

1001 South 27th Street

Billings, Montana 59101

Phone 406-294-9609

Fax 406-245-4886

**Alcohol and Drug Treatment**

**No visits will be allowed until resident has reached Phase II. Due to space, the number of visitors must be limited.**

Please print. Any incorrect, incomplete, false, or misleading information on this application will void this application.

**The approval or denial of this visitor application will take 7 – 10 days. Your relative at Passages will notify you.**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Name ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Middle Last)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip

Height \_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_ Hair \_\_\_\_\_\_\_\_\_\_\_\_ Eyes \_\_\_\_\_\_\_\_\_\_ Date of Birth­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*This information is needed should we determine to have a background check conducted prior to approval/denial only.*

**\*\*Must be an immediate relative (parents, siblings, legal spouse, children and grandparents) to go through approval process or adult who has custody of resident’s children\*\* Limited to two adults with resident’s children or 2 adults.**

Your relationship to client: [ ]  Spouse [ ]  Parent [ ]  Sibling [ ]  Grandparent [ ]  Child

Do you have custody of the resident’s child or children? [ ]  Yes [ ]  No

**LIST MINOR CHILDREN THAT MAY ACCOMPANY YOU**

**(Note: We can only allow immediate minor children to visit)**

1. Child’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Relation to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Child’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Relation to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Child’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Relation to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All questions must be answered truthfully. Any false or misleading information will void this and any future applications.

Have you ever been arrested? [ ]  Yes [ ]  No

If Yes, for what offense(s)?

Are you under the supervisor of either State or Federal Probation or Parole? [ ]  Yes [ ]  No

If Yes, for what offense(s): Discharge Date

Supervising Officer’s Name: Phone Number

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do currently have any charges pending against you? [ ]  Yes [ ]  No

If Yes, what charge and what are the circumstances:

**Visitor Rules and Requirements**

1. You must be able to produce and submit a valid picture ID at each visitation.
2. All potential visitors may be subject to an NCIC background check.
3. All visitors must be the age of 18, unless children of client listed on the application.
4. Visitors are responsible for the behavior of the children that may be attending. Our visiting area is also shared by other residents and children. Staff have the right to ask you to remove children if they are too disruptive.
5. Any or all loud, threatening, or abusive language will not be tolerated and the visit will be immediately terminated.
6. Any visitors suspected of being under the influence of drugs and/or alcohol will be requested to immediately leave. Any future plans to visit will not be allowed.
7. The current visiting hours are on Sunday mornings from 9 a.m. to 11 a.m. Any visitors arriving after 9:00 a.m. will be refused visitation.
8. You must be approved **before** visits on Sunday.
9. You will be notified by your family member if you have been approved or denied.

**Allowed:**

1. Check or money orders for clients must be turned into the staff present in order to be received in the client’s account. Please do not give money to the client. Please do not bring in cash.

**Not Allowed:**

1. Cell phones and cameras of any kind.
2. You cannot bring homemade baked goods, fast foods, snacks, gum, candy, chips, cookies, soda, etc. Snacks for young children are allowed.
3. You are not allowed to bring any clothing for the client.
4. You are not allowed to bring in any tobacco products into the building. No exceptions. Your visit will be terminated immediately if staff notice any tobacco products on your person or belongings. We are a tobacco-free campus.
5. Shampoo, conditioner and lotion.
6. No personal effects (i.e. purse, backpack, books). Diaper bags are approved yet can be subject to search

**Statement of Confidentiality: I understand the confidentiality of alcohol and drug abuse family members in this program is protected by Federal law and regulations. Federal law and regulations prohibit disclosure of any information identifying an ADT program family member (client) as an alcohol or drug user. Violation of the Federal law and regulations is a crime. Suspected violations may be reported and all further visitation privileges to this facility will be terminated.**

Visits are usually very healthy for everyone. Our clients are experiencing some significant emotions due to past issues while they are in treatment. Please be supportive of her treatment and what she is going through. Please try not to confront them for past behaviors or actions; our professional staff are already doing this. *Should your visit be deemed inappropriate by our staff for any reason, the visit can and will be terminated at any time*.

The client that you are here to visit is subject to room searches, pat downs, UA’s and BA’s after your visit. Please do not put her into a position to be subject to any further incarceration or increased charges by attempting to smuggle any contraband or illegal substances into the facility. This is a correctional treatment facility and we do hold our client accountable to the conditions by which she was accepted into this program.

**I AGREE TO ABIDE BY ALL OF THE ABOVE CONDITIONS AS APPLIED TO MY VISITATION PRIVILEGES AT THE PASSAGES ALCOHOL AND DRUG TREATMENT PROGRAM**.

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Signature Printed Name Date

[ ]  Approved [ ]  Disapproved

 Program Supervisor Date