Residential Services Application

CASA TRINITY

Hope begins, here.

Hornell Inpatient Rehab
7309 Seneca Road N
Suite 121
Hornell, NY 14843
P: 607-282-5200 Option 1
F: 585-335-5061
E: intake@casa-trinity.org
Please fax or email completed application using the information above.

Wellness Center
820 Stabilization/Rehabilitation
45 Maple St
Dansville, NY 14437
P: 585-335-5052 Option 2
F: 585-335-5061
E: intake@casa-trinity.org
Please fax or email completed application using the information above.

Wendy House & Avon House
Supportive Living
201 S. Union St.
PO Box 567
Olean, NY 14760
P: 585-335-5052 Option 2
F: 585-335-5061
E: intake@casa-trinity.org
Please fax or email completed application using the information above.

Weston's Manor
820 Reintegration
PO Box 229
1351 Olean Portville Rd
Weston Mills, NY 14788
P: 585-335-5052 Option 2
F: 585-335-5061
E: intake@casa-trinity.org
Please fax or email completed application using the information above.

Willow House
820 Stabilization/Rehabilitation
PO Box 210
1355 Olean Portville Rd
Weston Mills, NY 14788
P: 585-335-5052 Option 2
F: 585-335-5061
E: intake@casa-trinity.org
Please fax or email completed application using the information 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.

Reintegration (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.

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

☐ Weston's Manor ☐ 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.**
☐ **Approval Letter for Public Assistance.**
☐ **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 Amherst, NY.

Part 1- To be completed by referring agency

Referring Agency**:** _____

Expected Discharge: _____

Demographic:

Applicant Name: _____ _____
First Last

SS#: _____ DOB: _____ Sex**:** _____

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
Are you able to go up and down stairs throughout the day?	☐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 Option 1
Wellness Center	585.335.5052 Option 2
Weston's Manor	585.335.5052 Option 2
Willow House	585.335.5052 Option 2
Supportive Living (Olean apartments)	585.335.5052 Option 2

REVISED 11/02/2023.