



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: Billie Jo Owens  
Supportive Living Coordinator  
PO Box 789  
Ithaca, NY 14850  
Fax: 607-273-1277  
e-mail: bowens@carsny.org



# Cayuga Addiction Recovery Services SUPPORTIVE LIVING PROGRAM

Billie Jo Owens  
334 W State Street  
Ithaca, NY 14850  
(607) 273-5500  
FAX (607) 273-1277

## Application for Admission

### PART 1- TO BE COMPLETED BY REFERRAL SOURCE

#### Client Demographics:

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Gender: \_\_\_\_\_ Pregnancy Status \_\_\_\_\_ SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Is the client an intravenous drug user? \_\_\_\_\_ Race / Ethnicity \_\_\_\_\_  
Anticipated discharge date: \_\_\_\_\_ Clients Primary Language: \_\_\_\_\_  
Is this date flexible?      Yes      No  
Home County: \_\_\_\_\_ Zip Code in Home County: \_\_\_\_\_  
Current Address (and type of Residence)      Veteran Status: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Client's phone #: \_\_\_\_\_

#### Financial Info (please include a copy of the DSS Benefit card):

Source of Payment for Services:       DSS – Congregate Care LVL II  
Medicaid # \_\_\_\_\_  
 Social Security Disability  
 Self       SSI  
 Other: (indicate)  
\_\_\_\_\_

Payment Source Name, Title & Phone #: \_\_\_\_\_

Contact Agency of Payment Source: \_\_\_\_\_

#### Referral Source Info:

Referral Agency: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Fax #: \_\_\_\_\_  
\_\_\_\_\_  
E-Mail: \_\_\_\_\_

Hours of Operation: \_\_\_\_\_



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**

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

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 (IRS-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 \_\_\_\_\_

NEW YORK STATE  
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE  
SERVICES

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

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

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

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<b>EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED</b> Results of evaluations, urine screens, alcosensors, progress reports, diagnosis, treatment recommendations, discharge summary, collateral information, treatment plan	
<b>PURPOSE OR NEED FOR DISCLOSURE/RELEASE</b> To inform the criminal justice agency of attendance and progress in treatment	
<b>NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION</b> <b>Between:</b> <b>Name:</b> _____ <b>(Court, Probation, Parole, Pros. Atty, Judge)</b> <b>Address:</b> _____ _____ <b>Phone:</b> _____ <b>ext.</b> _____ <b>Fax:</b> _____	<b>NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE</b> <b>And:</b> <b>Name:</b> Billie Jo Owens or designee <b>Facility:</b> Cayuga Addictions Recovery Svcs <b>Address:</b> 334 W. State Street Ithaca, NY 14850 <b>Phone:</b> (607) 273-5500 <b>Fax:</b> (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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**PLEASE HAVE APPLICANT READ AND INITIAL EACH  
AGREEMENT**

**Supportive Living Program - Guiding Principles and Agreements**

The CARS supportive living program is designed with one goal in mind: to help an individual develop and maintain a recovery oriented lifestyle and reenter the community with the skills to maintain that lifestyle. The program's guiding principles are the methods by which residents can achieve that goal. Supportive living residents make agreements to abide by those guiding principles and demonstrate their compliance with the program goal. In other words, keeping the agreements helps residents build their internal accountability for creating and maintaining their recovery oriented lifestyle.

**RESIDENT ACTIVITIES / TIME MANAGEMENT**

**Guiding Principle:** Recovery oriented activities help residents gain interpersonal skills and increase self awareness around making healthy choices in recovery. Residents will commit to and engage in up to 35 hours of program and/or recovery related activities (including outpatient appointments, supportive living meetings, community support meetings, and education / volunteer work). Residents demonstrate their compliance with this principle through their weekly schedules.

**Agreements:**

\_\_\_\_\_ I agree to keep a weekly schedule, following the instructions of CARS staff, and hand in that schedule on Mondays (or Wednesdays if there is no morning meeting on Monday due to a holiday). Note: Handing in a schedule late is considered breaking this agreement.

\_\_\_\_\_ I agree to comply with all outpatient treatment recommendations (including chemical dependence treatment recommendations, mental health recommendations, and medical orders).

\_\_\_\_\_ I agree to build my sober support network through community based support meetings (such as AA, NA, Alanon, etc.) according to my individual service plan.

\_\_\_\_\_ I agree to attend the supportive living morning meeting on Monday, Wednesday and Friday from 9 – 10 a.m. I agree to contact the supportive living coordinator ahead of time if I need to miss the meeting. I agree to avoid making commitments that conflict with attending morning meeting.

## OVERNIGHT PASSES AND VISITORS

**Guiding Principle:** Residents use overnight passes as a way to practice maintaining a recovery oriented lifestyle outside the structured environment of the program. Residents must be in compliance with program principles to be eligible for an overnight pass.

### **Agreement:**

\_\_\_\_\_ I agree to follow the overnight pass policy at all times. I understand an overnight pass requires prior approval and is requested through the use of the pass request form. This form must be fully completed and handed in on Monday prior to the requested time (or Wednesday if there is no morning meeting due to a holiday). After two weeks in the program I may request an overnight pass (one night only). After one month I may request a two night pass. I understand that extended passes can be allowed if the activity is directly related to my service plan.

**Guiding Principle:** Being able to demonstrate appropriate decision making to preserve the safety of one's living space is an important skill in a recovery oriented lifestyle. Residents practice these skills when they have visitors in the apartment.

### **Agreements:**

\_\_\_\_\_ I agree to follow the visitor policy at all times. I understand that visitors are defined as anyone who is not assigned to the apartment (including other CARS supportive living residents). I may have visitors between the hours of 9:00 a.m. and 10:00 p.m. without prior permission. I know I must be with my visitor at all times. I understand that visitors are not permitted on the 2<sup>nd</sup> floor of the apartment (with the exception of moving in or out and with CARS staff present). I agree that extended visitor hours must have prior approval of the supportive living coordinator.

\_\_\_\_\_ I agree that overnight visitors require an overnight visitor pass and the request must be submitted to the coordinator on the Monday prior to the overnight visit.

Note: The outside areas are considered a part of the apartment. No person is permitted to be on the property without someone from the apartment taking responsibility. If an unwanted person is on the property the residents should ask the person to leave. If the resident feels unsafe he/she should call the police.

## CURFEW / QUIET HOURS

**Guiding Principle:** A healthy recovery oriented lifestyle involves having a regular routine. Residents keep a regular daytime schedule and strive to get adequate rest at night. Residents are also expected to be respectful of the others in the apartment who are trying to rest as part of their routine.

### **Agreements:**

\_\_\_\_\_ I agree to follow the curfew policy. Night curfew is 10:00 p.m. Sunday – Thursday and Midnight on Friday, Saturday and approved holidays. Morning curfew is 6:00 a.m. (residents do not leave the apartments earlier than 6:00 a.m.). I understand that an extended curfew needs prior approval and is at the discretion of the supportive living coordinator.

\_\_\_\_\_ I agree to demonstrate my compliance with this principle by using the curfew call-in line (273-5500 x48) from the phone in my apartment (not a cell phone). When I call I will provide my name and the time of my call. I understand that calling in late is not keeping this agreement.

\_\_\_\_\_ I agree to keep quiet hours between 10:00 p.m. and 9:00 a.m. I understand that loud stereos, musical instruments, or television volume that disturbs my room mates is not allowed at any time. I agree to use headphones for stereo use after 10:00 p.m.

## HOUSEKEEPING & APARTMENT RULES / MAINTENANCE

**Guiding Principle:** Building and maintaining healthy and respectful social relationships with housemates, landlords, employers, and neighbors are important in a recovery oriented lifestyle. Residents demonstrate these skills by following agreed upon rules & policies.

### Agreements:

\_\_\_\_\_ I agree to maintain my room in a clean and sanitary state at all times. I will contribute towards keeping the common areas of the apartment clean and neat by keeping my agreements with my housemates regarding household chores.

\_\_\_\_\_ I agree to abide by the regulations of the Ithaca Housing Authority and Cayuga Addiction Recovery Services. These include: no pets of any kind; no alterations to the program site (including painting); no use of space heaters, kerosene heaters, or electric heaters; no use of air conditioners; windows and doors must be closed during the winter months (residents may be fined by IHA for breaking this rule); apartment doors must be kept locked at all times, even when clients are on the premises; no tampering with fire safety equipment (IHA fines may apply), telephone lines, or cable lines. No long distance calls may be made from the apartment without the use of a phone card. An unauthorized charge to the CARS telephone account may be charged to the resident.

\_\_\_\_\_ I agree to report all accidents and injuries (including visits to the ER via ambulance or personal transport) while in the supportive living apartments, at the outpatient building, or while on pass. Reports are made to the supportive living coordinator or other CARS staff by calling the outpatient clinic during regular business hours, or using the emergency on-call number during the evening and on weekends and holidays.

CARS outpatient telephone#: (607) 273-5500; CARS Supportive Living on-call telephone: 275-6471. (Always leave a voice mail message if staff does not answer telephone immediately).

## DISCHARGE AND MOVING OUT

**Guiding Principle:** It is important to leave the program in a way that demonstrates the skills and abilities that were gained and practiced while here.

### **Agreements:**

\_\_\_\_\_ I agree to follow the discharge and move out procedures. All residents must have a discharge plan in place, a discharge agreement, and complete an exit interview to receive a successful completion.

\_\_\_\_\_ I agree that moving out must be done in coordination with CARS staff and/or another authorized person (such as the resident assistant). Moving out must take place during business hours Monday thru Friday 9 a.m. – 4 p.m. Residents must make their own moving arrangements prior to their discharge date. The room must be left clean (all personal belongings removed, trash taken to the dumpster, furniture dusted, and floor mopped). The resident may remove personal belongings from the room prior to the move out inspection. The resident may not remove any CARS property from the premises. All keys (including personal door lock if applicable) must be returned to CARS staff on the day of discharge.

Note: With prior approval of CARS, there may be circumstances when a resident may leave belongings in the supportive living apartment after discharge. CARS is not responsible or liable for any loss or damage to the items left, and after 30 (thirty) days, the items will be disposed of at the discretion of CARS staff.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date