APPLICATION FOR MONROE COUNTY OASAS RESIDENTIAL SERVICES

APPLICANT INFORMATION

Last Name:	First Name:	Middle Initial:

Maiden Name (Name on birth certificate):

Gender: ☐Male ☐Female ☐Transgender   Have you ever been in the military? ☐Yes ☐No

Date of birth:	SSN:	Your Phone # May We Leave a Message: ☐Yes ☐No

Current address:	City:	Zip Code:

1. Please check your housing situation at the time of this application:

☐Homeless ☐Living in Shelter ☐Hospital/Inpatient Rehab	☐Private Residence ☐Other OASAS/OMH Residence ☐Correctional Facility	☐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

CURRENT SERVICE PROVIDER INFORMATION

Please provide the information below for the service(s) you presently receive

Inpatient Rehab/Detox:	Phone:
Counselor Name:	Fax:
Outpatient Addiction Agency:	Phone:
Counselor Name:	Fax:
Inpatient Mental Health Agency:	Phone:
Counselor Name:	Fax:
Outpatient Mental Health Agency:	Phone:
Counselor Name:	Fax:
Case Management Agency:	Phone:
Case Manager Name:	Fax:
Primary Care Physician:	Phone:
Address:	Fax:
Other Health Provider:	Phone:
Address:	Fax:
Other Provider:	Phone:
Address:	Fax:

EMERGENCY CONTACT (Person that you permit us to contact in case of an emergency)

Name:	Relationship:
Address:	Phone #:

PLEASE ATTACH THE FOLLOWING OR HAVE YOUR MOST CURRENT PROVIDER SEND THIS INFORMATION	
	ATTACHED
1. Most recent **psychosocial/evaluation** for substance use and mental health disorders with DSM IV TR 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(s) for Release of Information** Between Current Service Provider and Residential Provider	☐Yes ☐No

*****If you have not had a history and physical, the required lab work, and TB screening done within the past 12 months, please schedule them immediately.*****

PLEASE ANSWER YES OR NO THE FOLLOWING STATEMENTS	
1. I need services for my addiction.	☐Yes ☐No
2. I believe that I am free of any communicable (infectious) disease that can be spread through 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	
I applied for full cash assistance on:	
DHS Case #: **BA**	*(If your number starts with MA, you do not have full cash assistance)*
DHS Case Worker's Name:	
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 ☐SSD	
Please provide monthly SSI/SSD income. Monthly SSI/SSD income: $	
If you have a **Rep Payee**, please provide the name and phone number below:	
NAME:	
AGENCY:	PHONE:

SELECT RESIDENTIAL SERVICES FOR WHICH YOU ARE APPLYING

I could benefit from OASAS residential services; I am interested in receiving services from the following agency/agencies.

Please consider the most appropriate level of care as indicated by the following admission criteria:

Intensive Residential: needs a 24-hour setting to successfully maintain abstinence, participate in treatment, and work toward habilitation or rehabilitation in order to achieve lasting recovery in a more independent setting.

Community Residence: homeless or a living environment not conducive to recovery; and needs outpatient treatment and/or other support services such as vocational or educational services.

Supportive Living: requires residential support that provides a substance free environment; requires peer support to maintain abstinence; doesn't require 24-hour on-site supervision; and exhibits the skills to maintain abstinence and readapt to independent living.

☐ **Catholic Family Center**

- ☐ Intensive Residential: Freedom House (male) - Intake Coordinator, John Barbaro 546-7220, ext 5030, fax 423-2201
  Liberty Manor (female) - Intake Coordinator, Emily Price 342- 8202 fax 266-0214
- ☐ Community Residence: (Alexander- Jones- and Barrington-) - Intake 546-7220, ext. 5033, fax 423-2201
- ☐ Supportive Living: Intake 546-7220, ext. 5033, fax 423-2201

☐ **East House Inc**

☐ **Community Residence**: (Blake, Cody, Pinny Cooke, Hanson) - Penny McBride, Evaluation/Admission Coordinator, East House, 1701 LacDeVille Blvd, Rochester, NY 14618 Phone: (585) 256-3800x229 FAX:, 585-256-3802 pmcbride@easthouse.org

☐ **Supportive Living (men, women, family with children):** Susan Lambert, Program Supervisor, East House Crossroads Apartment Program, 758 South Avenue, Rochester, NY 14620 Phone: (585) 244-3530 FAX: (585) 244-3742

☐ **Pathway Houses of Rochester**

☐ **Supportive Living (men only):** Glen Smith, Executive Director, Pathways, 55 Troup Street, Suite 208, Rochester, NY 14608, Phone: (585) 232-4674, FAX: (585) 325-5001, website: pwhouses.org

☐ **PRCD Inc Daisy Marquis Jones Women's Residence**

☐ **Community Residence (women only)**: Intake Coordinator, Daisy Marquis Jones Women's Community Residence PRCD, Inc., Phone (585) 723-7717, FAX (585) 723-7358

☐ **YWCA**

☐ **Supportive Living (women alone OR with children)**: Amy Wells, Phone (585) 546-5820 Fax (585) 232-3540

☐ **Veteran's Outreach Center**

☐ **Supportive Living (male veterans only)**: Bozena Robertson, Ph.D., CRC, LMHC, VP Clinical & Supportive Services, 447 South Avenue, Rochester NY 14620, Main #: (585) 546-1081, Fax #: (585) 547-5324, bozena.robertson@veteransoutreachcenter.org

If being completed with the assistance of another individual, please complete:

Name of **Agency** person Assisting with application:	**Agency**:	Phone: Date:
Signature of Applicant (person seeking residential service):		Date: