

APPLICATION FOR MONROE COUNTY OASAS RESIDENTIAL PROGRAMS

Last Name:		First Name:		Middle Initial:
TA Application Submitted? ☐ Yes ☐ No Which County? _____ RAS Request Done? Yes No				
Medicaid Managed Care Application Submitted? ☐ Yes ☐ No Date _____				
Gender:	Male	Female	Have you ever been in the military? Yes No	
Pronoun:	He/Him	She/Her	They/Them	Your Phone # where you can be reached now and after discharge (if inpatient):
Date of birth:	SSN:		May We Leave a Text Message: ☐ Yes ☐ No	
Current address:		City:		Zip Code:
Alternate Contact Phone:			Email:	
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? ☐ No ☐ Yes Describe:				
CURRENT SERVICE PROVIDER INFORMATION Please provide the information below for the service(s) you presently receive				
Inpatient:			Phone:	
Counselor Name:			Email:	
Stabilization:			Phone:	
Counselor Name:			Email:	
Rehabilitation:			Phone:	
Counselor Name:			Email:	
Outpatient Substance Use Treatment:			Phone:	
Counselor Name:			Email:	
Inpatient Mental Health Agency:			Phone:	
Counselor Name:			Email:	
Outpatient Mental Health Agency:			Phone:	
Counselor Name:			Email:	
Care Management Agency:			Phone:	
Case Manager Name:			Email:	
Primary Care Physician:			Phone:	
Address:			Email:	

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

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| 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 RAS approval | ☐ Yes ☐ No |

***PLEASE NOTE-The referring outpatient/inpatient therapist must make the request for residential services in RAS 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.
Date physical scheduled:**

PLEASE ANSWER YES OR NO THE FOLLOWING STATEMENTS

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| 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 #
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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 Charities Family and Communities Services

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

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

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

Re-Integration Community Residence 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

Re-Integration Community Residence (male, female, co-ed) Admissions (585) 238-4810, Admissions@easthouse.org

Supportive Living (men, women, family with children) Admissions (585) 238-4810, Admissions@easthouse.org

ACACIA Network - OUT OF THE DARKNESS

Re-Integration Community Residence (female) (585) 232-3777, Fax (585) 585-270-4962

Sonia, sorodriguez@outofthedarknessroc.org or Nitza, nrodriguez@outofthedarknessroc.org

Other organization optional

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:

Phone:
Date:

Signature of Applicant (person seeking residential service):

Date: