

ALCOHOL LUXURY TAX TREATMENT REQUEST FORM

Applicant Name: _____

Address: _____ City _____ State _____ Zip _____

Phone No. _____ Cell No. _____ Msg. No. _____

Have you been convicted or indicted of a crime? Yes ___ No ___ If yes, provide date and provide information

PURPOSE OF REQUEST

___ Necessities ___ Fees ___ Treatment Cost ___ Transportation ___ Family Visitation ___ Other

Reason for request: _____

Have you ever received funding from Revenue Office? _____ If yes, what date? _____

What date is treatment activity? _____

Attach acceptance letter of person attending treatment or other information in relation to treatment cost, visitation, or transportation

PLEASE READ AND INITIAL

For those attending treatment program. I agree to purchase necessities, such as: shampoo, deodorant, toothpaste, toothbrush, or clothing items necessary to complete treatment program. _____

For those attending family visitation or transporting. I agree to attend family visitation or provide transportation to treatment center and return all receipts for gas, lodging, or food. _____

I agree to return receipts and funding not used within 10 days to the Revenue Office. _____

I agree to attend an After-Care Program and continue with AA or similar classes at Four Bands Healing Center or another Treatment Program when I complete my treatment program. _____

I hereby acknowledge that the above is true and will follow all guidelines for treatment

Signature _____ Print Name _____ Date _____

Amount Approved _____ Disapproved _____

Office Use: _____

CRST REVENUE OFFICE
BOX 590
Eagle Butte, SD 57625
Phone No. 964-7071 - Fax No. 964-7070