

Residential Services Application

CASA



TRINITY

Hope begins, here.

Hornell Inpatient Rehab

7309 Seneca Road N
Suite 121
Hornell, NY 14843

Phone: 607-282-5200 Option 1
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 x5403
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: 585-335-5052 x5403
Fax: 585-335-5061

Please fax completed application & needed information to the number above

Hawthorn House Community Residence

PO Box 229
1351 Olean Portville Rd
Weston Mills, NY 14788

Phone: 585-335-5052 x5403
Fax: 585-335-5061

Please fax completed application & needed information to the number above

Willow House Residential 820

PO Box 210
1355 Olean Portville Rd
Weston Mills, NY 14788

Phone: 585-335-5052 x5403
Fax: 585-335-5061

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:

<input type="checkbox"/> Most recent physical examination, with medication list.
<input type="checkbox"/> Complete blood count with differential.
<input type="checkbox"/> Routine and microscopic urinalysis.
<input type="checkbox"/> Most recent urine toxicology.
<input type="checkbox"/> PPD Results or Chest X-Ray.
<input type="checkbox"/> Approval Letter for Public Assistance.
<input type="checkbox"/> Level of Care Determination (LOCADTR) if Available.
<input type="checkbox"/> 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: _____

Expected Discharge: _____

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: _____

Able to self-administer medications if necessary? YES NO

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

Are you able to self-administer medications if necessary? 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