# UConnectCare Bedded Treatment Program Application

**Completed Referral Packets should be sent to the Residential Intake Coordinator at:**
mailto:residentialintake@uconnectcare.org

**Detox/Atwater 820**
Ph: (585)815-1824
Fax: (585)815-1815

**Women & Children's Center**
Ph: (585)695-5781
Fax: (585)201-7381

**Supportive Living 820 Reintegration**
Ph: (585)815-1841
Fax: (585)343-8720

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

- ☐ **Detox** (Opioid, Alcohol, Benzodiazepine - mild/moderate withdrawal only)
- ☐ **Supportive Living 820 Reintegration**
- ☐ **Atwater 820**
  - ☐ Stabilization
  - ☐ Rehabilitation
  - ☐ Reintegration
- ☐ **Women & Children's Center**
  - ☐ Stabilization
  - ☐ Rehabilitation
  - ☐ Reintegration

**Complete referral packages 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
- ☐ IV User
- ☐ Homeless
- ☐ PPD
- ☐ Alcohol Use Disorder
- ☐ Pregnant
- ☐ Children in foster care or in jeopardy of foster care
- ☐ Referred from a crisis center or seeking 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 |
|---|---|---|---|
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**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 |
|---|---|---|---|---|
| | | | | |
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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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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## 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

# Methadone Referral Form

If the residential applicant is also taking methadone, please forward the following information (allow a minimum of **two weeks**' notice):

- ☐ Consent to Release Information
- ☐ Letter/Note stating reason for referral/transfer
- ☐ Demographics (Name, Address, Contact Information, SSN, DOB, etc.)
- ☐ Most Recent Intake/Assessment
- ☐ Urine Screens (Last 3)
- ☐ Most Recent Physical Examination
- ☐ Latest PPD Results & EKG Results
- ☐ Blood Work (CMP, Hep C, CBC, Magnesium)
- ☐ Medical History/Medication List
- ☐ Dosing History (last 3 months, if available)
- ☐ Current Dosing Schedule/Take Home Schedule
- ☐ Active Methadone Order with Provider Signature

Once all the above documents are received, the patient and primary counselor will be contacted for evaluation and admission/first dose date. Please make sure to provide any new updates if a patient's dose is changing right before they leave.

| | |
|---|---|
| UConnectCare BATAVIA OTP<br>Attention: Danielle Kewin<br>430 E Main St<br>Batavia, NY 14020<br>P: 585-343-1124<br>Fax: 585-343-1197 | UConnectCare ALBION OTP<br>Attention: Nicole Mickey<br>249 East Ave<br>Albion, NY 14411<br>P: 585-331-8740<br>Fax: 585-201-7380 |

Sending Clinic: _____

Completed By: _____

Phone Number: _____

Date: _____