Catholic Charities of Cortland County
Recovery Apartment Program Referral

Referral Source _____ Phone _____ Date _____

Contact Name _____ QHP Signature _____

CLIENT INFORMATION

Name _____ Date of Birth _____ Soc. Sec. # _____

Address _____ Phone _____

Male _____ Female _____

Emergency Contact_____ Relationship _____

Address _____Phone _____

Has the applicant been referred to us before? Yes _____ No _____
If yes, explain. When, for what services and circumstances:_____

_____

_____

Current Living Situation: _____

Client is seriously and persistently mentally ill ☐ Yes ☐ No

FINANCIAL STATUS

Client Receives: ☐ SSI ☐ SSD ☐ SSI/SSD Pending ☐ VA Benefit ☐ Wages

☐ PA - If yes, County of origin _____
Caseworker _____Caseworker Phone _____
☐ Other – Explain _____
☐ Medicaid # _____ ☐ Medicare ☐ Private Ins.: _____
☐ Current Representative Payee _____
☐ Applicant needs Representative Payee services
☐ Has the client ever been sanctioned by DSS? If yes, please explain:

_____

Current Financial Obligations

List all appropriate bills and amounts

Rent/Housing	_____	Heat	_____	Electricity	_____
Phone	_____	Other Utilities	_____	Food	_____
Child Support	_____	Alimony	_____	Fines/Restitutions	_____
Other (i.e. loans)	_____				

MEDICAL STATUS

Does applicant have any medical conditions that we should be aware of? (i.e. seizures, allergies, special diet, visual impairment, limited impairment, chronic illness, etc.)

☐ Yes ☐ No If yes, explain _____

_____

Applicant's Doctor(s) Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Is applicant capable of self- preservation in case of emergency? (Evacuating housing safely) ☐ Yes ☐ No

MENTAL HEALTH HISTORY

High Risk Alerts: Check if history of the following

☐ Suicide/Attempts	Date: _____	☐ Inappropriate Sexual Behavior	Date: _____
☐ Suicidal Threats	Date: _____	☐ Self Injurious Behaviors	Date: _____
☐ Fire Setting	Date: _____	☐ Frequent crisis requiring readmission	Date: _____
☐ Violence	Date: _____	☐ Non-compliance with Medication	Date: _____
☐ Assault	Date: _____	☐ Non-compliance with Appointments	Date: _____
☐ Medical Issues	Date: _____	☐ Substance Abuse	Date: _____
☐ Other	Date: _____		

If checked, provide brief detail: _____

_____

_____

_____

_____

SERVICE UTILIZATION

Check any services used. If checked, give dates and provider.

☐ Inpatient treatment: _____

☐ Outpatient treatment: _____

☐ OPWDD Service: _____

☐ Care Coordination: _____

☐ Other: _____

Describe past situations precipitating hospitalizations or professional interventions _____

_____

_____

HOUSING

Check if applicant has experienced. If checked, give date and location.

☐ Homelessness _____
☐ Group home/Community Residence (OMH)_____
☐ Group home/Community Residence (OASAS)_____
☐ Other Supported or Supervised Living Environment _____
☐ Independent Living, alone _____
☐ Independent Living, with others _____
☐ Supported Housing Assistance _____
☐ Section 8 Application and/or Subsidy_____
☐ Evictions? If yes, please explain:_____

VOCATIONAL

Check applicant's experience. If checked, give dates and locations.

☐ Highest Grade Level Completed_____
☐ Sheltered Workshop _____
☐ Supported Employment _____
☐ Vocational Training _____
☐ Special Education _____
☐ Competitive Employment _____
☐ GED _____
☐ College Degree_____
☐ VESID _____
☐ Other _____

CRIMINAL JUSTICE SYSTEM

Check if current or past history of the following - Provide name of Probation/Parole Officer if current.

☐ Probation _____
☐ Parole _____
☐ Conviction of a Crime
☐ Charges Pending
☐ CPL Date _____
☐

Provide Details: _____

_____

_____

FAMILY, SOCIAL & COMMUNITY SUPPORTS

Check applicant's current supports and note names when possible.

☐ Family _____

☐ Friends _____

☐ Religious _____

☐ Support Groups _____

☐ Care Coordinator_____

COMMUNITY LIVING/NEEDS

Check needed Services.

☐ Outpatient Treatment	☐ Transportation	☐ Connection to a Psychiatrist
☐ Psychosocial Rehab	☐ Family Support	☐ Case Management
☐ General Health Care	☐ Financial Guidance	☐ Friends or Social Needs
☐ Housing (OMH)	☐ Other	

_____

_____

CLINICAL ASSESSMENT

	ICD 10 Codes	Diagnosis
Primary	_____	_____
Secondary	_____	_____

Note any recommendations, or focus of treatment, and why this level of care may be appropriate?

_____
_____
_____
_____

MEDICATIONS

List all medications used or attach a copy of a current medication list.

Medication	Dosage	Prescribing MD

Is client capable of self-administration of medications? ☐ Yes ☐ No

What does the individual think about living in this residential setting?

_____

What are the strengths (skills/personal resources that can be used in this residential setting?

_____

Are there any areas which might be challenging (i.e., expectations, responsibilities, staff supervision, living with others?)_____

Is the individual willing to share a bedroom? Ever shared a bedroom before? _____

PLEASE SEND REFERRALS VIA ONE OF THE FOLLOWING METHODS:

By Mail: Catholic Charities
33-35 Central Avenue
Cortland, New York 13045
ATTN: Recovery Apartment Program

By e-mail: info@ccocc.org

By Fax: (607) 756-7214

CONFIDENTIAL INFORMATION CONSENT
Today's Date: _____

I, _____, do hereby consent to and authorize the Recovery Apartment Program of Cortland, New York, to obtain from and/or release to:

Cortland County Probation Department (Representative):
Cortland County Court House, Cortland, New York, 13045; (607)753-5091

Family Counseling Services of Cortland County, Inc. (Representative):
10 North Main Street, Cortland, New York, 13045; (607)753-0234

Beacon Center (Representative):
20 Crawford Street, Cortland, New York, 13045; (607)428-5601

Syracuse Recovery Services of Cortland, Incorporated (Representative):
17 Main Street, Suite 411, Cortland, New York, 13045; (607)756-4167

Adult Drug Treatment Court (Representative):
Courtland County Court House, Cortland, New York, 13045; (607)428-5432

Cortland City Police Department (Representative):
25 Court Street, Cortland, New York, 13045; (607)756-2811

Cortland County Mental Health Department (Representative):
7 Clayton Avenue, Cortland, New York, 13045; (607)758-6100

Cortland Regional Medical Center (Representative):
134 Homer Avenue, Cortland, New York, 13045; (607)756-3500

Cortland County Department of Social Services (Representative):
60 Central Avenue, Cortland, New York, 13045; (607)753-5323

Cortland County Jail (Representative):
54 Greenbush Street, Cortland, New York, 13045; (607)756-4275

The following information pertaining to *MYSELF*:

Obtain	Release	
☒	☒	Presence in treatment (including admission and discharge dates)
☒	☒	Medical history and physical examination
☒	☒	Diagnoses and brief description of prognosis
☒	☒	Discharge summary and continuing care program
☒	☒	Educational records including achievements and assessments/testing
☒	☒	Case Management/Care Coordination history/assessments
☒	☒	Health records
☒	☒	Department of Social Services records; Benefits pending/received
☒	☒	Treatment Plans

This information is needed for the following purposes:

- ☒ To provide ongoing treatment/continuing care
- ☐ To provide educational services
- ☐ To coordinate educational planning and workforce re-entry programs with Department of Social Services and/or employment agencies.
- ☐ To enable judges, attorneys, probations/parole officers to support treatment goals or make legal decisions on my behalf.
- ☐ To have person(s) to contact in the event of an emergency
- ☐ To allow person(s) listed to visit the resident named above
- ☐ To verify volunteer/community service workplace and hours of attendance
- ☒ Admission Committee Review/Case conference clients as needed

I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for the purposes specified above.

The duration of this authorization is one (1) year from the above date/date signed, unless I specify a date, event or condition upon which it will expire sooner.

I understand that I may revoke this consent at any time by notifying the Program Supervisor in writing, except to the extent that action has already been taken with my consent.

Resident/Applicant Signature _____ Date _____

Witness Signature_____ Date _____

Specify date, event and/or condition upon which it will expire sooner than one (1) year, if applicable:

_____

CONFIDENTIAL INFORMATION CONSENT

Today's Date: _____

I, _____, do hereby consent to and authorize the Recovery Apartment Program of Cortland, New York, to obtain from and/or release to:

_____**County Department of Social Services**

Name of Person/Facility/Organization: _____

Address/City/State/Telephone: _____

The following information pertaining to *MYSELF*:

Obtain	Release	
☒	☒	Presence in treatment (including admission and discharge dates)
☒	☒	Medical history and physical examination
☒	☒	Diagnoses and brief description of prognosis
☒	☒	Discharge summary and continuing care plan
☒	☒	Educational records including achievements and assessments/testing
☒	☒	Case management/care coordination history/assessments
☒	☒	Health Records
☒	☒	Department of Social Services records; benefits pending/received
☒	☒	Treatment plan
☒	☒	**Re-disclosure** of Discharge/Aftercare plan supporting referral to the Recovery Apartment Program from _____

This information is needed for the following purposes:

☒ To provide ongoing treatment/continuing care

☐ To provide educational services

☐ To coordinate treatment efforts with my family/concerned persons

☒ To coordinate educational planning and work force re-entry programs with Department of Social Services and/or employment agencies

☒ To obtain insurance, employment, and government benefits

☐ To enable judges, attorneys, probation/parole officers to support treatment goals or make Legal decisions on my behalf

☐ To have person(s) to contact in the event of an emergency

☐ To verify volunteer/community service workplace and house of attendance

I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for the purposes specified above.

The duration of this authorization is one (1) year from the above date/date signed, unless I specify a date, event or condition upon which it will expire sooner.

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Resident/Applicant Signature _____ Date _____

Witness Signature_____ Date _____

Specify date, event and/or condition upon which it will expire sooner than one (1) year, if applicable:

_____

CONFIDENTIAL INFORMATION CONSENT

Today's Date: _____

I, _____, do hereby consent to and authorize the Recovery Apartment Program of Cortland, New York, to obtain from and/or release to:

Precision Care
243 Main Street, Suite 270, New Paltz, NewYork 12561; (877) 429-5511

The following information pertaining to *MYSELF*:

Obtain	Release	
☒	☒	Presence in treatment (including admission and discharge dates)
☒	☒	Medical history and physical examination
☒	☒	Diagnoses and brief description of prognosis
☒	☒	Discharge Summary and Continuing Care Program
☒	☒	Educational records including achievements and assessments/testing
☒	☒	Case Management/care coordination history/assessments
☒	☒	Health Records
☒	☒	Department of Social Services records; benefits pending/received
☒	☒	Treatment Plans
☒	☒	Other: To allow usage of /access to Precision Care System for client records

This information is needed for the following purposes:

☐ To provide ongoing treatment/continuing care
☐ To provide educational services
☐ To coordinate treatment efforts with my family/ concerned persons
☐ To coordinate educational planning and work-force re-entry programs with Department of Social Services and/or employment agencies.
☐ To obtain insurance, employment, and government benefits
☐ To enable judges, attorneys, probations/parole officers to support treatment goals or make legal decisions on my behalf
☐ To have person(s) to contact in the event of an emergency
☐ To verify volunteer/community service workplace and hours of attendance
☐ To coordinate Apartment Program and Outpatient Clinic Services
☒ Other: To allow usage of/ access to Precision Care Computing Systems for client records

I understand that I need not consent to the release of information in order to obtain services. I choose to do so willingly and voluntarily for the purposes specified above.

The duration of this authorization is one (1) year from the above date/date signed, unless I specify a date, event or condition upon which it will expire sooner.

I understand that I may revoke this consent at any time by notifying the Program Supervisor in writing, except to the extent that action has already been taken with my consent.

Resident/Applicant Signature _____ Date _____

Witness Signature_____ Date _____

Specify date, event and/or condition upon which it will expire sooner than one (1) year, if applicable:

_____