



Comanche Nation Prevention & Recovery Residential Treatment Center

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Application for Inpatient Treatment

Directions: Fill out the entire form to the best of your ability, including dates and names.

Full Legal Name: _____

Other Names Used: _____

Physical Address: _____

P.O. Box: _____

City, State & Zip: _____

Tribal Affiliation: _____ Enrollment Number: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Sex: _____

Phone number: _____ Message Number: _____ Email: _____

Marital Status (circle one): **Married** **Single** **Divorced** **Separated** **Widowed**

Are you pregnant? Yes or No If yes, due date: _____

Do you have any children? Yes or No If yes, how many? _____ List below:

Name	Age	DOB	Tribal Affiliation	Legal Guardian

Are you employed? _____ **Full-Time** **Part-Time** **NOT Employed** **Disabled** **Retired**

If yes, the name of your employer: _____

Highest Grade Completed (circle one): **8th Grade or Below** **9th** **10th** **11th** **12th-GED**

Some College

2/4-Year College

Are you currently incarcerated? **Y / N** Where? _____

Do you have an attorney? **Y / N** If yes, who? _____

Attorney's Number: _____ Attorney's email: _____

Number of Total Arrests: _____ Number of DUI/DWI Arrests: _____ Number in Household: _____

Have you been to a substance treatment facility before? **Y / N** When?: _____ How many times? _____

Did you complete the program? **Y / N**

If not, why did you leave? _____
_____.

Have you been to the Comanche Nation treatment facility before? **Y / N** When? _____

Did you complete the program? **Y / N**

If not, why did you leave? _____
_____.

****Why are you requesting 12 months of residential treatment?*****

What substances have you recently used? Please list below and the last date you used.

(Please state if you're actively using; detox may be required before entry.)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have any mental health conditions? **Y / N** If yes, please explain in detail and list all prescribed medications. _____

Do you have any physical health conditions? **Y / N** If yes, please explain in detail and list all prescribed medications. _____

Are you currently or have you ever received mental health services? Y / N If yes, please explain in detail.

Have you ever been hospitalized for any mental health illness? Y / N If yes, please explain in detail.

Do you have any violent or sexual, pending or historical, criminal history? Y / N If yes, please explain in detail.

Do you have any open DHS/ICW cases? Y / N If yes, who is the assigned worker?

Name: _____ Phone: _____ Email: _____

My signature affirms that the information in this application is correct to the best of my knowledge and belief. I understand that all service and funding are subject to the availability of funds and final approval of the department director.

Applicant Signature

Date: _____

Received by CNP&R Staff

Date: _____

Office Notes:

