



Cayuga Addiction Recovery Services

Application for Admission- Residential Addiction Recovery Center

Fax or email completed application with required documentation to:

Fax: 607-387-5793 or Scan/email: admissions@carsny.org

Please call with any questions: 607-275-5678

The following items must be attached to complete the application process. The consents are attached at the end of this application.

- PSYCKES Consent
- Release of Information for CARS and the Referral Source
- Release of Information for CARS and Tompkins County DSS
- Release of Information for CARS and the Clients Emergency Contact
- Release of Information for CARS and Medicaid Managed Care or Private Insurance
- Copy of insurance card and/or Benefit cards (Medicaid, Medicare, Private Insurance)
- LOCADTR 3.0 Assessment

Please Provide When Available:

- Physical Exam
- PPD results with chest ex-ray when positive

Please be Advised:

Applications that are not completed fully, legibly, and accurately WILL delay the admission process. To process your referral please complete the application in its entirety including attachments so we may process your application as soon as possible.

Client Demographics

Full Name: _____ DOB: _____ Sex: _____
Last Name at Birth: _____ SSN: _____
County of Residence: _____ Zip Code of Residence: _____
Ethnicity/Race: _____
Emergency Contact Person (Name and Relationship): _____ Phone: _____
Are you mandated to Attend treatment? Yes _____ No _____
Copy of Court Mandate Letter Attached? Yes _____ No _____
Have you been on Public Assistance within the past 5 years?
If yes, When? _____ What county? _____

Substance Use Information

Total Number of prior treatment episodes: _____
Substance Use Diagnosis: _____

Primary Substance

Substance Used: _____ Age First Used: _____
Date of Last Use: _____ Frequency: _____
Amount per Day: _____ Route of Admission: _____

Secondary Substance

Substance Used: _____ Age First Used: _____
Date of Last Use: _____ Frequency: _____
Amount per Day: _____ Route of Admission: _____

Tertiary Substance

Substance Used: _____ Age First Used: _____
Date of Last Use: _____ Frequency: _____
Amount per Day: _____ Route of Admission: _____

Financial Information:

Insurance Provider: _____

Policy Number: _____

Medicaid ID: _____

If you do not have insurance, how will you be paying for medication while in treatment (If Applicable)?

Referral Source Information

Who Is Referring You to Treatment? _____

Address and Phone of Agency Referring You to Treatment (If Applicable):

Address: _____

Phone: _____ Fax: _____

Email: _____

Legal Information

Please check YES or NO for the following– Please add comments where applicable.

	Yes	No	Comments:
Arson:			
Perpetrator of physical/emotional/sexual abuse:			
Stalking:			
Violence:			
Pending charges:			
Legal History? (Arrests, charges, convictions, sentences)			

Do You Have A Pending Court Appearance?

Yes _____ No _____

Date of Appearance _____

County _____

Are You on Probation/Parole? Yes _____ No _____

Probation/Parole Officer Name: _____

Phone: _____

Medical Information

Please check YES or NO for the following– Please add comments where applicable.

	Yes	No	Comments
Diabetes:			Type:
Asthma:			
Eating Disorders:			
COPD:			
Heart/Cardiac:			
High Blood Pressure:			
Nicotine Use:			
Pregnant:			Due Date:
Allergies:			
Digestion Issues:			
Blood Disorders:			
Liver Disorders:			
Hepatitis C, B, A:			
HIV/AIDS:			
Menstrual Disorders:			
Emphysema:			
Hearing Loss:			
Acute or Chronic Pain:			
Mobility Issues:			<input type="checkbox"/> Wheelchair <input type="checkbox"/> Elevator <input type="checkbox"/> Respiratory Equipment
Infections:			
Scabies:			
Open Wounds:			
MRSA (history/current):			
Visual Impairments:			
Dental Issues:			
Recent Surgeries:			
Cancer History:			Current Status:

Please List Current Medications:

Have You Been Hospitalized for Medical Reasons Within the Past Year? Yes _____ No _____

If Yes, Please Explain: _____

Have You Ever Been Prescribed Medication Assisted Treatment? Yes _____ No _____

If Yes, What Medication? _____

Dates MAT Was Used: _____

Are You Currently Prescribed MAT? If Yes, What Medication? _____

Please Provide When Possible

- Physical Exam
- PPD Results with Chest X-Ray When Positive

Mental Health Information

Have You Ever Been Diagnosed with A Mental Illness? Yes _____ No _____

Mental Health Diagnosis: _____

Please check Yes or No for the following – Please add comments where applicable.

	Yes	No	Comments:
Suicidal Attempts:			
Suicidal Ideation:			
Homicidal Attempts:			
Homicidal Ideation:			
Anger/Rage:			

Have you experienced physical/emotional abuse or victimization? Yes _____ No _____

Comments: _____

Have You Been Hospitalized for Mental Illness? Yes _____ No _____

If Yes, When Was Your Last Hospitalization? _____

Referral Source Signature: _____

Date: _____

Client Name: _____

Date of Birth: _____

TO BE COMPLETED BY APPLICANT

Please provide all information requested.

What is your primary substance choice? _____

In a 12-month period have you: *(mark all that apply)*

- Taken a substance in larger amounts or over a longer period of time that you had intended
- Had persistent desire or unsuccessful efforts to cut down or control substance use
- Spent a great deal of time in activities necessary to obtain the substance, use substance, or recover from its effects
- Had cravings or strong desire to use the substance
- Had recurrent use resulting in failure to fulfill major role obligations at work, school, home
- Had continued substance use despite having persistent or recurrent social or interpersonal problems
- Given up or reduced important social, occupational, or recreational activities because of substance use
- Had recurrent substance use in situations in which it is physically hazardous
- Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
- A need for markedly increased amounts of the substance to achieve intoxication or desired effect

Define your current tolerance to the substance: _____]

- Characteristic withdrawal syndrome for the substance
- A markedly diminished effect with continued use of the same amount of substance

Define withdrawal that is specific to you:

- _____
- Use of the substance or closely related substance is taken to relieve or avoid withdrawal symptoms

Please Complete the Following Questions Related to Treatment and Discharge:

1. What would you hope to gain from treatment at CARS?

2. Do you have a safe place to live upon your completion/discharge from CARS? If yes, where? Please include county where you hope to return.

3. Upon completion/discharge from cars, will you need step-down housing arranged? (half-way house, supportive living).

**CONSENT TO RELEASE OF INFORMATION
CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT
LOCADTR ASSESSMENT**

Patient's Last Name	First	M.I.
Case Number		
Facility	Unit	
Cayuga Addiction Recovery Services	Residential Services Unit	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED:

All information necessary to complete a personalized Level of Care for Alcohol and Drug Treatment Referral "LOCADTR" assessment.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION:

I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the OASAS-Certified treatment facility identified above, and Payer / Managed Care Plan _____ of my clinical treatment including information from the OASAS Client Data System (CDS) and my Social Security Number.

I understand that the level of care determination assessment will only be shared with me, the OASAS treatment facility, and Payer / Plan identified above. Unless I have given written permission to share the information with other agencies, programs or payers.

I further understand that non-personal identifying information may be evaluated so that the effectiveness of the LOCADTR assessment tool can be evaluated.

I, the undersigned, have read the above and authorize the New York State Office of Alcoholism and Substance Abuse Services and the staff of the OASAS-certified treatment facility named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient (TRS-1)**

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

(Signature of Patient)

(Signature of Parent/Guardian)

(Print Name of Patient)

(Print Name of Parent/Guardian)

(Date)

(Date)

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

**CONSENT FOR RELEASE OF
INFORMATION CONCERNING
ALCOHOLISM/DRUG ABUSE PATIENT**

PATIENT'S LAST NAME	FIRST	M.I.
DATE OF BIRTH		CASE NO.
FACILITY Cayuga Addiction Recovery Services		UNIT Residential Services Unit

INSTRUCTIONS: GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT (Circle One)

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

Presence in treatment, Diagnosis, participation in individual and/or group therapy, treatment notes, treatment progress, treatment planning, medication records and other information relevant to ongoing treatment and discharge from treatment

PURPOSE OR NEED FOR DISCLOSURE/RELEASE ***Coordinate and facilitate the client's admission, ongoing treatment, and discharge from Intensive Residential Treatment.***

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION Between: (Referral Source) Name: Facility: Address: Phone:	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION And: Facility: Cayuga Addiction Recovery Services Address: 6621 Rt. 227, PO Box 724 Trumansburg, NY 14886 Phone 607-275-5678 Fax 607-387-5793
--	---

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 & 164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: _____

NOTE: Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

(Signature of Patient)

(Signature of Parent/Guardian, when required)

(Print Name of Patient)

(Print name of Parent/Guardian)

(Date)

(Date)

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME	FIRST	M.I.
DATE OF BIRTH		CASE NO.
FACILITY Cayuga Addiction Recovery Services		UNIT Residential Services Unit

INSTRUCTIONS: GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT (Circle One)

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED
Presence in treatment

PURPOSE OR NEED FOR DISCLOSURE/RELEASE
Coordinate payment, benefit certification, and food stamp eligibility determination.

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION
Between:

Name: Tompkins County -

Facility: Department of Social Services

Address: 320 West State St.
Ithaca, NY 14850

Phone: 607-274-5252 Fax: 607-274-5227

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION
And:

Facility: Cayuga Addiction Recovery Services

Address: 6621 Rt. 227, PO Box 724
Trumansburg, NY 14886

Phone 607-275-5678 Fax: 607-387-5793

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 & 164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. Time period, event or condition replacing period specified above:

NOTE: Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

(Signature of Patient)

(Signature of Parent/Guardian, when required)

(Print Name of Patient)

(Print name of Parent/Guardian)

(Date)

(Date)

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME	FIRST	M.I.
DATE OF BIRTH		CASE NO.
FACILITY Cayuga Addiction Recovery Services		UNIT Residential Services Unit

INSTRUCTIONS: GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT (Circle One)

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED
Diagnosis, participation in individual and/or group therapy, treatment notes, treatment progress, treatment planning, and other information relevant to ongoing treatment and discharge from treatment.

PURPOSE OR NEED FOR DISCLOSURE/RELEASE
Coordinate payment, benefit certification.

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION Between: (Insurance Provider) Name: Facility: Address: Phone: Fax:	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION And: Facility: Cayuga Addiction Recovery Services Address: 6621 Rt. 227, PO Box 724 Trumansburg, NY 14886 Phone 607-275-5678 Fax 607-387-5793
--	---

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 & 164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. Time period, event or condition replacing period specified above: _____

NOTE: Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

 (Signature of Patient)

 (Signature of Parent/Guardian, when required)

 (Print Name of Patient)

 (Print name of Parent/Guardian)

 (Date)

What to Bring to Treatment?

Please see the following list for what should and should not be brought for a stay at the Residential Addiction Recovery Center.

CARS is not responsible for lost or damaged property. Please do not bring valuables to CARS.

All clothing and some other items will be heat treated at admission.

Please Bring:

- 7-10 days of weather appropriate clothing. You will be responsible for washing your own clothing at CARS in the facility machines. Allergen free detergent is provided by CARS.
- Shower Caps/Flip Flops for showers
- Insurance/ID Cards
- MP3 Player/Headphones (if you desire). Your MP3 player must **not** have internet connectivity capabilities, recording capabilities, picture taking capabilities, storage of photo/video capabilities
- Stamps/Envelopes (if you desire)

Excessive amounts of clothing and other items will be sent at the client's expense to a home address at the time of admission.

Hygiene products:

- All hygiene products including makeup and cosmetics must arrive at admission brand new and factory sealed in the original packaging.
- After admission items are only approved if they are shipped from an online store and if they meet all guidelines (this means no drop offs of products and no packages sent from home)
- Alcohol may not be any of the first 3 ingredients in any product. Please check carefully for this.
- Mouthwash must be alcohol free
- Grooming tools may not have sharp edges or pointed edges except for personal use razors. No straightrazors
- No scissors of any kind
- No aerosol products
- No perfume, cologne or heavily scented products
- No nail polish or nail polish remover
- All products must be in reasonable amounts as space is limited

Note that the decision to allow a product or not is at staff discretion. All unapproved products will be stored in contraband until the time of discharge.

Items not Allowed:

- Any medication not in original prescription containers
- Over the counter medication
- Laundry soap and other cleaning products
- Blankets, pillows, towels, stuffed animals
- Cell phones/chargers, cameras, pagers
- Food or beverages

Items not Allowed- Continued from previous page:

- Hats are not allowed inside the building (hoods cannot be worn up)
- Nail polish, nail polish remover
- Q-tips, cotton balls
- Revealing clothing/clothing with inappropriate language, images or reference to drugs, alcohol or tobacco
- Scissors
- Weapons (or anything that may be interpreted as a weapon)
- Pornographic material
- Perfume/cologne/scented oils
- Cash
- Loose medications
- Nonprescribed medications
- Radios or music devices other than single person devices
- Any electronic device that has video or recording capabilities

Items that will be Destroyed Upon Admission:

- Cigarettes/chewing Tobacco
- Lighters/Matches
- E-Cigarettes/ E-Cigarette Batteries/any vaping materials
- Drug paraphernalia

All belongings including any stored items must be taken at the time of the successful discharge. Any items left behind will be discarded. If the discharge is unplanned or unsuccessful all belongings will be stored for 30 days. It is the responsibility of the individual to contact CARS with a plan for pick-up of the belongings. CARS is not responsible to ship belongings. You will not have access to stored items during your stay.



"Your Team for Transformation"