Admission Application: Rehabilitation / Community Residence / Supportive Living

INTRODUCTION

Please check which level of care to which the applicant is applying. Complete referral packages* should be faxed to **(716) 362-0221** or scanned and emailed to **intake@cazenoviarecovery.org**. Thank you.

☐ **Rehabilitation (Men): Cazenovia Manor and Turning Point House**

☐ **Rehabilitation (Women): Madonna House**

Applicants may be women, pregnant women, or women with children preschool-age or younger

☐ **Community Residences (Men): Unity House** and Sundram Manor**

**Verification of homelessness required for Unity House applicants

☐ **Community Residences (Women): Casa Di Vita and Somerset House**

☐ **Supportive Living (Erie County)** | Apartments located in Buffalo and surrounding areas

☐ **Supportive Living (Niagara County)** | Apartments located in Niagara Falls and Lockport

Limited beds are available in both counties for parents with children preschool-age or younger

*Complete referral packages must include a Psycho-Social Assessment and proof of income. The following items are also helpful in the intake process, but are not required:

- Current Treatment Plan
- Relevant consent forms
- Medical documentation including a history, medical clearance for communicable diseases, lab work with a PPD test and verification, etc.

Referral Completed By:

Name: _____ Phone: _____

APPLICANT INFORMATION

Name: _____ Phone: _____

Is the applicant homeless or at risk for homelessness? ☐Yes ☐No If yes, please explain:

_____

D.O.B. _____ S.S.N. _____ County of Origin: _____

Medicaid Number: _____ Managed Care Number: _____

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Managed Care Provider:

Gender: ☐ Male ☐ Female ☐ Transgender / Other (Please explain):

If the applicant is female, is she pregnant? ☐Yes ☐No ☐ N/A If yes, please answer the following:

When is her due date? Is she receiving prenatal care? ☐Yes ☐No

If she is receiving prenatal care, where?

Where is she expected to deliver?

SUBSTANCE HISTORY

Does the applicant have a substance disorder diagnosis? ☐Yes ☐No If yes, list DSM / ICD Code:

Code	Description

Primary Substance:

Onset	Frequency	Amount	Route of Ingestion	Date of Last Use

Other Substance:

Onset	Frequency	Amount	Route of Ingestion	Date of Last Use

Other Substance:

Onset	Frequency	Amount	Route of Ingestion	Date of Last Use

Other Substance:

Onset	Frequency	Amount	Route of Ingestion	Date of Last Use

TREATMENT HISTORY

(e.g. Detox, Outpatient, Inpatient, Community Residence, etc.):

Facility Name	Type	Dates	Successful Completion
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

MEDICAL / MENTAL HEALTH

The applicant has: ☐ Medical issues ☐ Mental health issues ☐ Neither (skip to next section)

If the applicant has medical or mental health issues, please explain:

Is the applicant currently receiving mental health treatment? ☐Yes ☐No If yes, who is the provider?

Does the applicant have previous mental health treatment, including hospitalization? ☐Yes ☐No

If yes, please answer the following:

Events leading to mental health treatment	Program	Dates / Length of Stay

Does the applicant have a history of suicide attempts? ☐Yes ☐No If yes, please explain below:

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LEGAL

Is the applicant mandated to this level of care? ☐Yes ☐No If yes, by whom:

Please provide any legal entities with which the applicant has involvement:

Entity (Drug Court*, Probation, etc.)	Jurisdiction	Contact Person	Contact Number

Please check whether the applicant has any of the following:

☐ Outstanding warrants ☐ History of assault ☐ Convicted of any crimes ☐ History of incarceration
☐ History of setting fires ☐ Convicted of arson ☐ Order of protection
☐ History of rape, sexual abuse, or violent crimes

If the applicant has any of the above checked, please explain the circumstances:

If you are a Drug Court making this referral, please include the applicant's NYS ID and a criminal justice release with the completed application.

FINANCIAL (***Proof of income must be submitted with the application)***

Does the applicant currently receive cash assistance or public assistance? ☐Yes ☐No

From which county? Current monthly amount:

Does the applicant currently receive SSI / SSD benefits? ☐Yes ☐No If yes, please provide:

☐ Self-Payee ☐ Rep Payee Payee Name: Phone No.:

Payee Address:

Current monthly income received from SSI / SSD:

Does the applicant have any other sources of income? ☐Yes ☐No If yes, please explain:

Please email the completed application to intake@cazenoviarecovery.org or fax it to (716) 362-0221.