ADMISSION APPLICATION (REHABILITATION, REINTEGRATION, STEP TOWARD SUCCESS)

Instructions

Please check which element of care to which the applicant is applying.
Complete referral packages* should be faxed to 716-362-0221 or scanned and emailed to intake@cazenoviarecovery.org. Thank you.

☐ **Rehabilitation (Men):** Cazenovia Manor and Turning Point House
☐ **Rehabilitation (Women):** Madonna House
Applicants may be women, pregnant women, or women with children preschool-age or younger
☐ **Reintegration (Men):** Unity House** and Sundram Manor
**Verification of homelessness required for Unity House applicants
☐ **Reintegration (Women):** Casa Di Vita and Somerset House
☐ **Step Toward Success (Erie County):** apartments located in Buffalo and surrounding areas
☐ **Step Toward Success (Niagara County):** apartments located in Niagara Falls and Lockport
Limited beds are available for parents with children preschool-age or younger

* Complete referral packages must include a Psycho-Social Assessment and proof of income.
The following items are also helpful in the intake process, but are not required:

- Current treatment plan
- Relevant consent forms
- Medical documentation including a history, medical clearance for communicable diseases, lab work with a PPD test and verification, etc.

Referral Completed By:

Name: _____ Phone: _____

Applicant Information

Name: _____ Phone: _____
Is the applicant homeless or at risk for homelessness? ☐ Yes ☐ No If yes, please explain:

_____

Birthdate: _____ SSN: _____ County of Origin: _____
Medicaid Number: _____ Managed Care Number: _____
Managed Care Provider: _____
Sex: ☐ Male ☐ Female Gender (optional): _____
Is the applicant pregnant? ☐ Yes ☐ No If yes, please answer the following:
When is the due date? _____ Are they receiving prenatal care? ☐ Yes ☐ No

If they are receiving prenatal care, where?	
Where are they expected to deliver?	

Race / Ethnicity: ☐ Asian or Pacific Islander ☐ Black or African American
☐ Hispanic or Latinx ☐Native American or Alaskan Native
☐ White or Caucasian ☐ Multiracial or Biracial ☐Other

Substance History

Does the applicant have a substance disorder diagnosis? ☐ Yes ☐ No
If yes, please list the relevant DSM / ICD Code(s) below:

Code	Description

Primary Substance:				
Onset	Frequency	Amount	Route of Ingestion	Date of Last Use
Other Substance:				
Onset	Frequency	Amount	Route of Ingestion	Date of Last Use
Other Substance:				
Onset	Frequency	Amount	Route of Ingestion	Date of Last Use
Other Substance:				
Onset	Frequency	Amount	Route of Ingestion	Date of Last Use

Treatment History (e.g. Detox, Outpatient, Inpatient, Community Residence, etc.):

Facility Name	Type	Dates	Successful Completion
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Medical / Mental Health

The applicant has: ☐ Medical diagnoses ☐ Mental health diagnoses ☐Neither (skip to next section)

Do you have any allergies or dietary restrictions? ☐Yes ☐No If yes, please describe:

If the applicant has medical or mental health diagnoses, please explain:

Is the applicant currently receiving mental health treatment? ☐ Yes ☐ No

If yes, who is the provider?

Does the applicant have previous mental health treatment including hospitalization? ☐ Yes ☐ No

If yes, please answer the following:

Events leading to mental health treatment	Program	Dates / Length of Stay

Does the applicant have a history of suicide attempts? ☐ Yes ☐ No If yes, please explain:

Legal

Is the applicant mandated to this element or level of care? ☐ Yes ☐ No

If yes, by whom? | |

Please provide any legal entities with which the applicant has involvement:

Entity (Drug Court*, Probation, etc.)	Jurisdiction	Contact Person	Contact Number

Please check whether the applicant has any of the following:

☐ Outstanding warrants ☐ History of assault ☐ Convicted of any crimes

☐ History of incarceration ☐ History of setting fires ☐ Convicted of arson

☐ Order of protection ☐ History of rape, sexual abuse, or violent crimes

If the applicant has any of the above checked, please explain the circumstances:

** If you are a Drug Court making this referral, please include the applicant's NYS ID and a criminal justice release with the completed application.*

Financial (Proof of income must be submitted with the application)

Does the applicant currently receive cash assistance or public assistance? ☐ Yes ☐ No
If yes, from which county? Current monthly amount:
Does the applicant currently receive SSI / SSD benefits? ☐ Yes ☐ No If yes, please provide:
☐ Self-Payee ☐ Rep Payee Payee Name: Phone No.
Payee Address:
Current monthly income received from SSI / SSD:
Does the applicant have any other sources of income? ☐ Yes ☐ No If yes, please explain:

Please email the completed application to intake@cazenoviarecovery.org or fax it to 716-362-0221.