UConnectCare Bedded Treatment Program Application

Completed referral packages should be faxed to:
585-815-1815
Attn: Intake Counselor

Please contact our intake counselor with any questions you may have at:
Ph: 585-815-1810 E: residentialintake@uconnectcare.org

Please select which level of care to which the applicant is applying:

- ☐ **Detox** (Opioid, Alcohol, Benzodiazepine – Mild/Moderate withdrawal only)
- ☐ **Supportive Living**
- ☐ **Atwater** 820
  - ☐ Stabilization
  - ☐ Rehabilitation
  - ☐ Reintegration

Complete referral packages for Community Residence and Supportive Living MUST include:

- ☐ Psycho-social assessment
- ☐ History and Physical
- ☐ Blood work
- ☐ PPD
- ☐ Urinalysis

Indications for Referral (check all that apply):

- ☐ Opioid Use Disorder
- ☐ Alcohol Use Disorder
- ☐ IV User
- ☐ Pregnant
- ☐ Homeless
- ☐ Children in foster care or in jeopardy of being placed in foster care
- ☐ Referred from a crisis center or looking to go bed to bed

Please explain:

CLIENT INFORMATION

Name: DOB:

Gender: SSN:

Address (prior to treatment):

County of Origin:

Phone: Email:

Does client currently receive benefits through Social Services? ☐ Yes ☐ No

If yes, what county?

Is client receiving SSI or SSD benefits? ☐ Yes ☐ No

If yes, complete the following:

Case Number: County:

Case Worker: Amount of benefit:

Has the client ever been refused/sanctioned for Social Services or Social Security Benefits?

☐ Yes ☐ No

If yes, explain:

Highest grade level completed:

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12 ◯ GED

◯ Some college ◯ Bachelors ◯ Doctorate

◯ Associates ◯ Masters

Please indicate any diplomas, degrees, trade school certificates, etc.:

INSURANCE

Primary Insurance:

Policy number: Group number:

Subscriber:

Subscriber address:

Secondary Insurance? ☐ Yes ☐ No

Secondary Insurance (if applicable):

REFERRAL SOURCE

Name: Relationship:

Agency (if applicable):

Phone number: Fax:

Email:

Will you be providing ongoing support: ☐ Yes ☐ No

MEDICAL INFORMATION

Primary Care Provider Name:

Location:

PCP Phone: PCP Fax:

Medical Diagnoses (i.e. heart disease, thyroid disease, epilepsy, cancer, diabetes, etc.):

Medications and dosages:

History of seizures: ☐ Yes ☐ No

History of Eating Disorder: ☐ Yes ☐ No

If yes for either, please provide dates and any additional information known:

Does client experience problems with mobility (i.e. inability to use stairs, requires a wheelchair or walker, etc.): ☐ Yes ☐ No

If yes, please explain:

Does client use tobacco products? ☐ Yes ☐ No

If yes, how much daily?

Dates and results of last TB test (PPD or IGRA):

MENTAL HEALTH INFORMATION

Has a mental health diagnosis been assigned to the client? ☐ Yes ☐ No

If yes, by whom? When?

Mental Health Diagnoses (i.e. depression, anxiety, bipolar disorder, schizophrenia, etc.):

Any suicidal or homicidal ideation in the last 30 days: ☐ Yes ☐ No

If yes, please provide any additional information known:

Mental Health Treatment History:

Events Leading to Treatment	Program	Length of Stay	Dates

SUBSTANCE USE HISTORY

Has a substance use and/or alcohol use diagnosis been assigned to the client? ☐Yes ☐No

If yes, by whom? When?

Diagnosis:

Primary substance:

Substance Use History:

Substance	Amount	Frequency	Route	Date of Last Use

Substance Abuse Treatment History:

Facility Name	Type of Treatment	Month/Year	Completed
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

LEGAL

Is the client on probation or parole? ☐ Yes ☐ No

If yes, please provide probation/parole officer's name, county, and contact info:

Is the client attending treatment court? ☐ Yes ☐ No

Where?

Is the client mandated for treatment? ☐ Yes ☐ No

By who?

Has the client ever been arrested? ☐ Yes ☐ No

If yes, when and what were the charges?

Has the client ever been arrested for assault? ☐ Yes ☐ No

If yes, explain:

Has the client ever been arrested for arson or sexual assault? ☐ Yes ☐ No

If yes, explain:

Is the client a registered sex offender? ☐ Yes ☐ No

Current pending court appearances:

Does client have any outstanding warrants? ☐ Yes ☐ No

If yes, explain:

OTHER AGENCIES, SUPPORTS, OR INDIVIDUALS INVOLVED

Name	Relationship	Phone Number	Last Seen

COVID-19 VACCINATION STATUS

Has client ever received a dose of COVID-19 Vaccine? ☐ Yes ☐ No

If yes, which vaccine product did the client receive?

☐ Pfizer-BioTech ☐ Moderna ☐ Johnson & Johnson

Has the client received a complete COVID-19 vaccine series (1 dose Johnson & Johnson or 2 doses of Pfizer-BioTech or Moderna)? ☐ Yes ☐ No

Has the client received any of the booster shots? ☐ Yes ☐ No

If yes, what:

ADDITIONAL INFORMATION

Client Signature Date

Staff Signature and Title Date

Staff Phone Number