



MEDICAL, MENTAL HEALTH & SUBSTANCE ABUSE:

Do you have health insurance? Will you need assistance applying for Medicaid?

Have you ever been diagnosed with a mental illness? If yes, please explain:

Are you currently receiving mental health services or counseling? If yes, please state provider:

Please circle:

Do you currently use alcohol?	YES	NO
Do you feel you have an addiction to alcohol?	YES	NO
Do you smoke or use tobacco (please circle)?	YES	NO
Do you feel you have an addiction to tobacco?	YES	NO
Do you currently use any illegal substances/drugs?	YES	NO
Do you feel you have an addiction to any drugs?	YES	NO
Do you want treatment for any addiction you may have?	YES	NO

Additional comments:

Are you interested in (MAT) Medicated Assistance Treatment? YES NO

Have you ever been on a MAT program? YES NO

When: _____ Where: _____

Are you interested in attending MAT education classes? YES NO

Are you interested in counseling? YES NO



Additional Information:

Are you employed? YES NO

Will you require assistance applying for employment? YES NO

Do you have reliable transportation? YES NO

Highest Grade Completed/GED: _____

Total Number of Arrest in your life: _____

Total Number of DUI/DWI in your life: _____

Total Number of Prior of all Alcohol/Drug Treatment Centers attended: _____

What type of work experience do you have?

What type of assistance do you believe you will need in order to be successful?

By my signature, I affirm that the information in this application is correct to the best of my knowledge and belief. I understand that all services and funding are subject to the availability of funds and final approval of the departmental Director.

Signature

Date

Reentry Staff

Date



Comanche Nation Adult Reentry Program Release of Confidential Information

If you do not provide a complete address, to include street, city and zip code, **notification of your inquiry will not be mailed.**

I, _____ authorize:
(Print name)

**Comanche Nation Reintegration
#10 SW D Avenue
Lawton, OK 73501
580-360-0616**

To release my confidential information to:

Name of person to receive information: _____

Organization: _____

Address: _____

City, State, & Zip Code: _____

Telephone number: _____

Email: _____

- **Information may include but not limited to assessment results, the progress report, or certificate of completion.**
- **I understand that my records are protected under Federal and State Confidentiality Regulation (42: CFR) and cannot be released without my written consent.**
- **I understand that I may revoke this authorization, in writing at any time, except for actions that may have already taken place prior to the date on my written revocation.**
- **In any event, this consent expires automatically ninety (90) days after the termination of current services.**
- **I acknowledge the release of confidential information was fully explained to me and I consent.**

Print Name

Date

Signature



Comanche Nation Adult Reentry Program Authorization to Release Information

I, _____, **authorize** the release of my person and/or business-related information for eligibility requirements and/or program assistance to the named department/program listed below:

Name: Comanche Nation Adult Reentry Program

Address: PO Box 908

City: Lawton State: OK Zip: 73502

This request and authorization also apply to and or release of: (check all that apply)

- Tribal Related Records
- Employment Records
- Copies of Personal Information
- Education Records
- Financial Records
- Public Assistance Information
- Other: Please list any other items not specified above)

I, _____, **do not authorize** the release of my personal and/or business-related information to and department, program, organization, and/or business of any kind.

Signature

Date