ACASA Allegany Council on Alcoholism & Substance Abuse, Inc.

Resources for Growth and Prevention

Application Cover Page

ACASA, Inc. Reintegration Residential Congregate or Scattered Site

Dear Provider:

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

ACASA Trapping Brook House
3084 Trapping Brook Rd.
Wellsville, NY 14895
Phone: (585) 593-1920 Ext 721
Fax: (585) 593-7697
Email: sbrown@alleganycouncil.org or bcard@alleganycouncil.org

To obtain a referral interview, please submit a completed Admissions Application along with a current admissions assessment or biopsychosocial history. Please include the following required paperwork with the application:

___ Signed Admission Application

___ Current Admissions Assessment/BPS

___ Signed Releases/Consents

___ Copy of Medicaid/Insurance Cards

___ Most recent physical, lab work (including CBC with differential), urine screens & PPD

Thank you,

Shelbie Cuomo, BS, CASAC Advanced
Director of Residential Operations

ACASA Allegany Council on Alcoholism & Substance Abuse, Inc.

Resources for Growth and Prevention

ACASA Reintegration Congregate (TBH)/Scattered Site (SL)
Referral/Admission Application

Applicant Information

Application/Referral for Congregate (TBH) ☐ or Scattered Site ☐

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: _____

Type of Substance	*Onset*	*Frequency*	*Route of Ingestion*	*Last Use*

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

Facility Name	*Type*	*Dates*	*Length of Stay*	*Completion*

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:

Treatment Provider	*Dates*	*Reason*	*Medications*	*Outcome*

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

Treatment Provider	*Dates*	*Length of Stay*	*Reason*	*Outcome*

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: _____

Out of County Approval: Completed☐ Started☐ Not Started☐

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: _____