SUPPORTED HOUSING PROGRAM

ADMISSION APPLICATION
COVER PAGE

Referring Counselor:

Please check off the below information verifying that you are forwarding a complete application package. Incomplete admission application packages cannot be given an assessment date.

- ☐ Admission Application
- ☐ Release of Information Consent between your agency and Cazenovia Recovery Systems, Inc.
- ☐ Psychosocial History (most recent)
- ☐ Medical Evaluation (most recent)
- ☐ All legal documentation if your client is presently engaged in a criminal justice process
- ☐ Verification of Homelessness
- ☐ Verification of Disability signed by a Qualified Health Professional

Counselor Signature: _____

Printed Name: _____ Date: _____

Mail or fax the completed application package to the following:

Housing Program
1430 Main Street
Buffalo, NY 14209

Phone (716) 894-7298
Fax (716) 894-7308

SUPPORTED HOUSING
ADMISSION APPLICATION

TO BE COMPLETED BY REFERRING AGENCY AND/OR APPLICANT

Please complete each section carefully.
Adequate diagnostic information and documentation is essential to a prompt and informed intake decision.

APPLICANT INFORMATION

Name: _____
(Last) (First) (Middle)

Social Security Number: _____ Telephone Number: _____

Street Address: _____ City: _____

County: _____ State: _____ ZIP: _____

Reason for not returning to previous address at this time:

_____

Date of Birth (MM/DD/YY): _____ Sex: _____ Marital Status: _____

Please check the box to the left of the highest educational grade completed:

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐GED ☐College (list level below)

Please list any diplomas, degrees, certificates, and licenses below:

_____

MEDICAL INFORMATION

Does the applicant receive or has the applicant ever received mental health treatment? ☐ Yes ☐ No

IF YES, PLEASE COMPLETE THE FOLLOWING:

Events Leading to Treatment	Program	Admission Date	Discharge Date	Staff Contact

Has a Mental Health Diagnosis been assigned? ☐Yes ☐No

If yes, when? _____ Diagnosis: _____

Has a Substance Abuse Diagnosis been assigned? ☐Yes ☐No

If yes, when? _____ Diagnosis: _____

Is the applicant currently receiving medical treatment? ☐Yes ☐No

IF YES, PLEASE EXPLAIN:

Current medications:

Physician or Clinic Name: _____ Telephone Number: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

FINANCIAL INFORMATION

Is the applicant currently receiving Social Services benefits? ☐ Yes ☐ No

Is the applicant currently receiving SSI or SSD benefits? ☐ Yes ☐ No

IF YES TO THE QUESTIONS ABOVE, PLEASE COMPLETE THE FOLLOWING:

Case Number: | Case Worker:

Monthly Amount of Benefit: | Type (SSD, SSI, etc.):

Medicaid Number: | Managed Care Provider:

Has the applicant been refused or sanctioned for Social Services or Social Security Benefits? ☐Yes ☐No

IF YES, PLEASE EXPLAIN BELOW:

LEGAL INFORMATION

Is the applicant currently on probation? ☐ Yes ☐ No

Name of probation officer: | Phone:

Is the applicant currently on parole? ☐ Yes ☐ No

Name of parole officer: | Phone:

Does the applicant have a history of sexual offenses? ☐ Yes ☐ No

Does the applicant have a history of arson? ☐ Yes ☐ No

You **MUST** return the most recent Psycho-Social Assessment and a Release with this application. An interview appointment **WILL NOT** be scheduled until this application and the Psych-Social Assessment are received by this agency.

SIGNATURES

Applicant Signature: | Date:

Staff Signature: | Date:

Staff Printed Name: | Telephone Number: