



CITY OF SHAKOPEE
POLICE DEPARTMENT
 VOICE: (952) 233-9400 FAX (952) 233-3811

Contacts: **Barb Hedstrom**
 BHedstrom@ShakopeeMN.gov
Nicole Clifton
 NClifton@ShakopeeMN.gov

PARTICIPANT APPLICATION AND AUTHORIZATION

I wish to participate in the Shakopee Police Departments addiction recovery program to help me get drug and/or alcohol treatment. I am free to stop my participation in the program at any time without punishment by notifying the Shakopee Police Department. I agree to sign authorizations for the Shakopee Police Department to contact my treatment provider and/or other participating agencies to verify my participation in treatment.

Name:			ID No.: _____ (for office use only)	
Address:				
City:		State:		Zip Code:
Phone: () -	D.O.B: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> other	
Treatment Center:			Center phone: () -	
Treatment Type: <input type="checkbox"/> Drug <input type="checkbox"/> Alcohol <input type="checkbox"/> Both			Drug of choice:	

Statement of Need including estimate of \$ amount needed:

Upon acceptance into this program, Shakopee Police Department agrees to pay for the remaining cost of your treatment program (up to \$3,000.00) after insurance (if applicable) has been applied. This offer is only valid if the participant completes at least 30 days of outpatient, outpatient with lodging or residential treatment. Failure to complete treatment will result in this offer being revoked. Participants must be in good standing with their treatment center. This offer is only valid once per person, unless a special arrangement has been agreed upon beforehand.

I agree to sign authorizations for the Shakopee Police Department to contact my treatment provider and/or other participating agencies to verify my participation in treatment. I agree

I agree to provide the Shakopee Police Department with an update of my recovery process each month. I understand that this information may be shared with other interested parties and with local news or on city publications. Participants name and any other identifying information will be removed before any information is shared. I agree

Participant's signature	Date
Treatment Center Representative	Date
Police Department Representative	Date

Shakopee Police Department



Phone: 952-233-9400
Fax: 952-233-3811

Contact: Barb Hedstrom
or Nicole Clifton

30 DAY CHECK IN

Recovery Assistance Program

Name or Client ID #: _____ Date: _____

The scholarship program is a developing program for the Shakopee Police Department. We would appreciate your feedback on the following questions to help us improve our program and help to better assist in your recovery.

1. What else can the police department do to help you have a successful recovery?

2. If someone was considering treatment and/or joining the scholarship program, what would you tell them?

3. If you could give someone advice on how to stay away from drugs, drug related substances, or alcohol, what would you say?

4. What is your anticipated treatment ending and plans to maintain sobriety?

5. Would you be interested in continuing a connection with a Shakopee police officer who could support you in your recovery?

If yes, please provide your current phone number and/or mailing address:

*Shakopee Police Department
475 Gorman Street
Shakopee, MN 55379
Fax: 952-233-3811*