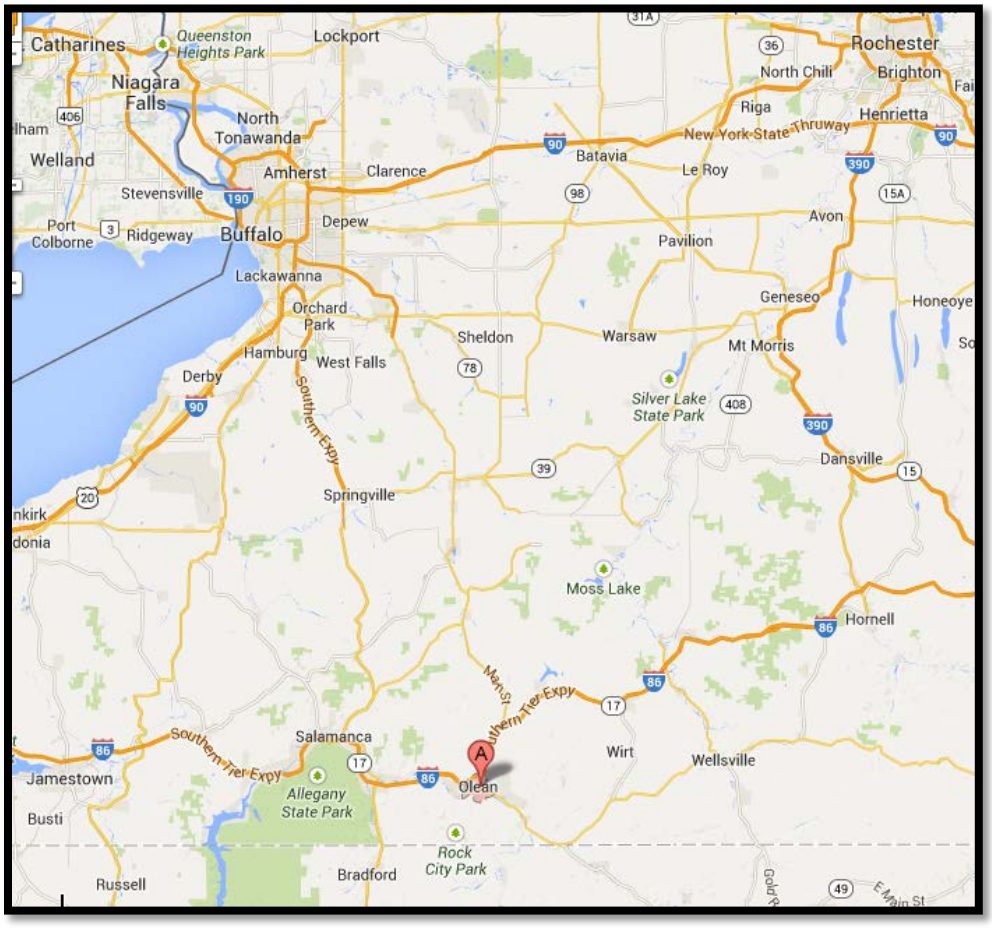
Council on ADDICTION RECOVERY Services Inc.
CARES

Clinical Services Application



Olean Office	**Salamanca Office**	**Franklinville Office**
201 S. Union St. PO Box 567 Olean, NY 14760	4039 Route 219 2nd Floor, Suite 205 Salamanca, NY 14779	86 South Main Street Franklinville, NY 14737
Phone: 716-373-4303 ext.504 Fax: 716-373-4327 **Please fax completed application & needed information to the number above**	Phone: 716-373-4303 ext. 504 Fax: 716-373-4327 **Please fax completed application & needed information to the number above**	Phone: 716-373-4303 ext. 504 Fax: 716-373-4327 **Please fax completed application & needed information to the number above**

Application for Admission to CAReS Clinical Services

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

☐ Olean Office ☐ Salamanca Office ☐ Franklinville Office

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

Client Status:
☐ Pregnant ☐ IV Drug Use ☐ Pregnant/IV Drug User ☐ Recent Overdose
☐ Veteran

Are you currently experiencing withdrawal? ☐ **Yes** ☐ **No**

Is client at risk of losing child/children? ☐ **Yes** ☐ **No**

Is this a MAT Rapid Referral? ☐ **Yes** ☐ **No**

Has the client had previous MAT treatment? ☐ **Yes** ☐ **No**

If yes to either question above, who is/was MAT provider, include address and phone #:

MAT Prescription: _____

Please fax, mail or drop off completed applications to our Olean Office for further assistance. Failure to send completed application may result in delay in treatment.

Part 1- To be completed by referring agency or potential client:

Referring Agency (if applicable)**:** _____

Demographic:
Applicant Name: _____
First Last
SS#: _____ DOB: _____

Address: _____ Phone: _____
_____

Is this address temporary? ☐YES ☐NO

NYS ID/Driver's License Number: _____
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: _____
☐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**	

Have you recently completed Detox/Hospitalization for Substance Use? ☐YES ☐NO

If yes, where? _____

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 at our agency? ☐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:

_____

_____

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: _____

☐IDS/DMV: _____

☐DSS: County: _____

Worker: _____

☐CPS: County: _____

Worker: _____

☐Court: _____

☐Drug Court: _____

☐Other: _____

☐ Mandated

By Whom: _____

Are you at risk of losing your child/children? ☐YES ☐NO

Registered Sex Offender? ☐YES ☐NO Level: _____

Any history of violence, arson, physical or sexual assault? ☐YES ☐NO

Please explain: _____

_____

_____

Name Of Person Completing Form(please print)

_____ _____

Signature of Person Completing Form Date

_____

Phone Number and Extension(if applicable)

Olean Office 201 S Union St. Olean, NY 14760
716-373-4303

Consent to Release Alcohol and/or Drug Information for Referral to Outpatient Treatment

Client Name:

_____ _____ _____

Last First Middle

Date of Birth: _____ Social Security Number_____

Permission is hereby given to:

Agency_____ Phone_____

Address_____ Fax_____

_____

☐ Release information to: Council on Addiction Recovery Services-Olean Office- 201 S Union St. Olean, NY 14760- 716-373-4303

Extent of nature of disclosure is limited to:

☐ Psychosocial Assessment	☐ Billing Information	☐ Referral Application
☐ Diagnosis	☐ Prognosis	
☐ Dates in Programs	☐ Status in Treatment	
☐ Treatment Recommendation	☐ Financial Status	
☐ Toxicology Results	☐ Psychiatric Notes	
☐ Treatment Summary	☐ Discharge Summary	

Purpose for disclosure:

☐ To Facilitate Evaluation, Assessment Screening for Outpatient services with Council on Addiction Recovery Services

I, the undersigned, have read the above and authorize staff at the facility named to disclose such information as indicated. I understand that the disclosure is bound by Title 42 of Federal Code governing the Confidentiality of Alcohol and Drug Abuse Records and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that re-disclosure of this information to any party other than indicated above is prohibited without additional written authorization by me. I understand that this consent may be withdrawn by me, with written notice, at any time expect to the extent that action has already been taken, In all cases, this release shall expire on **ONE YEAR FROM DISCHARGE**.

I understand that generally the Council on Addiction Recovery Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____ _____ _____ _____

Client Signature Date Witness Date

_____ _____

Parent/Guardian Signature Date