# Residential Services Application

CASA TRINITY

*Hope begins, here.*

**Hornell Inpatient Rehab (Co-Ed)**
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 (Co-Ed)**
**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 (F)/Avon House (M)**
**820 Reintegration Scatter Site**
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 Manor (M)**
**820 Reintegration Congregate Care**
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 (Co-Ed)**
**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 (Congregate Care)**: 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.

**Reintegration (Scatter Site)**: 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 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 Manor ☐ Wendy House/Avon House

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

**Please include the following items with this application:**

| |
|---|
| ☐ **History & Physical with a current active medication list including dose and frequency.** |
| ☐ **Negative PPD, Chest X-Ray, or Equivalent.** |
| ☐ **CBC with Differential** |
| ☐ **Routine and Microscopic Urinalysis.** |
| ☐ **Most recent Urine Drug Screen.** |
| ☐ **Completed Medication Self Administration Evaluation. (Weston Manor, Wendy House, Avon House)** |
| ☐ **Approval Letter for Public Assistance.** |
| ☐ **Completed sliding scale application if receiving SSI/SSD or other income.** |
| ☐ **Level of Care Determination (LOCADTR) if Available.** |
| ☐ **Psychosocial Assessment if Available.** |

***Failure to submit above information with the completed application may result in delay of review by the treatment team.***

**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.**

Date of referral: _____
Referring Agency**:** _____
Expected Discharge: _____

**Demographic:**
Applicant Name: _____ _____
First Last
SS#: _____ DOB: _____ Sex**:** _____

Address: _____ Phone: _____
_____

Preferred language: _____

**Source of Income:** Please attach proof of income.
☐ Public Assistance (DSS Award Letter) County: _____
☐ SSI
☐ SSD
☐ Unemployment
☐ Wages
☐ Other: _____

**Insurance:**
☐ Primary Insurance and Member ID: _____
☐ Secondary Insurance and Member ID: _____

**Priority:**
☐ Pregnant
☐ IV User
☐ Homeless
☐ Children are at risk of being placed in foster care.
☐ Overdose in the last 30 days.
☐ Released from incarceration in the last 30 days.

| SUBSTANCE | LAST USE | AMOUNT | FREQUENCY | NOTES |
|---|---|---|---|---|
| Nicotine | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

☐Currently experiencing withdrawal symptoms. Describe: _____
☐History of withdrawal seizures. Date of last seizure: _____
☐History of blackouts.
☐History of Delirium Tremens/DTS
☐History of hallucinations during withdrawal.

**Mental Health:**
Are you currently receiving treatment from a mental health provider? ☐YES☐NO
Mental Health Diagnoses: _____

☐History of Auditory/Visual hallucinations. Date of last hallucination: _____
☐My hallucinations command me to harm myself or others.
☐History of psychiatric hospitalization. Date of last admission and reason: _____
☐Current feelings of helplessness or hopelessness.
☐History of thoughts about harming myself or others.
☐I am currently having thoughts of harming myself or others.
☐I have a plan for how I am going to harm myself or others. Describe: _____
☐I intend to follow through with my plan.
☐History of suicide attempts. Date of last attempt: _____
☐History of self-harm/mutilation (cutting, burning, etc.) Date of last occurrence: _____

**Medical:**

Medication Allergies: _____
Food Allergies: _____
Dietary Restrictions: _____

Medical diagnoses:
_____
_____

☐I am an insulin dependent diabetic. **(MUST BRING INSULIN AND SUPPLIES TO ADMISSION APPOINTMENT)**
☐I have had a positive PPD in the past. Date and location of last chest x-ray: _____
☐I have been diagnosed with an active Hepatitis or Syphilis Infection. Being treated: ☐YES ☐NO
☐I use CPAP/BiPAP, suction, nebulizer, or supplemental oxygen.
☐I am currently on dialysis.
☐I require assistance with bathing, feeding, toileting, or clothing myself.
☐I am incontinent with bladder or bowels. I can self-manage: ☐YES ☐NO
☐I have an ostomy. I can self-manage: ☐YES ☐NO
☐I have a PEG tube/Feeding Tube/Trach. I can self-manage: ☐YES ☐NO
☐I have difficulties with going up and down stairs throughout the day.
☐I use a mobility device such as a cane, walker, wheelchair, or crutches.
☐I have an eating disorder. Describe: _____
☐I require assistance with taking my medications.

| MEDICATION | DOSE | FREQUENCY |
|---|---|---|
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☐ I am currently prescribed methadone for a substance use disorder.
My home clinic is: _____

****Our medical providers reserve the right to STOP, START, or CHANGE medications based on medical necessity. ****

**Legal/Mandate:**
☐ Probation/Parole:
County/State: _____
Officer: _____

☐ I am Mandated to treatment. (Please include court order if available.)
☐ I am currently involved in treatment court. Court: _____
☐ I am a registered sex offender. Level: _____
☐ I have been convicted of arson.
☐ I have been convicted of a violent offense. Charge: _____

**STAFF NAME, SIGNATURE, AND CONTACT INFORMATION**

_____
Staff Name (please print)

_____ _____
Staff Signature Date

_____
Phone Number with Extension and Email

# Appendix: XII

**Resident Evaluation of**
**Self-Administration of Medications**

**Resident name:** _____ **Date of evaluation:** _____ **Program:** _____

**Initial evaluation**: ❑ Yes
❑ No, Date of last evaluation/ Explain: _____

**Instructions for Rating Scale**: For each medication a resident should score a 6. Items listed in red: Dose, Untoward Affect and Administration may pose danger to resident and should be addressed immediately. Action taken should be documented.

---

**1** **Medication Name:** _____ **Time:** **Purpose:** _____ **Observations & Comments:**

❑ **Correctly named/identified** **(1)** ❑ **Correct** ❑ **Understands purpose (1)**
❑ **Not Correctly named/identified** **(0)** ❑ **Not Correct** ❑ **Does not understands purpose (0)**

**Dose:**
❑ Knows correct dose (1)
❑ Does not know correct dose (0)

**Untoward Affect**
❑ Can state (1)
❑ Cannot state (0)

**Administration:**
❑Demonstrates correct procedure (1)
❑Does not demonstrates correct procedure (0)

**Rate:**

---

**2** **Medication Name:** _____ **Time:** **Purpose:** _____ **Observations & Comments:**

❑ **Correctly named/identified** **(1)** ❑ **Correct** ❑ **Understands purpose (1)**
❑ **Not Correctly named/identified** **(0)** ❑ **Not Correct** ❑ **Does not understands purpose (0)**

**Dose:**
❑ Knows correct dose (1)
❑ Does not know correct dose (0)

**Untoward Affect**
❑ Can state (1)
❑ Cannot state (0)

**Administration:**
❑Demonstrates correct procedure (1)
❑Does not demonstrates correct procedure (0)

**Rate:**

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**3** **Medication Name:** _____ **Time:** **Purpose:** _____ **Observations & Comments:**

❑ **Correctly named/identified** **(1)** ❑ **Correct** ❑ **Understands purpose (1)**
❑ **Not Correctly named/identified** **(0)** ❑ **Not Correct** ❑ **Does not understands purpose (0)**

**Dose:**
❑ Knows correct dose (1)
❑ Does not know correct dose (0)

**Untoward Affect**
❑ Can state (1)
❑ Cannot state (0)

**Administration:**
❑Demonstrates correct procedure (1)
❑Does not demonstrates correct procedure (0)

**Rate:**

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**4** **Medication Name:** _____ **Time:** **Purpose:** _____ **Observations & Comments:**

❑ **Correctly named/identified** **(1)** ❑ **Correct** ❑ **Understands purpose (1)**
❑ **Not Correctly named/identified** **(0)** ❑ **Not Correct** ❑ **Does not understands purpose (0)**

**Dose:**
❑ Knows correct dose (1)
❑ Does not know correct dose (0)

**Untoward Affect**
❑ Can state (1)
❑ Cannot state (0)

**Administration:**
❑Demonstrates correct procedure (1)
❑Does not demonstrates correct procedure (0)

**Rate:**

**5** **Medication Name:** _____ **Time:** **Purpose:** _____ **Observations & Comments:**

❑ **Correctly named/identified** **(1)** ❑ **Correct** ❑ **Understands purpose (1)**
❑ **Not Correctly named/identified** **(0)** ❑ **Not Correct** ❑ **Does not understands purpose (0)**

**Dose:**
❑ Knows correct dose (1)
❑ Does not know correct dose (0)

**Untoward Affect**
❑ Can state (1)
❑ Cannot state (0)

**Administration:**
❑Demonstrates correct procedure (1)
❑Does not demonstrates correct procedure (0)

**Rate:**

**6** **Medication Name:** _____ **Time:** **Purpose:** _____ **Observations & Comments:**

❑ **Correctly named/identified** **(1)** ❑ **Correct** ❑ **Understands purpose (1)**
❑ **Not Correctly named/identified** **(0)** ❑ **Not Correct** ❑ **Does not understands purpose (0)**

**Dose:**
❑ Knows correct dose (1)
❑ Does not know correct dose (0)

**Untoward Affect**
❑ Can state (1)
❑ Cannot state (0)

**Administration:**
❑Demonstrates correct procedure (1)
❑Does not demonstrates correct procedure (0)

**Rate:**

**7** **Medication Name:** _____ **Time:** **Purpose:** _____ **Observations & Comments:**

❑ **Correctly named/identified** **(1)** ❑ **Correct** ❑ **Understands purpose (1)**
❑ **Not Correctly named/identified** **(0)** ❑ **Not Correct** ❑ **Does not understands purpose (0)**

**Dose:**
❑ Knows correct dose (1)
❑ Does not know correct dose (0)

**Untoward Affect**
❑ Can state (1)
❑ Cannot state (0)

**Administration:**
❑Demonstrates correct procedure (1)
❑Does not demonstrates correct procedure (0)

**Rate:**

**8** **Medication Name:** _____ **Time:** **Purpose:** _____ **Observations & Comments:**

❑ **Correctly named/identified** **(1)** ❑ **Correct** ❑ **Understands purpose (1)**
❑ **Not Correctly named/identified** **(0)** ❑ **Not Correct** ❑ **Does not understands purpose (0)**

**Dose:**
❑ Knows correct dose (1)
❑ Does not know correct dose (0)

**Untoward Affect**
❑ Can state (1)
❑ Cannot state (0)

**Administration:**
❑Demonstrates correct procedure (1)
❑Does not demonstrates correct procedure (0)

**Rate:**

**9** **Medication Name:** _____ **Time:** **Purpose:** _____ **Observations & Comments:**

❑ **Correctly named/identified** **(1)** ❑ **Correct** ❑ **Understands purpose (1)**
❑ **Not Correctly named/identified** **(0)** ❑ **Not Correct** ❑ **Does not understands purpose (0)**

**Dose:**
❑ Knows correct dose (1)
❑ Does not know correct dose (0)

**Untoward Affect**
❑ Can state (1)
❑ Cannot state (0)

**Administration:**
❑Demonstrates correct procedure (1)
❑Does not demonstrates correct procedure (0)

**Rate:**

**I, _____, have been educated on the medications prescribed to me by the MD overseeing my treatment.**

**Print Resident Name**

**My signature below indicates I understand my medication's name, time to be taken, purpose of taking, correct dosage, possible side effects and correct procedure for administering the medication. I have had an opportunity to ask questions and voice any concerns about my medication and how I self-administer it.**

_____ _____

**Resident Signature** **Date**

_____ _____

**Signature of Witness (Staff Name and Title)** **Date**

# SLIDING SCALE FEE PROGRAM

## APPLICATON

CASA-Trinity, Inc. provides essential services regardless of a patient's ability to pay. Our "Sliding Scale Fee Program" is based on family size and annual income. In order to qualify for a "Sliding Scale Fee Program" the client must have had previously applied for insurance and got denied or have no behavioral health benefits with their current coverage. This form must be completed to apply to the program and must be updated every 12 months and when a financial change occurs. To apply, complete this form and sign the attached Policy document. Submit both documents to CASA-Trinity Front Office staff along with required documents (3-4 current paystubs and driver's license or other form of identification), or mail signed policy and form along with copies of required documents to CASA-Trinity, Inc, Attn: Billing Department, 45 Maple Street, Dansville, NY 14437. All information is kept confidential.

| NAME OF HEAD OF HOUSEHOLD | | | PLACE OF EMPLOYMENT | |
|---|---|---|---|---|
| STREET | CITY | STATE | ZIP | PHONE |
| | | | | |

## LIST SPOUSE AND DEPENDENTS UNDER AGE 18

| NAME | DATE OF BIRTH | NAME | DATE OF BIRTH |
|---|---|---|---|
| SELF | | DEPENDENT | |
| SELF | | DEPENDENT | |
| SELF | | DEPENDENT | |
| SELF | | DEPENDEN | |

# ANNUAL HOUSEHOLD INCOME

| SOURCE | SELF | SPOUSE | OTHER | TOTAL |
|---|---|---|---|---|
| Gross wages, salaries, tips, etc. | | | | |
| Income from business, self-employment, and dependents | | | | |
| Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income | | | | |
| Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources | | | | |
| **TOTAL INCOME** | | | | |

***I certify that the family size and income information shown above is correct.***

| | |
|---|---|
| Print Name: | |
| Signature: | |
| Date: | |

## FOR OFFICE USE ONLY

Patient Name: _____
Approved Discount: _____
Billing Specialist: _____
Clinic & Clinician: _____
Clinic Supervisor: _____
Recommendation, Signature, Date: _____
Approved by (CFO):_____
Date Approved: _____

| VERIFICATION CHECKLIST | YES | NO |
|---|---|---|
| Identification/Address: Driver's License, employment ID, or other | | |
| Income: 3-4 current pay stubs | | |
| Insurance: Insurance Cards | | |