APPLICATION FOR MONROE COUNTY OASAS RESIDENTIAL SERVICES

UPDATED 1/18/2023 **APPLICANT INFORMATION**

Last Name: (Maiden)	First Name:	Middle Initial:

TA Application Submitted? ☐Yes ☐No **Which County?** _____ **ARES Request Done?** ☐Yes ☐No

Medicaid Managed Care Application Submitted? ☐Yes ☐No **Date** _____

Gender: ☐Male ☐Female ☐Transgender Have you ever been in the military? ☐Yes ☐No

Date of birth:	SSN:	Your Phone # where you can be reached now and after discharge (if inpatient): May We Leave a Message: ☐Yes ☐No

Current address:	City:	Zip Code:

1. Please check your housing situation at the time of this application:

☐Homeless ☐Living in Shelter	☐Private Residence ☐Other OASAS/OMH Residence ☐Correctional Facility	☐Hospital/Inpatient (please ensure contact number is on this referral to assist with contacting you after discharge) ☐Other (describe):

2. Do you inject non-prescribed drugs using a needle/syringe? ☐Yes ☐No

3. For women: Are you pregnant at this time? ☐Yes ☐No

4. Medical Problems:

5. Mental Health (past 6 months): Suicidal Ideations ☐Yes ☐No **Homicidal Ideations** ☐Yes ☐No

6. Current Legal involvement? ☐Yes ☐No **Describe:**

CURRENT SERVICE PROVIDER INFORMATION

Please provide the information below for the service(s) you presently receive

Inpatient:	Phone:
Counselor Name:	Fax:
Stabilization:	Phone:
Counselor Name:	Fax:
Rehabilitation:	Phone:
Counselor Name:	Fax:
Outpatient Substance Use Treatment:	Phone:
Counselor Name:	Fax:
Inpatient Mental Health Agency:	Phone:
Counselor Name:	Fax:
Outpatient Mental Health Agency:	Phone:
Counselor Name:	Fax:
Care Management Agency:	Phone:
Case Manager Name:	Fax:
Primary Care Physician:	Phone:
Address:	Fax:

PLEASE ATTACH THE FOLLOWING OR HAVE YOUR MOST CURRENT PROVIDER SEND THIS INFORMATION

	ATTACHED
1. Most recent **psychosocial/evaluation** for substance use and mental health disorders with DSM diagnoses	☐Yes ☐No
2. Most recent **history and physical *****	☐Yes ☐No
3. Most recent laboratory results including **complete blood count and differential**, **routine and microscopic urinalysis, urine screen for drugs *****	☐Yes ☐No
4. Most recent TB (Tuberculosis) screening **(PPD or Chest X-Ray) *****	☐Yes ☐No
5. **Consent for Release of Information** Between Current Service Provider and Residential Provider	☐Yes ☐No
6. Copy of **LOCADTR** indicating residential level of care needed for accurate Waiting List placement and ARES approval	☐Yes ☐No

PLEASE NOTE-The referring outpatient/inpatient therapist must make the request for residential services in ARES when the person is pending/receiving DHS temporary assistance
*****If you have not had a history and physical, the required lab work, and/or TB screening done within the past 12 months, please schedule them immediately.*****

PLEASE ANSWER YES OR NO THE FOLLOWING STATEMENTS

1. I need services for my substance use disorder.	☐Yes ☐No
2. I believe that I am free of any communicable (infectious) disease that can be spread by ordinary contact.	☐Yes ☐No
3. I believe that I need acute hospital care right now.	☐Yes ☐No
4. I have thoughts of hurting others or myself at this time.	☐Yes ☐No
5. I am experiencing serious withdrawal symptoms at this time.	☐Yes ☐No
6. I have experienced withdrawal seizures or "DT's" in the past.	☐Yes ☐No

RENT/PAYMENT

Wages/Other Income

Please provide monthly income including a pay stub. Monthly income: $

Please check source of income: ☐Family ☐Wages ☐Unemployment ☐Pension ☐Trust Fund

If you do not have any wages/SSI/SSD or other income, please apply for TA/cash assistance immediately.

DHS Funding-Temporary Assistance/Medicaid

I applied for full cash assistance on:

DHS Case #: **BA**	Medicaid #

Status of DHS case:

Phone #:

If you are not approved for DHS cash assistance you will remain responsible for the rent.

SSI/SSD

Please check the type of social security you are receiving: ☐SSI ☐SSDI

Please provide monthly SSI/SSDI income. Monthly SSI/SSDI income: $

If you have a **Rep Payee**, please provide the name and phone number below:

NAME:

AGENCY:	PHONE:

DESCRIPTION OF RESIDENTIAL SERVICES FOR WHICH YOU ARE APPLYING

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.

Community Re-Integration (Community Residence): 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.

Community Re-Integration (Supportive Living): 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 would 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.

☐ **Catholic Family Center**

☐ **Stabilization** Freedom House (male) (585) 546-7220 ext. 5053, Fax (585) 423-2201

☐ **Stabilization** Liberty manor (female) (585) 546-7220, ext. 5053, Fax (585) 423-2201

☐ **Rehabilitation** Freedom House (male) (585) 546-7220, ext. 5053, Fax (585) 423-2201

☐ **Stabilization** Liberty manor (female) (585) 546-7220, ext. 5053, Fax (585) 423-2201

☐ **Re-Integration** Alexander & Jones (male) (585) 546-7220, ext. 5057, Fax (585) 423-2201

☐ **Re-Integration** Barrington (female) (585) 546-7220, ext. 5057, Fax (585) 423-2201

☐ **Re-Integration Scattered Site** (585) 546-7220, ext. 5057, Fax (585) 423-2201

☐ **East House**

☐ **Community Residence** Admissions (585) 238-4810, Fax (585) 238-8998, Admissions@easthouse.org

☐ **Supportive Living (men, women, family with children):** Admissions (585) 238-4810, Fax (585) 238-8998, Admissions@easthouse.org

☐ **Villa of Hope Young Men's Community Residence (serving male youth):**
Phone (585) 328-0834, Fax (585) 436-0103 cdclinic@villaofhope.org

☐ **YWCA**

☐ **Supportive Living (women alone OR with children)**: Amy Wells,
Phone (585) 368-2225, Fax (585) 232-3540 awells@ywcarochester.org

If being completed with the assistance of another individual, please complete:

Name of **Agency** person Assisting with application:	**Agency**:	Phone: Date:

Signature of Applicant (person seeking residential service):	Date: