



CAYUGA ADDICTION RECOVERY SERVICES
SUPPORTIVE LIVING PROGRAM
ITHACA, NEW YORK
Telephone: 607-273-5500, Fax: 607-273-1277

Dear Colleague:

Thank you for your interest in the CARS Supportive Living program.

Application Packets should include:

- Supportive Living Application (please be sure to have the applicant complete Part II of the application in their own words).
- Signed, dated and witnessed consents.
- Current psychosocial evaluation.
- Medical information including: 1) Medical history, 2) Physical exam, 3) TB testing, and 4) Lab work (blood count & differential, routine microscopic urinalysis, most recent urine / drug screen).
- Current year financial agreement
- Copy of the Medicaid card (if applicable)
- Recent psychiatric evaluation (if applicable)

After the application is reviewed the primary counselor will be contacted to schedule a phone interview. Local candidates may be asked to complete a face to face interview.

Final approval and tentative bed dates will be given upon the receipt of financial approval from the CARS business office.

Return the packet to: Candice Emmons, CASAC
Clinical Supervisor
PO Box 789
Ithaca, NY 14850
Fax: 607-273-1277
e-mail: cemmons@carsny.org

5. What work and/or school goals do you have?
6. What financial resources do you have to use while in Supportive Living: (Family support, expected PNA, cash savings: \$ _____)

8. Medical Needs (these questions **must** be answered):
List all medical needs that have been identified:

Are you taking any medications? If so, what are they?

Are you taking those medications as prescribed? _____ Yes _____ No

- 9 Please describe your sober support system:

Sponsor's Name: _____

Number of support meetings attended each week: _____

Other Supports: (religious, social, recreational, etc)

10. Date of last use (any non-prescribed mind or mood-altering substance): ___/___/___

Legal Info:

Legal Status: None Charges Pending On Probation On Parole

Probation/ Parole Office Name, Address, and Phone _____

Legal History: (include all arrests, and charges in the past 3 years, include all convictions in lifetime, list all jail and prison terms)

Pending Charges: (list all including location)

Client Signature

Date

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE
SERVICES

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

REVOKED ON: _____

Staff signature: _____

PATIENT'S LAST NAME FIRST MI :	
DOB:	CODAP #:
FACILITY: Cayuga Addiction Recovery Services	UNIT: Supportive Living

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

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED Results of evaluation, psychosocial history, urine screens, alcosensors, progress notes, diagnosis, treatment recommendations, discharge summary, collateral information.	
PURPOSE OR NEED FOR DISCLOSURE/RELEASE To coordinate treatment	
NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION Between: Name: _____ (Referral source) Address: _____ _____ Phone: _____ ext. _____ Fax: _____	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE And: Name: Candice Emmons, CASAC or designee Facility: Cayuga Addictions Recovery Svcs Address: 334 W. State Street Ithaca, NY 14850 Phone: (607) 273-5500 Fax: (607) 273-1277

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 one (1) year 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 Witness)

This consent was executed on _____

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PURPOSE OR NEED FOR DISCLOSURE/RELEASE	
To coordinate treatment	
NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE
Between:	And:
Name: (_____) County Dept. of Social Services Home County Social Services	Name: Candice Emmons, CASAC or designee
Address: _____	Facility: Cayuga Addictions Recovery Svcs
_____	Address: 334 W. State Street
_____	Ithaca, NY 14850
Phone: _____ ext. _____ Fax: _____	Phone: (607) 273-5500 Fax: (607) 273-1277

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[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED Diagnosis, prognosis, events relevant to treatment and attendance, emergency information, collateral information	
PURPOSE OR NEED FOR DISCLOSURE/RELEASE To respond to emergencies, facilitate treatment planning, proffer incidental, collateral, or educational services as needed	
NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION Between: Name: _____ (Emergency Contact Information) Relationship: _____ Address: _____ Phone: _____ Work: _____ ext. _____	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE And: Name: Candice Emmons, CASAC or designee Facility: Cayuga Addictions Recovery Svcs Address: 334 W. State Street Ithaca, NY 14850 Phone: (607) 273-5500 Fax: (607) 273-1277

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

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EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

Results of evaluations, urine screens, alcosensors, progress reports, diagnosis, treatment recommendations, discharge summary, collateral information, treatment plan

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

To inform the criminal justice agency of attendance and progress in treatment

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION

Between:

Name: _____

(Court, Probation, Parole, Pros. Atty, Judge)

Address: _____

Phone: _____ **ext.** _____ **Fax:** _____

NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE

And:

Name: Candice Emmons, CASAC or designee

Facility: Cayuga Addictions Recovery Svcs

Address: 334 W. State Street

Ithaca, NY 14850

Phone: (607) 273-5500 Fax: (607) 273-1277

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 will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my probation, parole, conditional release or other proceeding under which I was mandated into evaluation and/or treatment and a final disposition of the matter related thereto. 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.

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