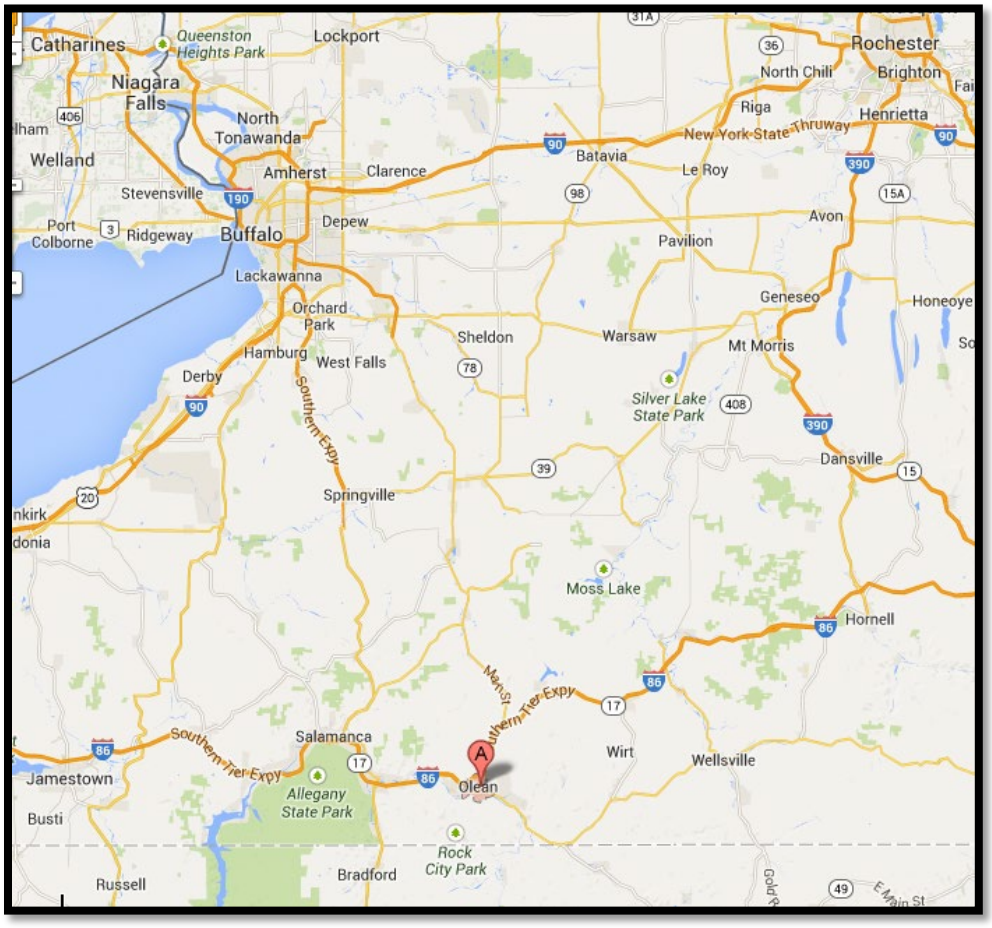
Council on ADDICTION RECOVERY Services Inc.
CARES

Residential Services Application



Supportive Living 201 S. Union St. PO Box 567 Olean, NY 14760 Phone: 716-373-4303 Fax: 716-373-1719 **Please fax completed application & needed information to the number above**	**Westons Manor Community Residence** PO Box 229 Olean, NY 14760 Phone: 716-373-0057 Fax: 716-373-1719 **Please fax completed application & needed information to the number above**	**Willow House Community Residence** PO Box 210 Olean, NY 14760 Phone: 716-373-0021 Fax: 716-373-1719 **Please fax completed application & needed information to the number above**

Application for Admission to CAReS Residential Services

☐Supportive Living ☐Westons Manor ☐Willow House

Please refer to our residential program details on our website at www.councilonaddiction.org

The following MUST be sent with pages 2-7 of this application:

☐**COVID 19 Results and/or Letter of Wellness**
☐**Most recent physical examination, with med list**
☐**Complete blood count with differential**
☐**Routine and microscopic urinalysis**
☐**Most recent urine toxicology**
☐**Signed releases of home county DSS & referral source**
☐**PPD results**
☐**Congregate Care Level II confirmation letter**
☐**Confirmation of active Public Assistance**
☐**If needed, Out of County Approval Letter**
☐**Level of Care Determination (LOCADTR)**
☐**Proof of insurance**
☐**Part 1 of application (pages 2-5)**
☐**Part 2 of application (pages 6-7)**
☐**Aftercare letter**
☐**Medication List**
☐**Copies of Insurance Card(s)**

Has the client travelled outside the country recently? ☐**Yes** ☐**No**

Failure to submit above information and completed application will result in delay of phone screen.

All new residents of any CAReS residential program MUST bring a 30 day supply of all medications with them to admission.

Part 1- To be completed by referring agency

Referring Agency**:** _____

Demographic:

Applicant Name: _____ _____
First Last

SS#: _____ DOB: _____

Address: _____ Phone: _____

_____

Is this address temporary? ☐YES ☐NO

Emergency Contact:

Name: _____ Relationship to applicant: _____

Contact Information: _____

Source of Income: Please attach proof of income

☐Public Assistance (DSS Award Letter) County: _____

Case Worker: _____ Phone: _____

☐SSI

☐SSD

☐Employed

Please explain: _____

☐Other: _____

Insurance: Please attach proof of insurance

☐Medicaid

Medicaid Number: _____

Managed Care: ☐YES ☐NO Provider: _____

Managed Care ID Number: _____

☐Medicare

☐Private Insurance: _____

Substance Abuse Clinical Diagnosis:

☐**F10. _____ Alcohol related disorders**	☐**F15. _____ Other stimulant related disorders**
☐**F11. _____ Opioid related disorders**	☐F16. _____ Hallucinogen related disorders
☐**F12. _____ Cannabis related disorders**	☐F18. _____ Inhalant related disorders
☐**F13. _____ Sedative, hypnotic or anxiolytic related disorders**	☐F19. _____ Other psychoactive substance related disorders
☐**F.14 _____ Cocaine related disorders**	

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Detailed substance use history included in attached psychosocial? ☐YES ☐NO

If no, please complete:

Substance(s) of choice:	Last Use:

Tobacco User? ☐YES ☐NO

If yes, is applicant willing to comply with tobacco-free policy on all residential residences? ☐YES ☐NO

Psychiatric Diagnosis:

Has applicant ever received treatment for mental health? ☐YES ☐NO

Mental Health Provider: _____

Mental Health Diagnosis: _____

Medical:

Primary Care Physician**:** _____

Date of most recent physical: _____

*Please attach most recent physical report from PCP

Known Allergies:

_____

_____

Medication list attached? ☐YES ☐NO

If no, please complete:

Medication:	Dosage:	Frequency:	Used for:

*Must accompany applicant upon program admission into Supportive Living: A minimum of one month supply of current medications or a prescription for a one month supply

Homeless Status:

Is the applicant homeless? ☐YES ☐NO

*If yes, please attach a letter documenting homelessness.

Been homeless for a year or more? ☐YES ☐NO

Been homeless at least 4 times in the past 3 years? ☐YES ☐NO

Is applicant currently residing in a homeless shelter? ☐YES ☐NO

Name of shelter: _____

If not, please explain: _____

	Residence/Address	Move in date	Move out date	Reason for move
Current				
Previous				

Legal/Mandate:

☐Probation: County: _____
Officer: _____
☐Parole: State: _____
Officer: _____
☐ Mandated
By Whom: _____
Registered Sex Offender? ☐YES ☐NO Level: _____
Any history of violence, arson, physical or sexual assault? ☐YES ☐NO
Please explain: _____
_____

Determination of appropriateness and level of care:

Motivation:

On the following scale, please rate applicant's motivation level:

Poor ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Excellent

What factors make this applicant appropriate for residential placement?

_____
_____

How does the applicant interact with staff and peers? _____
Has the applicant established a personal program of recovery? ☐YES ☐NO
Please explain: _____
What goals should the applicant work toward while connected with residential services?
1. _____
2. _____
3. _____

Do you have any other information that will be helpful in consideration of this applicant for residential placement?

_____
_____

Upon completion of part 1 residential application, please print, sign, and date.

_____
Staff Name (please print)

_____ _____
Staff Signature Date

_____
Phone Number and Extension

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Part 2- Please print the next 2 pages and provide to applicant (client) to complete prior to faxing

Please describe your daily recovery program:

_____
_____
_____
_____

Are you receptive to developing a self help/12 step program that includes getting a home group, choosing a sponsor, and working the 12 steps? ☐YES ☐NO

Please describe your experience in self help/12 step programs: _____
_____
_____
_____

Our residential residences are tobacco-free and offer support services in your effort to abstain from tobacco products; please explain your readiness to comply with this requirement: _____
_____
_____
_____

How will residential placement be valuable to your recovery? _____
_____
_____
_____

List your five main goals:

1._____
2._____
3._____
4._____
5._____

What are the three most serious problems you are facing?

1._____
2._____
3._____

Is there any additional information or circumstances we should be aware of? _____
_____
_____

_____ _____

Applicant Signature Date

Patient Questionnaire (to be completed by prospective patient)

Name: _____

Do you require dental care?	☐YES	☐NO
If you wear glasses, do you have them?	☐YES	☐NO
Do you have an eating disorder?	☐YES	☐NO
Are you taking all medications as prescribed by your physician?	☐YES	☐NO
Do you have any current medical problems?	☐YES	☐NO

If yes, please describe: _____

_____

_____

Will any of these illnesses or conditions interfere with your treatment?	☐YES	☐NO

For Women Only

Are you currently pregnant or have a chance of being pregnant?	☐YES	☐NO
Do you require any treatment from an OB/GYN at this time?	☐YES	☐NO

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