: __________________
Name: ____________________________________ Sex: _____ Phone: __________________

Applicant's Signature: ____________________________________ Date: ____/____/____

# APPLICATION - Adolescent Life Care Program

## Spiritual Information:

**Occult Activity:** (Please check all that you have been involved with)

| | | | |
|---|---|---|---|
| ☐ Animal Sacrifices | ☐ Fortune Tellers | ☐ Psychics | ☐ Witchcraft |
| ☐ Astrology | ☐ Ouija Boards | ☐ Satan Worship | ☐ Voodoo |
| ☐ Black Magic | ☐ Palm Reading | ☐ Séances | ☐ Other: _______________ |

**Church Activity:**

| | | | | |
|---|---|---|---|---|
| How often do you attend church? | ☐ Often | ☐ Occasionally | ☐ Seldom | ☐ Never |
| How often do you read the Bible? | ☐ Often | ☐ Occasionally | ☐ Seldom | ☐ Never |
| How often do you pray? | ☐ Often | ☐ Occasionally | ☐ Seldom | ☐ Never |

Have you ever accepted Jesus Christ as your Lord and Savior? ☐ Yes ☐ No Date: ____/____/____
Have you ever been baptized in water? ☐ Yes ☐ No Date: ____/____/____
Have you ever experienced being filled with the Holy Spirit? ☐ Yes ☐ No Date: ____/____/____

If you attend church, please provide as much of the following information as possible:
Name of the Pastor: ______________________________________
Name of the Church: ______________________________________
Street Address: ___________________________________________
City: _________________________________ State: _______
Phone: __________________

Have you talked with your Pastor about entering the Minnesota Teen Challenge program? ☐ Yes ☐ No
Does your Pastor support you coming into our program? ☐ Yes ☐ No

Do you want to live a happier, healthier life? ☐ Yes ☐ No
Do you want to be free of the burdens of your past? ☐ Yes ☐ No
Do you want a better relationship with your family? ☐ Yes ☐ No
Would you like a brand new start in life? ☐ Yes ☐ No
Do you believe that God wants to help you straighten out your life? ☐ Yes ☐ No
Do you want God to help you straighten out your life? ☐ Yes ☐ No

**Acknowledgements:** (Please read each item and check YES if you are willing to come into the program based on that statement and NO if you are not)

1. Minnesota Teen Challenge is a Faith Based Christian program. ☐ Yes ☐ No
2. Residents must participate in daily devotions and Bible reading ☐ Yes ☐ No
3. Residents must participate in choir, chapel services, and prayer. ☐ Yes ☐ No
4. Residents must attend all scheduled choir events including church each Sunday. ☐ Yes ☐ No
5. Residents will be offered communion periodically but are not required to partake. ☐ Yes ☐ No
6. Residents desiring to be baptized in water will be given the opportunity if eligible. ☐ Yes ☐ No

Applicant's Signature: ____________________________________ Date: ____/____/____

MnTeen Challenge

## APPLICATION - Adolescent Life Care Program

### Reason for Application:

In your own words, tell us why you want to come to Minnesota Teen Challenge: (Please **print** clearly)

What are the main issues that you believe you need to deal with while in our program? (Please **print** clearly)

Applicant's Signature: ______________________________ Date: ____/____/____

# APPLICATION - Adolescent Life Care Program

**General Information:**

A. The Minnesota Teen Challenge Life Care program is a Christian residential rehabilitation program. It consists of at least 12 months of instruction using a spiritual education model plus a few short breaks.

B. Possession and/or use of drugs, alcohol and tobacco are prohibited while enrolled in our program.

C. Students may be given drug and/or alcohol tests at any time without prior notice or approval. Students who test positive for drugs and/or alcohol use while in our program will face disciplinary action and possible expulsion from our program.

D. Students must be able to read, write, speak, and comprehend the English language.

E. Students may not buy or sell personal property to or from other students.

F. Minnesota Teen Challenge will not be responsible for any personal property that becomes lost, stolen, or damaged while on our premises.

G. Students, their rooms, and their personal property may be searched at any time without prior notice or approval.

H. Students are required to obtain a summary of each medical and dental visit prior to leaving the place of treatment and must provide the information to their charge staff immediately upon return to Minnesota Teen Challenge.

I. Students are **required** to take prescription medication exactly the way their doctor prescribes it. Students who wish to discontinue taking medications must provide written authorization from their doctor before they will be allowed to discontinue use.

J. Applicants must commit to complete the entire program in order to be approved for admission. Students who do not keep up with their daily assignments and those who fail to demonstrate satisfactory growth may require additional time.

K. Students should bring enough prescription medication to last at least 30 days, and bring it in their original containers bearing appropriate labels.

Applicant's Signature: ____________________________________ Date: ____/____/____

Parent/Guardian's Signature: ______________________________ Date: ____/____/____

# APPLICATION - Adolescent Life Care Program

**Admission Information:**

A. I understand that Minnesota Teen Challenge does not discriminate on the basis of race, color, creed, religion, sex, national and ethnic origin, marital status, public assistance status, sexual orientation, family status, or disability in the administration of it's educational, admission, or program policies or procedures.

B. No applicant will be admitted without picture identification, social security card, <u>and</u> a completed application.

C. Applicants requiring detoxification must do so prior to entry.

D. A physical examination is required. Some applicants may be approved for admission prior to having a physical examination provided they agree to obtain a physical immediately upon entering our program. Tests for the HIV Virus, Venereal Disease, Tuberculosis, and Hepatitis are required as part of the physical examination. In addition females will receive a pregnancy test.

E. In the case of applicants who were previously enrolled in our program, the Admissions Director will review the application and submit his/her recommendation and the completed application to the Program Director for review. For these applicants, re-admittance into the program <u>requires the approval of the Program Director.</u>

F. I release Minnesota Teen Challenge from all financial or legal responsibilities in case of accident, injury, illness or other misfortune.

Applicant's Signature: ____________________________________ Date: ____/____/____

Parent/Guardian's Signature: ______________________________ Date: ____/____/____

# APPLICATION - Adolescent Life Care Program

**Orientation Information:**

A. The first two weeks are considered the orientation period. During this period, it is crucial that the student become familiar with the program unhindered by outside distractions. During the orientation period, mail, phone, and visitation communication is limited to immediate family members, such as parents/guardians, children, and spouse. In addition to the immediate family, students may receive visits from their personal physician, religious advisor, county case manager, attorney, and parole/probation officer at any reasonable hour.

B. After the orientation period, correspondence will be limited to immediate family members and others who have been approved by the Program Dean. A student correspondence form will be completed by the student during admission. Once approved by the Program Dean, the student will be able to correspond with those authorized. Mail from those who have not been approved will be returned to the sender. We encourage family members to talk with us about the correspondence list during the admission process and anytime they have a question or concern. Students who are caught manipulating the system can expect to temporarily lose phone, mail, or visitor privileges.

C Although many staff members will be substantially contributing to the student's personal and spiritual growth, the Program Dean is the **most significant** in the life of the student. He/she spends considerable time reviewing the records of each student, determining the need for counseling, prayer, encouragement, motivation and discipline. The Program Dean is responsible to the Program Director for the overall growth and development of each student. Family members who have any questions concerning their loved one's progress should contact the Dean. The Dean has several staff members working directly under him/her to ensure each student gets what is required to bring about a change in attitude, behavior, and lifestyle. The Dean directly supervises his/her staff and ensures quality leadership is provided.

D. Each student will have access to our "Student Manual" which covers the policies of the program. We reserve the right to make changes in policy whenever necessary. When a change in policy occurs, students and staff will be immediately notified and the "Student Manual" will be updated to reflect the change.

Applicant's Signature: ____________________________________ Date: ____/____/____

Parent/Guardian's Signature: ______________________________ Date: ____/____/____

**APPLICATION - Adolescent Life Care Program**

# SCHOOL RECORD INFORMATION

This form allows Minnesota Teen Challenge Academy (MTCA) to obtain school records. The Parent or Legal Guardian must fill out the information below concerning the last educational institution of the student to be enrolled and sign the form at the bottom.

To: ____________________________________________
Name of last school attended

Address of School: ____________________________________________
Street Address

____________________ ______ __________
City State Zip

School Phone Number: (_______) __________ - ________________

School Fax Number: (_______) __________ - ________________

RE: AUTHORIZATION OF RELEASE OF SCHOOL RECORDS

To Whom It May Concern:

My child, ____________________________________, SS# ____________________, has withdrawn from your school. Please release all transcripts, the **most recent** Special Education evaluation report, IEP, 504 plan and Minnesota Basic Skills test results pertaining to my child immediately. However, **do not send** the contents of my child's complete cumulative folder.

**Facsimile copies** of these records **must** be sent to the Principal's Office, Minnesota Teen Challenge Academy **within two business days of receiving this request**, as required by Minnesota Statutes 2001 Supplement, Section 125A.515, Subdivision 5. MTCA's fax number is (612) 333-4111.

I appreciate your assistance. If you have any questions, please contact Minnesota Teen Challenge Academy at 1619 Portland Avenue South, Minneapolis, MN 55404. Phone: (612) 373-3366.

________________________________________
(Please type or print) Parent or legal guardian name

________________________________________ ____________________
Parent or legal guardian signature Date

# ADOLESCENT PROGRAM FEES

**Application Fee:**
A $100 non-refundable application fee is required for all adolescent students at the time of admission. This fee is assessed to help cover the costs associated with processing the application and admitting the student into the program.

**Damage Deposit:**
A $100 damage deposit is required for all adolescent students at the time of admission. Money from this deposit will be used to repair or replace damaged property caused by the student. Students are required to replace money used from the damage deposit so that a $100 deposit is maintained at all times. Upon discharge, the damage deposit minus any damage expenses will be refunded.

**Return Transportation Deposit:**
A $200 return transportation deposit is required for all adolescent applicants who reside outside of Minnesota. This deposit must be paid when the student is admitted into the program. Money from this deposit will be used to provide return transportation home if required. Upon discharge, the transportation deposit minus any transportation expenses will be refunded.

**Room and Board Fee:**
Room and board fees are pro-rated so that students are charged only for the days they are enrolled in the program. Students are considered enrolled in the program even though they may be temporarily away from our facility while on pass or holiday break. Students will be charged for the day they are admitted into the program but will not be charged for the day they are discharged.

Students are required to pay the current month's pro-rated room and board fee at the time of admission. If the admission date occurs after the 15th of the month, the next month's room and board fee is also due. Each month thereafter, the room and board fee is due on the 1st day of each month. Upon discharge, any room and board fees collected will be refunded minus the amount for days spent in the program. A 30-day written notice will be given prior to any room and board rate increase.

**Late Fees:**
If the room and board fee is not received by the 5th of the month, a late fee of $10 per day will be assessed beginning on the due date. (If payment is received on the 6th, a late fee of $60 will be assessed. If received on the 8th, a late fee of $80 will be assessed).

**Reinstatement Fee:** Students who leave the program and are allowed to re-enter the program within 30 days are required to pay a $100 reinstatement fee.

Applicant's Signature:____________________________________ Date: ____________

Parent/Guardian's Signature: ______________________________ Date: ____________

# Break Policy

Minnesota Teen Challenge takes three short breaks each year. These breaks occur over the Fourth of July, Thanksgiving, and Christmas. Normal student activities cease during scheduled breaks. Minnesota Teen Challenge is not liable for the safety of students who are away from our facility on break.

**Eligibility:**
Students may go home during these breaks only if all of the following conditions are met:
1. They must be in our program at least 90 consecutive days prior to the start of the break.
2. They must have the approval of their program dean.
3. If on parole/probation, they must have written permission from their probation officer.

**Transportation:**
Minnesota Teen Challenge does not provide transportation for students who are going away on break. This includes transportation to/from airports, train stations, bus stations, or any other location.

**Students Remaining At Teen Challenge During Break:**
Recreation and other activities will be scheduled for students who remain in our facility during these breaks. Family and friends desiring to visit students during scheduled breaks must contact the program dean to arrange dates and times of visitation.

**Break Schedule:**
A schedule of when students may depart and when they must return during each break is listed below and is also posted on the bulletin board in the student's living facility. Students who do not return from break on time may be discharged, set back in the program, and/or lose future opportunities to go home during scheduled breaks.

***Fourth of July 2006*:** Students may not leave our facility prior to 1:00 pm on Friday, June 30, 2006 and must return to our facility no later than 6:00 pm on Wednesday, July 5, 2006.

***Thanksgiving 2006:*** Students may not leave our facility prior to 1:00 pm on Tuesday November 21, 2006 and must return to our facility no later than 6:00 pm on Saturday November 25, 2006.

***Christmas 2006:*** Students may not leave our facility prior to 1:00 pm on Friday, December 22, 2006 and must return to our facility no later than 6:00 pm on Wednesday, December 27, 2006.

**I have read and understand Minnesota Teen Challenge's policy regarding scheduled breaks. I understand that in order to go home on break, I must meet the eligibility requirements listed above and initial each acknowledgement item on the next page.**

Parent/Guardian's Name: ______________________________
(Please Print)

Parent/Guardian's Signature: ______________________________ Date: ____/____/____

Student's Signature: ______________________________ Date: ____/____/____

# Break Policy

**(Acknowledgement Form)**

This form serves as an acknowledgement that you have read and understand our policy regarding the scheduled breaks of our Minnesota Teen Challenge Life Care program. It also releases Minnesota Teen Challenge from liability for your safety during the time you are away from our facility on break. Please read each acknowledgement before you initial that item. All acknowledgements must be initialed in order for you to be authorized to go home during any scheduled break.

Initials

_____ I understand that I am responsible for my child's transportation to and from the Minnesota Teen Challenge facility in conjunction with any scheduled break. This includes transportation to/from airports, train stations, bus stations, and any other location.

_____ I understand that Minnesota Teen Challenge is not liable for my child's safety while away from their facility during this break.

_____ I assume responsibility for my child's safety from the time my child departs the Minnesota Teen Challenge facility, until the time he/she returns to their facility and is officially received by their program staff.

_____ I understand that my child may not depart the Minnesota Teen Challenge facility to go on break prior to the date and time authorized in the policy on the reverse side.

_____ I understand that my child must return to the Minnesota Teen Challenge facility not later than the date and time authorized in the policy on the reverse side.

_____ I understand that if my child does not return to the Minnesota Teen Challenge facility by the time specified in the policy on the reverse side, certain consequences will occur. He/she may be discharged from the program, be set back in the program which will result in additional room and board charges for the additional time spent in the program, and/or lose future opportunities to return home during scheduled breaks.

_____ I understand that my child is not required to return home during this scheduled break and that Minnesota Teen Challenge has recreational and other activities planned for all students who remain at their facility during breaks.

_____ I understand that if my child remains at Minnesota Teen Challenge during a scheduled break and I desire to visit my child during that break, I must contact the program dean to arrange a date and time of visitation to insure there is no conflict with other scheduled activities.

Parent/Guardian's Name: ________________________________________
(Please Print)

Parent/Guardian's Signature: ____________________________________ Date: ____/____/____

Student's Signature: ___________________________________________ Date: ____/____/____

# PARENTAL RELEASE OF LIABILITY AGREEMENT

I/We, ________________________________________, parent(s), guardian(s), or conservator(s) of ______________________________, a minor child born on ________________, hereby agree that he/she can enroll in Minnesota Teen Challenge Academy (MTCA), a 12-month Christian residential rehabilitative program. I/We further agree that I/we relieve MTCA, its Staff, Employees, Students, and Board Members from any responsibility or liability for any damages to him or his property during his residence at MTCA or during any related travel and/or activities. I/We also agree to release, hold harmless, and relinquish all rights to pursue any cause of action whatsoever against MTCA, its Staff, Employees, Students, and Board Members if a student voluntarily leaves MTCA or for any damages incurred during his/her residence.

State of _____________________________________

County of ___________________________________

Subscribed and sworn before me by:

____________________________________________ and

____________________________________________

On this ____________ day of ____________, 20___

____________________________________________

Notary Public

My commission expires: _______________________

# EMERGENCY MEDICAL, SURGICAL, & DENTAL PERMIT

Minnesota Teen Challenge may provide emergency services anytime the parent(s), guardian(s), or emergency contact person(s) can not be reached, when, in the opinion of the attending, duly qualified physician, said services are deemed necessary or advisable. I/we consent to the administration of whatever anesthetics are advisable or necessary and I/we agree to be solely responsible for payment of any and all medical or dental services obtained.

Parent/Guardian Signature: ________________________________ Date: ____________

Parent/Guardian Signature: ________________________________ Date: ____________

# APPLICATION - Adolescent Life Care Program

### Documents For Admission:

- Driver's License or Other Picture ID - **Required**
- Social Security Card – **Required**
- Birth Certificate (Original or Certified Copy) – If Available
- DD 214 Form (Applicants with Prior Military Service) – If Available

### Other Items You May Bring:

You should bring the following items if you have them. If you do not have them and do not have the means to purchase them, do not worry. We have the ability to provide many of these items at no cost to you.

**CLOTHING:**

- ☐ Gloves
- ☐ Black or dark blue suit jacket (male)
- ☐ Black or dark blue dress pants (male)
- ☐ White dress shirts (long or short sleeve) (male)
- ☐ Black or dark blue socks (male)
- ☐ Underwear
- ☐ Belt (male)
- ☐ Neckties (male)
- ☐ Black skirt (female)
- ☐ White Blouses (female)
- ☐ Nylons (female)
- ☐ Slips (female)
- ☐ Dress shoes (male & female)
- ☐ Jeans or casual slacks
- ☐ Collared shirts or blouses
- ☐ T-shirts (no obscene or inappropriate logos)
- ☐ Shorts (must cover ¾ of thigh)
- ☐ Coat (during winter) – Raincoat - Umbrella
- ☐ Dresses or skirts
- ☐ Sweatshirt
- ☐ Sweat pants
- ☐ White socks

**Shoes:**

- ☐ Shower shoes
- ☐ Slippers
- ☐ Tennis shoes
- ☐ Casual shoes
- ☐ Boots (during winter)
- ☐ Dress Shoes

**SCHOOL SUPPLIES:** (if in High School)

- ☐ Spiral Notebooks
- ☐ Black or blue ink pens – Pencils #2
- ☐ Ruler, Calculator

**TOILETRIES:**

- ☐ Soap - Shampoo
- ☐ Comb - Brush
- ☐ Toothbrush - Toothpaste
- ☐ Towel - Washcloth
- ☐ Deodorant
- ☐ Disposable or electric razor – shaving cream
- ☐ Makeup
- ☐ Blow Dryer
- ☐ Foot Powder or spray
- ☐ Sanitary items

**LINENS:** (If you don't want to use ours)

- ☐ Blanket, Pillow, Pillow Case
- ☐ Twin Sheets

**MISC:**

- ☐ Bible
- ☐ Envelopes - Stamps
- ☐ Small Clock Radio
- ☐ Family Picture (8"x10" maximum)
- ☐ Camera - Film
- ☐ Jewelry (leave expensive jewelry at home)

**MEDICAL:**

- ☐ Immunization Records (if in High School)
- ☐ Health Insurance Data
- ☐ Prescription Medications (30 day supply)
- ☐ Non-prescription Medications (if desired)

**Note:** It is strongly recommended that you make yourself a copy of this page for future reference **before** returning this application to our admission office.

Applicant's Signature: ______________________________ Date: ____/____/____

Parent/Guardian's Signature: ______________________________ Date: ____/____/____

# APPLICATION - Adolescent Life Care Program

**Items You May Not Bring:**
You **may not** bring any of the following items with you when being admitted. If you do, you will be required to immediately dispose of them or mail them home at your own expense.

- More than two suitcases of items
- Expensive Jewelry
- Expensive Clothing or other valuable items
- Items of Sentimental Value (except family photo - 8”x10” maximum)
- Cassette Players – Cassettes
- CD Players - CDs
- VCRs – VHS Tapes
- DVD Players – DVDs
- Headsets
- Video Games
- Radios – (except as part of an alarm clock)
- Televisions
- Computers
- Cell Phones
- Musical Instruments
- Books (other than a Bible and one devotional book)
- Magazines, newspapers, or other printed articles
- Weapons of any kind
- Tools of any kind
- Recreation Equipment
- Playing Cards
- Games
- Dice
- Illegal Drugs
- Drug Paraphernalia
- Alcohol
- Tobacco Products
- Personal Vehicle

We recognize the importance of music, games, recreation, entertainment, and other activities in the proper growth and development of our residents. We will provide the necessary equipment and opportunity for these activities.

**Note:** It is strongly recommended that you make yourself a copy of this page for future reference **before** returning this application to our admission office.

Applicant’s Signature: ______________________________ Date: ____/____/____

Parent/Guardian’s Signature: ___________________________ Date: ____/____/____

## APPLICATION - Adolescent Life Care Program

# Physical Examination Form

Patient's Name: ____________________________ SSN: _____-____-_____ Date of Birth: ____/____/____

Sex: ___Male ___Female Height: _______ Weight: _______

I authorize the release of the physical examination information contained on this form to Minnesota Teen Challenge for the purpose of determining my eligibility for admission. I also authorrize the physician who provided the physical examination and/or his/her staff to discuss my medical conditon with Minnesota Teen Challenge to whatever extent necessary to determine admission eligibility.

Patient's Signature: _________________________________________ Date: ____/____/____

**Send Completed Form To:**
Admission Director
Minnesota Teen Challenge
1619 Portland Ave
Minneapolis, MN 55404-1598
Phone: (612) 373-3366
Fax: (612) 333-4111

**Medications:** **(List all medications the applicant is currently taking)**

1. ____________________ Reason: ________________________________
2. ____________________ Reason: ________________________________
3. ____________________ Reason: ________________________________
4. ____________________ Reason: ________________________________
5. ____________________ Reason: ________________________________

**Please Circle All That Require Further Medical Treatment:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Ears | Nose | Throat | Eyes | Neck | Back | Abdomen |
| Skin | Rectal | Pelvic | Genitals | Thyroid | Lymph Glands | Neurological |
| Heart | Lungs | Bones | Joints | Extremeties | | |

**Required Medical Information:**

| | | | |
|---|---|---|---|
| Hepatitis | Yes | No | Specify: ________________________________ |
| Venereal Disease | Yes | No | Specify: ________________________________ |
| HIV | Yes | No | |
| Tuberculosis | Yes | No | |
| Pregnancy | Yes | No | |

**Is there any medical condition that may endanger the health of the staff or students in our residential program?**

Yes No Condition: ________________________________________________
Condition: ________________________________________________
Condition: ________________________________________________

**Is there any reason why this applicant should not assist in the preparation of food or medical services?**

Yes No Reason: ________________________________________________

Physician's Printed Name: ______________________________________ Date of Physical Exam: ____/____/____

Physician's Signature: __________________________________________ Phone: (______) ________-_________

## APPLICATION - Adolescent Life Care Program

# Pupil Health Immunization Record

| Name | Student Number |
|---|---|
| Birth Date | |

FOR SCHOOL USE ONLY
- ❑ Complete; booster required in ______________________
- ❑ In process; 18 mo. Expires ______________________
- ❑ Medical exemption for ___________________________
- ❑ Conscientious objection for ______________________

**Minnesota Statutes Section 121A.15 requires that all children who are enrolled in a Minnesota school be immunized against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, and hepatitis B* allowing for certain specified exceptions (see reverse side). This form is designed to provide the school with information required by the law and will be available for review by the Minnesota Department of Health and the local community health board.**

Enter the MONTH, DAY and YEAR for all vaccines the pupil received. DO NOT USE (✓) or ( X ).

| Type of Vaccine | 1st Dose Mo/Day/Yr | 2nd Dose Mo/Day/Yr | 3rd Dose Mo/Day/Yr | 4th Dose Mo/Day/Yr | 5th Dose Mo/Day/Yr |
|---|---|---|---|---|---|
| **Diphtheria, Tetanus and Pertussis (DtaP, DTP)** | | | | | |
| **Diphtheria and Tetanus (DT)** – pediatric formulation (<7 yrs) | | | | | |
| **Tetanus and Diphtheria** (TD) – adult formulation (>7 years) | | | | | |
| **Polio** (IPV, OPV) | | | | | |
| **Measles, Mumps, & Rubella** (MMR) [minimum age: 12 mos] | | | | | |
| **Hepatitis B** (HBV)* | | | | | |
| ***Haemophilus influenzae* type b** (Hib)** | | | | | |
| **Varicella** (chickenpox)*** | | | | | |

* HBV will be required for kindergarten enrollees in 2000-01 and both kindergarten and 7th grade enrollees in 2001-02.
** Hib vaccine is recommended only for children through age 4 years.
*** Varicella vaccine is recommended, but currently not required.

*Not for school personnel: Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, Record combination vaccines (e.g./ DTP+Hib, Hib+HBV) in each applicable space.*

### Indicate immunization status and source of above information by choosing one of the following alternatives:

❑ I certify that this student has received all immunizations required by law.

_______________________________________ ________________

Signature of parent/guardian or physician/public clinic Date

❑ I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B*, measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B*, and/or polio vaccine series within the next 18 months. The dates for which the remaining doses are to be given are:

_________________________________________________________________

_______________________________________ ________________

Signature of physician or public clinic Date

## LEGAL EXEMPTIONS TO MINNESOTA SCHOOL IMMUNIZATION LAW

- Students 7 years of age or older do not need pertussis vaccine.
- Students 18 years of age or older do not need polio vaccine.
- **Medical exemption:** No student is required to receive and immunization if they have a medical contraindication or laboratory evidence of immunity. To receive a medical exemption, a physician must sign the following statement.

*I hereby certify that immunization is contraindicated for medical reasons or that laboratory confirmation of adequate immunity exists for the following immunizations:* ______________________________

________________________________________________________________________________

__________________________________________________ ______________________________

Signature of physician Date

- **Conscientious exemption**: No student is required to have an immunization which is contrary to the conscientiously held beliefs of his/her parent or guardian. To receive this exemption, a parent or legal guardian must complete and sign the following statement and have it notarized.

*I hereby certify by notarization that immunization of my child is contrary to my conscientiously held beliefs. Indicate vaccine(s):*

________________________________________________________________________________

__________________________________________________ ______________________________

Signature of parent of legal guardian Date

Subscribed and sworn to before me this ________ day
of_________________________ 19 ______.

_______________________________________________________________________

Signature of notary

### Special Exceptions for DTP, Td, and Polio

**Children less than 7 years of age:** The 5th dose of DtaP/DTP/DT (similarly, the 4th dose of polio vaccine) is not necessary if the 4th DtaP/DTP/DT (3rd dose of polio) was administered after the 4th birthday.

**Children 7 years of age and older:** A history of 3 doses of DtaP/DTP/DT/Td and 3 doses of polio vaccine meets the minimum requirements of the law.

**Students in grades 7-12:** A Td booster given at age 11 years or later is not required for students in grades 7-12 whose most recent Td was given after their 7th birthday but before their 11th birthday. Instead, it will be required 10 years after the date of the most recent dose.

**APPLICATION - Adolescent Life Care Program**

# Media Release Form

School: ____________________________

Date: __________________

Dear Parent or Guardian:

Throughout the school year, the media may visit your school to cover special events. Minneapolis Public Schools may also wish to use your child's photograph, voice or student work for promotional and educational reasons, such as in publications, posters, brochures and newsletters; on the district web site, radio station or Cable TV channel; or at community fairs. Because of state law, a school must obtain permission before your child's photograph or voice can be used by the media or by the district. Please sign and return the bottom part of this page stating whether the district and the media have permission to use your child's photograph, student work or voice for promotional and educational purposes. Thank you for your cooperation.

---

_____ **I give my permission** for ______________________________________
*Student's name (please print)*
to be filmed/photographed/interviewed by the media during school events and for the district to use my child's photograph/work/voice for promotional and educational purposes.

___________________________________ ____________
*Parent/Guardian signature* *Date*

_____ **I do not give my permission** for ______________________________________
*Student's name (please print)*
to be filmed/photographed/interviewed by the media during school events and for the district to use my child's photograph/work/voice for promotional and educational purposes.

___________________________________ ____________
*Parent/Guardian signature* *Date*

***If you have any questions about this form, please call your school.***

## APPLICATION - Adolescent Life Care Program

**Student Data Release Form**

# For Military Recruitment (11th & 12th Grades)

School: _________________________________ Date: ____/____/____

Dear Parent or Guardian:

Effective August 1, 2001, the Minnesota State Legislature amended the Data Practices Act, which governs the release of student information. The amendment requires schools to release to military recruiting officers upon request the names, addresses, and home telephone numbers of students in grades 11 and 12. The data released to military recruiting officers under this Act: (1) may be used only for the purpose of providing information to students about military service, state and federal veterans' education benefits, and other career and educational opportunities provided by the military; and (2) shall not be further disseminated to any other person except personnel of the recruiting services of the armed forces.

As parent/guardian, you have a right to refuse to release this information by signing and returning this form to the school office. If you do not return this form, information on your student will be released to military officers if requested. Thank you for your cooperation.

---

**I do not give permission** for the school to release data on ___________________________________
*Student's Name (please print)*
to military recruiting officers.

_____________________________________________ ______/______/______
*Parent/Guardian Signature* *Date*

**I give permission** for the school to release data on ________________________________________
*Student's Name (please print)*
to military recruiting officers.

_____________________________________________ ______/______/______
*Parent/Guardian Signature* *Date*

***If you have any questions about this form, please call your school.***