

Application Cover Page

ACASA, Inc. Community Residence/Supportive Living

Dear Provider:

Please mail, email, or fax all requests for alcohol and other drug residential services to:

Community Residence & Supportive Living (Male Applicants 18+)

ACASA Trapping Brook House

3084 Trapping Brook Rd

Wellsville, NY 14895

Phone: (585) 593-1920 Choose Option 1

Fax: (585) 593-7697

Email: ckalkbrenner@alleganycouncil.org

To obtain a referral interview, please submit a completed Admission Application along with a current bio-psycho-social history. The following information may be included with the application (otherwise, it may be required after the interview to obtain admission):

Signed Admission Application Current Bio-Psycho-Social History

Releases Copy of Medicaid/Insurance Cards

Most recent physical, lab work (including CBC with differential), urine screens, and a PPD from within the last calendar year.

Thank You

Christell Kalkbrenner
Administrative Liaison

ACASA Inc. Trapping Brook House (TBH)/Supportive Living (SL)
Referral/Admission Application

Applicant Information

Application/Referral for TBH _____ or Supportive Living _____

Client Name: _____ Phone: _____

Street Address _____

City: _____ County: _____ State: _____ Zip: _____

Is the applicant homeless? Yes _____ No _____ Legal Mandate: Yes _____ No _____

D.O.B: _____ S.S.N: _____ Medicaid Number: _____

Insurance Company: _____ Policy #: _____

Substance History

Does the applicant have a substance use disorder diagnosis: Yes _____ No _____

If yes, list DSM-V diagnosis _____

<u>Type of Substance</u>	<u>Onset</u>	<u>Frequency</u>	<u>Route of Ingestion</u>	<u>Last Use</u>

Treatment History (ex: Detox, Outpatient, Inpatient, Community Residence etc.):

<u>Facility Name</u>	<u>Type</u>	<u>Dates</u>	<u>Length of Stay</u>	<u>Completion</u>

Mental Health

Does the applicant have a diagnosis of mental illness? Yes _____ No _____

If yes, please explain _____

Has the applicant ever received Mental Health Treatment? Yes _____ No _____

If yes, please complete:

<u>Treatment Provider</u>	<u>Dates</u>	<u>Reason</u>	<u>Medications</u>	<u>Outcome</u>
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List any inpatient psychiatric admissions or evaluations and outpatient treatment history:

<u>Treatment Provider</u>	<u>Dates</u>	<u>Length of Stay</u>	<u>Reason</u>	<u>Outcome</u>
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Does the applicant have a history of suicide attempts? Yes _____ No _____

If yes, please explain: _____

Medical

Does the applicant have a Primary Physician? Yes _____ No _____

If yes, please list name and address: _____

Date of last physical exam/lab/blood work _____ Date of TB test _____

List any physical disabilities or limitations: _____

Is the applicant currently being treated for any communicable diseases: Yes _____ No _____

If yes, please explain: _____

Is the applicant currently on Medication Assisted Treatment (MAT)? Yes _____ No _____

Medications

Current Medication

Dosage

Prescribing Doctor

Legal

Current Probation: Yes__ No__ Probation Officer & Number _____

Current Parole: Yes__ No__ Parole Officer & Number _____

Current Drug Court Yes__ No__ Jurisdiction _____

Pending Court Yes__ No__ Jurisdiction _____

Domestic Violence Yes__ No__ Order of Protection Yes__ No__

Outstanding Warrants: Yes__ No__ Unknown__ If yes, please explain:

History of Assaults: Yes__ No__ If yes, please explain:

Has the applicant accidentally or intentionally set fires? Yes__ No__

Has the applicant been arrested or convicted of arson: Yes__ No__

If yes to either question, please explain: _____

Does the applicant have any history of rape, sexual abuse, or violent crimes against a person?

Yes__ No__ If yes, please explain _____

Financial

Does the applicant current receive Social Service Benefits from Allegany County?

Yes___ No___

Does the applicant currently receive benefits from another county? Yes___ No___

If yes, which county? _____

Case Workers Name: _____

Does the applicant currently receive SSI/SSD benefits? Yes___ No___

If yes, list payee: _____

Current monthly income received: _____

Has the applicant ever been sanctioned/refused Social Services or Social Security benefits:

Yes___ No___ If yes, please explain _____

Education

Please mark the highest grade completed:

1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ 11__ 12__ GED__ College__

Please list any diplomas, degrees, certifications, and licenses: _____

Signatures

Applicant's Signature: _____ Date: ___/___/___

Printed Name: _____

Referring Staff Signature: _____ Date ___/___/___

Printed Name: _____

Facility: _____