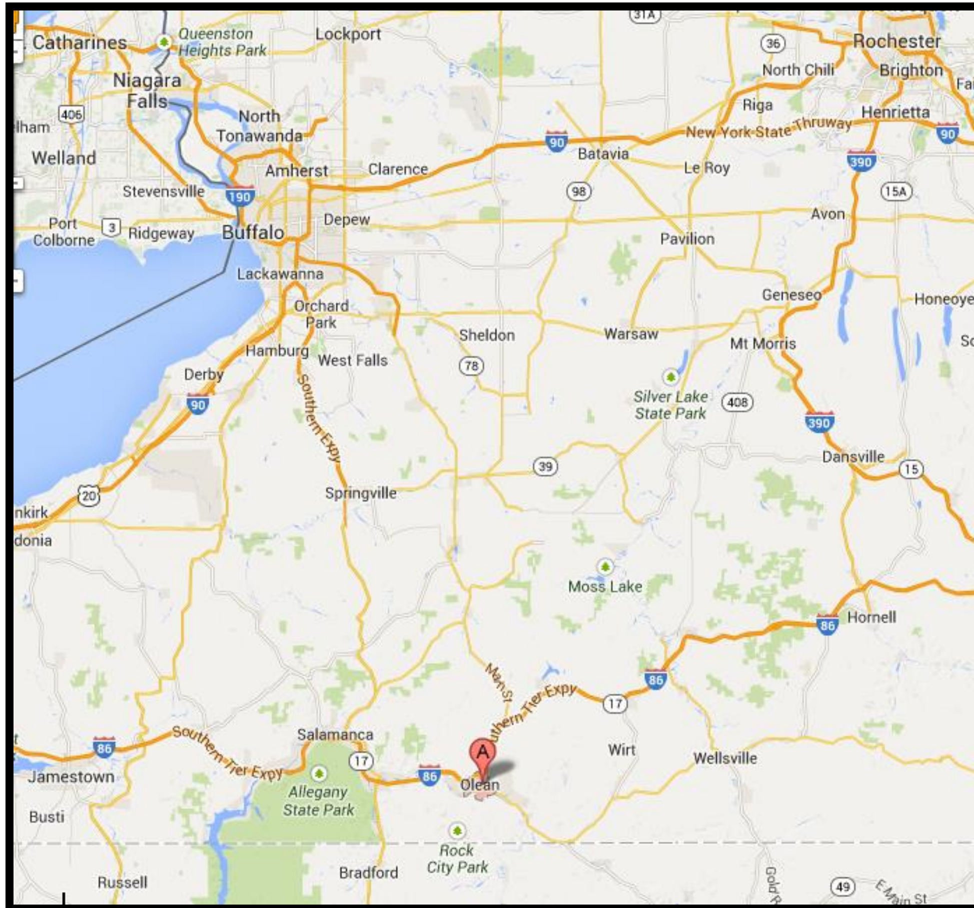
Clinical Services Application



Olean Office
201 S. Union St.
PO Box 567
Olean, NY 14760

Phone: 716-373-4303 ext. 532
Fax: 716-372-0758
Please fax completed application & needed information to the number above

Salamanca Office
4039 Route 219
2nd Floor, Suite 205
Salamanca, NY 14779

Phone: 716-373-4303 ext. 532
Fax: 716-372-0758
Please fax completed application & needed information to the number above

Franklinville Office

86 South Main Street
Franklinville, NY 14737

Phone: 716-373-4303 ext. 532
Fax: 716-372-0758
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

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

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 except 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