

APPLICATION FOR MONROE COUNTY OASAS RESIDENTIAL SERVICES

UPDATED 07/03/2019

APPLICANT INFORMATION

Last Name: _____ (Maiden)	First Name: _____	Middle Initial: _____
TA Application Submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No Which County? _____ ARES Request Done? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medicaid Managed Care Application Submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender		Have you ever been in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth: _____	SSN: _____	Your Phone # where you can be reached now and after discharge (if inpatient): _____ May We Leave a Message: <input type="checkbox"/> Yes <input type="checkbox"/> No
Current address: _____	City: _____	Zip Code: _____
1. Please check your housing situation at the time of this application:		
<input type="checkbox"/> Homeless <input type="checkbox"/> Living in Shelter	<input type="checkbox"/> Private Residence <input type="checkbox"/> Other OASAS/OMH Residence <input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Hospital/Inpatient (please ensure contact number is on this referral to assist with contacting you after discharge) <input type="checkbox"/> Other (describe): _____
2. Do you inject non-prescribed drugs using a needle/syringe? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. For women: Are you pregnant at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Medical Problems:		
5. Mental Health (past 6 months): Suicidal Ideations <input type="checkbox"/> Yes <input type="checkbox"/> No Homicidal Ideations <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Current Legal involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____		
CURRENT SERVICE PROVIDER INFORMATION Please provide the information below for the service(s) you presently receive		
Inpatient:		Phone: _____
Counselor Name: _____		Fax: _____
Stabilization:		Phone: _____
Counselor Name: _____		Fax: _____
Rehabilitation:		Phone: _____
Counselor Name: _____		Fax: _____
Outpatient Substance Use Treatment:		Phone: _____
Counselor Name: _____		Fax: _____
Inpatient Mental Health Agency:		Phone: _____
Counselor Name: _____		Fax: _____
Outpatient Mental Health Agency:		Phone: _____
Counselor Name: _____		Fax: _____
Care Management Agency:		Phone: _____
Case Manager Name: _____		Fax: _____
Primary Care Physician:		Phone: _____
Address: _____		Fax: _____

PLEASE ATTACH THE FOLLOWING OR HAVE YOUR MOST CURRENT PROVIDER SEND THIS INFORMATION

ATTACHED

- 1. Most recent **psychosocial/evaluation** for substance use and mental health disorders with DSM diagnoses Yes No
- 2. Most recent **history and physical ***** Yes No
- 3. Most recent laboratory results including **complete blood count and differential, routine and microscopic urinalysis, urine screen for drugs ***** Yes No
- 4. Most recent TB (Tuberculosis) screening (**PPD or Chest X-Ray**) *** Yes No
- 5. **Consent for Release of Information** Between Current Service Provider and Residential Provider Yes No
- 6. Copy of **LOCADTR** indicating residential level of care needed for accurate Waiting List placement and ARES approval Yes No

***PLEASE NOTE-The referring outpatient/inpatient therapist must make the request for residential services in ARES when the person is pending/receiving DHS temporary assistance*
If you have not had a history and physical, the required lab work, and/or TB screening done within the past 12 months, please schedule them immediately.**

PLEASE ANSWER YES OR NO THE FOLLOWING STATEMENTS

- 1. I need services for my substance use disorder. Yes No
- 2. I believe that I am free of any communicable (infectious) disease that can be spread by ordinary contact. Yes No
- 3. I believe that I need acute hospital care right now. Yes No
- 4. I have thoughts of hurting others or myself at this time. Yes No
- 5. I am experiencing serious withdrawal symptoms at this time. Yes No
- 6. I have experienced withdrawal seizures or "DT's" in the past. Yes No

RENT/PAYMENT

Wages/Other Income

Please provide monthly income including a pay stub. Monthly income: \$

Please check source of income: Family Wages Unemployment Pension Trust Fund

If you do not have any wages/SSI/SSD or other income, please apply for TA/cash assistance immediately.

DHS Funding-Temporary Assistance/Medicaid

I applied for full cash assistance on:

DHS Case #: **BA** Medicaid #

Status of DHS case:

Phone #:

If you are not approved for DHS cash assistance you will remain responsible for the rent.

SSI/SSD

Please check the type of social security you are receiving: SSI SSDI

Please provide monthly SSI/SSDI income. Monthly SSI/SSDI income: \$

If you have a **Rep Payee**, please provide the name and phone number below:

NAME:

AGENCY:

PHONE:

DESCRIPTION OF RESIDENTIAL SERVICES FOR WHICH YOU ARE APPLYING

Stabilization (Intensive Residential): I would benefit from 24-hour supervised setting to successfully maintain abstinence, participate in treatment, and achieve lasting recovery in a more independent setting. Services provided within the facility include medical and psychiatric care, nursing services, vocational services and clinical groups.

Rehabilitation (Intensive Residential): I am not experiencing cravings or withdrawal symptoms. If applicable my physical and mental health are stable. Services provided include support with emotional regulation, interpersonal skills and social role functioning.

Community Re-Integration (Community Residence): I am living in an environment not conducive to recovery and need a 24-hour supervised setting and/or other support services such as engagement in outpatient treatment services, vocational or educational services, medication management, and a structured environment.

Community Re-Integration (Supportive Living): I require residential support that provides a substance free environment; I require peer support to maintain abstinence; I don't require 24-hour on-site supervision; I exhibit the skills to maintain abstinence and readapt to independent living as evidenced by engagement in recovery related services including outpatient continuing care, attendance at self-help or community related supports, engagement in volunteer and or work related activities.

When referring to a residential setting please consider the following placement questions:

_____ What level of care does the LOCADTR 3.0 indicate?

_____ Does the person have serious psychiatric or medical symptoms that would require 24-hour psychiatric or medical oversight? Is the person using substances with risk of medical complications from withdrawal or risk of Overdose?

_____ Does the person have the ability to tolerate group living? Does the person have any interpersonal or personal skills deficits that would cause disruption or harm in a congregate setting? Does the individual have a history of physical violence, aggression or exhibit predatory behavior?

When referring to a residential setting please refer to Level of Care indicated on LOCADTR.

- Catholic Family Center**
- Stabilization** Freedom House (male) Intake Coordinator, John Barbaro (585) 546-7220, ext. 5030, Fax (585) 423-2201
- 2201 Stabilization** Liberty manor (female) Intake Coordinator, Emily Price (585) 546-7220, ext. 5053, Fax (585) 423-2201
- 2201 Rehabilitation** Freedom House (male) Intake Coordinator, John Barbaro (585) 546-7220, ext. 5030, Fax (585) 423-2201
- Stabilization** Liberty manor (female) Intake Coordinator, Emily Price (585) 546-7220, ext. 5053, Fax (585) 423-2201
- Community Residence** Alexander & Jones (male) Intake Coordinator, John Barbaro (585) 546-7220, ext. 5030, Fax (585) 423-2201
- Community Residence** Barrington (female) Intake Coordinator, Emily Price (585) 546-7220, ext. 5053, Fax (585) 423-2201
- Supportive Living** Intake Coordinator, John Barbaro (585) 546-7220, ext. 5030, Fax (585) 423-2201

- East House**
- Community Residence** Jocelyn Dixon, Admissions (585) 238-4810
Fax (585) 238-8998, j.dixon@easthouse.org
- Supportive Living (men, women, family with children):** Jocelyn Dixon, Admissions (585) 238-4810
Fax (585) 238-8998, j.dixon@easthouse.org

- Pathway Houses of Helio Health, Inc.**
- Supportive Living** Deanna Cappon, Team Leader, 1350 University Ave. Phone: (585) 232-4674
Fax: (585) 325-5001 website: pwhouses.org e-mail dcappon@helio.health

- Rochester Regional**
- Young Men's Community Residence (serving male youth):** Anna Kennedy, Admissions Coordinator.
Phone (585) 723-7959, Fax (585) 723-7353
- Women's Community Residence Barbara Wolk Schwarz (serving women only):** Intake Coordinator,
Phone (585) 723-7717, Fax (585) 723-7358

- Villa of Hope Young Men's Community Residence (serving male youth):** Lynsay Diaz
Phone (585) 328-0834, Fax (585) 436-0103 cdclinic@villaofhope.org

- YWCA**
- Supportive Living (women alone OR with children):** Amy Wells,
Phone (585) 368-2225, Fax (585) 232-3540 awells@ywcarochester.org

Veteran's Outreach Center

Supportive Living (male veterans only): 290 South Avenue, Rochester NY 14620, Alec Andrest Alec.Andrest@vocroc.org Phone (585) 506-9060, Fax : (585) 506-9063

If being completed with the assistance of another individual, please complete:

Name of Agency person
Assisting with application:

Agency:

Phone:

Date:

Signature of Applicant (person seeking residential service):

Date: