Residential Services Application

CASA

TRINITY

Hope begins, here.

Hornell Inpatient Rehab
7309 Seneca Road N
Suite 121
Hornell, NY 14843

Phone: 607-282-5200
Fax: 585-335-5061
Please fax completed application & needed information to the number above

Wellness Center
Residential 820
45 Maple St
Dansville, NY 14437

Phone: 585-335-5052
Fax: 585-335-5061
Please fax completed application & needed information to the number above

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

Phone: 716-373-4303 ext. 401
Fax: 716-790-8496
Please fax completed application & needed information to the number above

Hawthorn House Community Residence
PO Box 229
Weston Mills, NY 14760

Phone: 716-373-4303 ext. 401
Fax: 716-790-8496
Please fax completed application & needed information to the number above

Willow House
Residential 820
PO Box 210
Weston Mills, NY 14760

Phone: 716-373-4303 ext. 401
Fax: 716-790-8496
Please fax completed application & needed information to the number above

DESCRIPTION OF RESIDENTIAL SERVICES FOR WHICH YOU ARE APPLYING

Inpatient Rehabilitation): Inpatient programs provide a safe and supportive setting for the evaluation, treatment, and rehabilitation of people with substance use disorders. These facilities offer 24-hour, 7-day a-week care that is always supervised by a medical professional. Inpatient services include intensive management of symptoms related to addiction and monitoring of the physical and mental complications resulting from substance use.

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.

Application for Admission to CASA-Trinity Residential Services

☐Hornell Inpatient ☐Wellness Center ☐Willow House

☐Hawthorn House ☐Supportive Living

Please refer to our residential program details on our website at www.casa-trinity.org

The following MUST be sent with pages 4-7 of this application:

☐**Most recent physical examination, with medication list.**
☐**Complete blood count with differential.**
☐**Routine and microscopic urinalysis.**
☐**Most recent urine toxicology.**
☐**PPD Results or Chest X-Ray.**
☐ **Signed releases for home county DSS & referral source.**
☐**Level of Care Determination (LOCADTR) if Available.**
☐**Psychosocial Assessment if Available.**

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 CASA-Trinity residential program MUST bring a 30-day supply of all medications with them at admission or have prescriptions sent to Parkview Health Services in Buffalo, NY.

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: ____________________

☐Out of County Approval Obtained (If Required)

☐SSI

☐SSD

☐Unemployment

☐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**	

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: A minimum of one month supply of current medications or a prescription for a one-month supply sent to Parkview Health Services in Buffalo, NY.

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 four 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 with Extension and Email

Patient Questionnaire (to be completed by prospective patient)

Name: ____

Do you require assistance with bathing, feeding, or clothing yourself?	☐YES	☐NO
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 or mobility issues?	☐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 currently?	☐YES	☐NO

PLEASE REVIEW BEFORE PACKING

PERSONAL ITEMS:

_____ Bring enough clothes for 1 week (there is a washer and dryer for you to use)

_____ Residents may bring sweatpants, sweatshirts, and closed shoes/sneakers for exercise

_____ Please bring shower shoes, for sanitary purposes

_____ Journals and Notebooks are acceptable

_____ Treatment related reading material is acceptable

_____ Paper, envelopes, and stamps are not necessary to bring, we will provide these for you

ACCEPTABLE PERSONAL ITEMS (ALCOHOL FREE ITEMS).

Soap/Body Wash	Dental Adhesive	Contact Solution
Deodorant (non-aerosol)	Shampoo/Conditioner	Gum
Toothbrush/Paste	Hairbrush/Comb	Feminine Hygiene Products
Face Cream/Lotion	Dental Floss	Nail Clippers
Make-up	Tweezers	Curling Iron/Flat Iron
Eyelash Curler		

UNACCEPTABLE PERSONAL ITEMS (DO NOT BRING TO TREATMENT):

Any Aerosol Items	Towels, Linens, Stuffed Animals	Picture Frames
Heating Pads	Hair Clippers	I-Pods/Pads/Tablets
Tobacco Products	Nail Polish Remover	Televisions
Computers/Laptops	Head Coverings/Bandanas	

If you have any questions about what to bring, please call the appropriate program # below.

Hornell Inpatient	607.282.5200
Wellness Center	585.335.5052
Hawthorn House (formerly Westons Manor)	716.373.0057
Willow House	716.373.0021
Supportive Living (Olean apartments)	716.373.4303

REVISED 3/25/2022