



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

LOCADTR

Copy of insurance

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