Application for Admission

Fax or email completed application with required documentation to:
Fax: (607) 273-1277 or Scan/email: admissions@carsny.org
Please call with any questions: Office: 607-391-1040, Cell: 607-342-1229

Date of Referral: _____
Client Name: _____
Date of Birth: _____ / _____ / _____
Mark all that apply: ☐ Pregnant ☐ History of IV Drug Use ☐ In Danger of Losing Children

- ☐ **Medical history/physical exam** *(within last 6 months)* **Date of TB test:** _____ **Results:** _____
- ☐ **Copy of clients MAR**
- ☐ **LOCADTR 3.0 Assessment (if no LOCADTR 3.0 is completed, have a LOCADTR consent signed)**
- ☐ **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)**
- ☐ **Court Mandated 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?** _____

Financial Information:

Medical Coverage:

- ☐ Medicaid MA # _____
- ☐ Health Insurance Company: _____
  Policy # _____
- ☐ Self-Pay

Referral Source Information:

Referral Name: _____ Referral Agency: _____
Address: _____
Phone #: _____ Fax #: _____ Email: _____

Client Demographics:

Client Name: _____ Last Name at Birth: _____ DOB: _____
County of Residence: _____ Zip Code of Residence: _____Ethnicity/Race: _____
SS#: _____ Gender: _____ Sexual Identity: _____ Gender on Birth Certificate: _____
Current Placement ☐ Home ☐ Jail ☐ Program ☐ Other: _____
Address: _____
Phone #:_____ Email:_____
Emergency Contact Person: _____ Phone #:_____

Substance Use Information: *(Please include alcohol and other drugs including nicotine and caffeine)*

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

Substance Used:	Age First Used:	Date of Last Use:	Frequency:	Amount per Day:	Route of Admission:
Primary:					
Secondary:					
Tertiary:					

Mental Health Treatment Information:

Mental Health Diagnosis: _____
_____
_____

Any history or current of: ***(If yes to any of the following please elaborate in the comments section)***

	YES	NO	Comments	Last Hospitalization
Suicidal ideation/attempts?				
Homicidal ideation/attempts?				
Anger Rage?				
Physical/emotional/sexual abuse or victimization?				

Medical Information:

Please check YES or NO for the following medical issues:
(If yes to any of the following please elaborate in the comments section)

	Yes	No	
Diabetes:			Type:
Asthma:			
Eating Disorders:			
COPD:			

Heart/Cardiac:			
High Blood Pressure:			
Nicotine Use:			
Pregnant:			
Allergies:			
Digestion Issues:			
Blood Disorders:			
Liver Disorders:			
Hepatitis C, B, A:			
HIV/AIDS:			
Menstrual Disorders:			
Emphysema:			
Hearing Loss:			
Acute or Chronic Pain:			
Mobility Issues:			❑Wheelchair ❑Elevator ❑Respiratory Equipment
Infections:			
Scabies:			
Open Wounds:			
MRSA (history/current):			
Visual Impairments:			
Dental Issues:			
Recent Surgeries:			
Cancer History:			Current Status:
History of Medication Assisted Treatment:			When: Medication used:

Please provide:

- ❑ Last physical health provider evaluation (from MD, PA, or NP)
- ❑ Last mental health provider evaluation

Referral Source Signature: _____ Date: _____

Legal Information:

Any history or current of: ***(If yes to any of the following please elaborate in the comments section)***

	YES	NO	COMMENTS
Arson?			
Perpetrator of physical/emotional/sexual abuse?			
Stalking?			
Violence?			
Pending charges?			
Court Appearances? (include court name & phone #)			
Legal History? (Arrests, charges, convictions, sentences)			

Probation/Parole Officer _____

Phone #: _____ Fax # _____

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 **Define your current tolerance to the substance:**
- ❑ A need for markedly increased amounts of the substance to achieve intoxication or desired effect
- ❑ A markedly diminished effect with continued use of the same amount of substance **Define withdrawal that is specific to you:**
- ❑ Characteristic withdrawal syndrome for the substance
- ❑ Use of the substance or closely related substance is taken to relieve or avoid withdrawal symptoms

How has your substance use impacted the following areas of your life:

Employment/Vocation: _____

_____

Education: _____

_____

Financial: _____

_____

Family/Relationships: _____

_____

Social Support: _____

_____

Have you been involved with the criminal justice system? ☐ **Yes** ☐ **No**

Have you violated judicial orders in the past? ☐ **Yes** ☐ **No**

Have you committed crimes while under the influence of substances? ☐ **Yes** ☐ **No**

Client Name: _____ **Date of Birth:** _____

1. Please identify 3 problem areas you hope to work on while in treatment.

2. Please identify 3 strengths you have.

3. Please identify barriers that prevent you from achieving your goals.

4. List & elaborate on areas of your life that you are dissatisfied with.

5. What do you like to do for fun? (Hobbies, sports, crafts, reading, exercising, etc.)

6. Please describe what you will need to be successful.

7. What is your plan for discharge?

8. Please see the last page of this packet for a list of items that should and should not come to CARS.

_____ _____

Client Signature **Date**

Revoked On: _____ Staff Initials: _____

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

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

Patient's Last Name	First	M.I.
Case Number		
Facility **Cayuga Addiction Recovery Services**	Unit **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 OF OPPORTUNITY. Office of Mental Health

PSYCKES Consent Form

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is an administrative database maintained by the New York State Office of Mental Health (OMH). It contains health information from the NYS Medicaid claims database, health information from the clinical records of persons who have received care from State operated psychiatric centers, and health information from other NYS health databases. This administrative data includes identifying information (such as name, date of birth), information about health services that have been paid for by Medicaid, and information about a person's health care history (such as treatment for illnesses or injuries a person has had, test results, and lists of medication a person has taken). For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

The health information in PSYCKES can help your provider provide you with good care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I give consent"** box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the **"I deny consent"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," this does not mean your provider is completely barred from accessing your medical information in any way. For example, if the Medicaid program has a quality concern about your healthcare, then under federal and state regulations your provider may be given access to your data to address the quality concern. There are also exceptions to the confidentiality laws that may permit your provider to obtain necessary information directly from another provider for treatment purposes under state and federal laws and regulations.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

- ☐ **I give consent for this provider to access all** of my electronic health information that is in PSYCKES in connection with providing me any health care services.
- ☐ **I deny consent for this provider to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

_____ _____ _____
Print Name of Patient | Date of Birth of Patient | Patient's Medicaid ID Number

_____ _____
Signature of Patient or Patient's Legal Representative | Date

_____ _____
Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Patient (if applicable)

_____ _____
Signature of Witness | Print Name of Witness

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	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION
Between: (Referral Source) **Name:** **Facility:** **Address:** **Phone: ( ) Fax: ( )**	**And:** **Facility: Cayuga Addiction Recovery Services** **Address: 6621 Rt. 227, PO Box 724** **Trumansburg, NY 14886** **Phone (607)387-6118 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)

NEW YORK STATE

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	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 Street** **Ithaca, NY 14850** **Phone: (607) 274-5252 Fax: (607)274-5227**	**And:** **Facility: Cayuga Addiction Recovery Services** **Address: 6621 Rt. 227, PO Box 724** **Trumansburg, NY 14886** **Phone (607)387-6118 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)

NEW YORK STATE

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

Status in Treatment

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

Coordinate care and/or discharge planning in case of an emergency.

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION
Between: (Emergency Contact) **Name:** **Facility:** **Address:** **Phone: ( ) Fax: ( )**	**And:** **Facility: Cayuga Addiction Recovery Services** **Address: 6621 Rt. 227, PO Box 724** **Trumansburg, NY 14886** **Phone (607)398-6118 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)

NEW YORK STATE

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	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION
Between: (Insurance Provider) **Name:** **Facility:** **Address:** **Phone: ( ) Fax: ( )**	**And:** **Facility: Cayuga Addiction Recovery Services** **Address: 6621 Rt. 227, PO Box 724** **Trumansburg, NY 14886** **Phone (607)398-6118 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)

Please adhere to 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 the 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)

Hygiene products:
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.

- All hygiene products 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
- Mouthwash must be alcohol free
- Grooming tools may not have sharp edges except for personal use razors. No straight razors
- 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

Items not Allowed:
Most items will be stored during treatment. You will not have access to stored items while in treatment. Excessive amounts of clothing and other items will be sent at the client's expense to a home address at the time of admission.

- Any medication not in original prescription containers
- Over the counter medication
- Blankets, Pillows, Towels, Stuffed Animals
- Cell Phones/Chargers, Cameras, Pagers
- Food or Beverages
- Hats are not allowed inside the building (Hoods cannot be worn up)
- Nail Polish, nail polish remover
- Revealing clothing/clothing with inappropriate language, images or reference to drugs, alcohol or tobacco

- Scissors
- Weapons (anything that may be interpreted as a weapon)
- Pornographic Material
- Perfume/Cologne/Scented Oils
- Cash
- Loose Medications
- Nonprescribed Medications

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.