SUPPORTIVE LIVING Referral Packet Mannion House

To All Applicants: The Supportive Living VOLUNTEER VOC/ED AGREEMENT must be completed and signed by the Career Choices Unlimited VOC/ED Case Manager, Residential Case Manager and Applicant **Prior** to submitting this packet.

Fairview Recovery Services

Fairview Recovery Services helps people with the disease of alcoholism, chemical dependency, and co-occurring conditions live independent, healthy, and productive lives by providing a continuum of individualized services and care.

Updated August 2017

SUPPORTIVE LIVING
MANNION HOUSE
REFERRAL PACKET
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Fairview Recovery Services

Administration

Fairview & Merrick Community Residences

Supportive Living

Shelter + Care

Career Choices Unlimited

5 Merrick Street
Binghamton, NY
13904
607-722-8987
Fax: 607-722-6767
fairview@frsinc.org
www.frsinc.org

To the Referred Person and the Referral Source,

In order for your referral to be accepted and processed the following MUST be provided to the Supportive Living Program Coordinator:

1. An admission packet that has been entirely completed and reviewed by both the referred person and the referral source. This can be found on the Fairview Recovery Services website at: www.frsinc.org or we will be happy to mail one to you. Feel free to make copies to keep on file.
2. A recent psychosocial (within the last year) that must include a chemical dependency diagnosis, and where applicable, a mental health diagnosis.
3. Documentation of a negative PPD/Mantoux test for TB (tuberculosis) within the past year.
4. A complete history and physical from a health care provider completed within the last year, including lab (blood) work with a CBC Count; urinalysis.
5. Proof of funding from DSS or Social Security; Release for funding source.
6. Copy of NYS Benefit Card
7. Current medication list

Referrals that are **not** complete will **not** be processed until the Supportive Living Coordinator has received **all** of the above named components.

Thank you,
Supportive Living Program

Addictions Crisis Center
247 Court Street
Binghamton, NY
13901
607-722-4080
Fax: 607-723-1858

FAIRVIEW RECOVERY SERVICES, INC.
Michele Napolitano, MSEd, CRC, CASAC
Executive Director
5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 722-6767

FAIRVIEW COMMUNITY RESIDENCE
MERRICK COMMUNITY RESIDENCE
SUPPORTIVE LIVING
CAREER CHOICES UNLIMITED
5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 722-6767

ADDICTIONS CRISIS CENTER
247 Court Street
Binghamton, NY 13901
Phone (607) 722-4080
Fax (607) 723-1858

2-WAY CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Social Security Number: _____ Date: _____

I, _____, hereby authorize and consent to

communication **BETWEEN** _____ and

_____
(Agency Name, Full Address, Phone Number)

_____ (or his/her successors).
(Name & Title of a Contact Person)

The extent of information to be disclosed **Medical history, laboratory results, physical; psychosocial evaluation & recommendations; psychiatric evaluation; diagnosis; treatment history; progress in treatment; discharge summary & discharge status.**

The purpose of the disclosure authorized herein is to: **Coordinate treatment and share pertinent information for this purpose.**

I, the undersigned, have read and authorized the staff of the disclosing facility name to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire 6 months from its signing, unless a different time period, event or condition is specified below, in which case such time period, even or condition shall apply. I also understand that any disclosure is bound by Title 42 of the Code of Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information is forbidden without written authorization on my part.

Time period, event or condition replacing period specified above: 6months from discharge date

Note: Any information released through this form will be accompanied by Form A-4400 Prohibition on Re-disclosure of Information Concerning Alcoholism/Drug Abuse Patient.

_____ _____
Patient Signature Witness Signature

_____ _____
Patient Name (Printed) Witness Name (Printed)

_____ _____
Date Date

Fairview Recovery Services, Inc.
Counselor Questionnaire

Client Name: _____

Thank you for taking time to help us evaluate your client for placement into Fairview Supportive Living Program. Your answers to all of the following questions are critical to our assessment of your client's appropriateness for admission to our facility.

1. Why do you feel that your client has the ability to remain clean and sober outside of a community residence?

   _____
   _____
   _____

2. Please tell us your impressions of your client's current denial system. Please circle the most appropriate number:

No Denial	Moderate Denial	High Denial	Extreme Denial
1	2	3	4

3. In what areas has your client made the most progress in treatment? _____

   _____
   _____
   _____

4. In what specific areas will your client need the most encouragement and support if admitted to Supportive Living? _____

   _____
   _____
   _____

5. It can be a challenge for people in early recovery to live in close contact and harmony with others. Please describe if your client will benefit from peer support:

   _____
   _____
   _____

6. Please add any additional information that will help us help your client. _____

   _____
   _____

Thank you for spending the time to help your client through this referral process. Should your client live at Fairview/Merrick Community Residence, we would like to stay in contact with your agency and yourself so that we can all be supportive of this resident. Please let us know the best times to contact you and, if possible, a direct phone line.

_____
REFERRING AGENT

_____
DATE

Client Introduction

Thank you for applying to Fairview Recovery Services Supportive Living Program. Supportive Living is a program for the recovering individual struggling with chemical dependence. Our Supportive Living program is a scattered site apartment setting. We will develop an individualized Recovery Plan (i.e. Alcohol and Drug, Mental Health, Marital/ Family, Social, Educational/Vocational/Employment, Heath and Legal), with you within thirty days (30) of admission to Supportive Living, with input from the referral source. Length of stay is based on an individual's progress and need for continued services.

To help us know you better, we ask you to fill out the accompanying forms in a **thorough and honest manner.**

All information will be treated confidentially. If you are accepted into Supportive Living, all information supplied by yourself, your primary counselor, and your current treatment agency will be part of your permanent record and will be referred to throughout your stay at Fairview.

After we receive all of this information, from you and your counselor, your counselor will be notified of your appropriateness as a candidate for our Supportive Living Program. Your admission will be prioritized in conjunction with the waiting list policy in compliance with the NYS OASAS guidelines.

Again, thank you for applying for residence at Fairview Supportive Living Program.

Fairview Recovery Services, Inc.
Client Questionnaire

Client Name: _____
DOB: _____
SS#: _____

1. Please tell us your impressions of where you are at in treatment at the present time. What have you gained? What do you need to work on in treatment:
_____
_____
_____
_____
_____

2. This Supportive Living provides a safe, sober living environment. Why are you seeking to live in this type of environment at this time? _____
_____
_____
_____
_____

3. There will be 5 other people living with you in Supportive Living Mannion House who are also in early recovery. How will you add to the quality of recovery in this setting?
_____
_____
_____
_____

4. What are your personal assets and your personal liabilities in this phase of your recovery?
_____
_____
_____
_____
_____

5. What are you willing to do specifically in the area of self help, continuing treatment and personal growth during the next 4-6 months?_____
_____
_____
_____
_____

1. Do you have a court case pending? _____ If yes, are you facing jail time? _____
If yes, explain_____
_____
_____
_____

7. Have you ever been treated for mental illness? _____ If yes, explain: _____
_____
_____
_____

CLIENT QUESTIONAIRE, CONTINUED NEXT PAGE

8. Do you have a learning disability? _____ If yes, explain: _____
_____
_____
_____

9. Have you ever sexually abused a minor? _____

10. Have you ever been convicted of arson? _____

11. Have you ever been in jail or prison? _____ If yes, how many different times? _____
How much total time have you spent in jail or prisons? _____

12. Do you have any medical problems? _____ If yes, explain: _____
_____
_____
_____

13. In the past 12 months has anyone hit, slapped, pushed, punched or kicked you? If yes who?
_____
_____
_____
_____

14. Have you hit, slapped, pushed, punched or kicked anyone in the past 12 months? If yes, who?
_____
_____
_____

15. What is your level of contact or involvement on an on going basis with the person named above?
_____
_____
_____

16. Do you have a current order of protection in place against someone else or against you? If yes, against or by whom? Through what court?
_____
_____
_____

17. In the event you relapse, or leave Supportive Living, who can you stay with?

Name: _____

Address: _____

Phone #: _____

_____ _____
Signature of Client Date

Application for F.R.S. Supportive Living Program

Name: _____ Case Manager: _____

Admission Date to Supportive Living: _____

Sobriety Date: _____

Where and when did last relapse occur: _____

_____

Please list all treatment and/or residential placements you have completed in the last 6 months.

_____ _____

_____ _____

_____ _____

_____ _____

Are you presently in treatment? Where? Name of treatment counselor?

_____

Do you currently attend a 12 step program? _____

On average how many meetings do you attend weekly? _____

Do you have a home group? _____

Do you work with a sponsor? _____

Have you developed a sober support system? _____

Do you have Educational goals? _____

_____

_____

Do you have Vocational goals? _____

_____

_____

What have you done so far to achieve these goals? _____

_____

_____

Fairview Recovery Services

SUPPORTIVE LIVING VOLUNTEER & VOC/ED AGREEMENT

As a resident of FRS Supportive Living Program (SLP), I agree to the following guidelines:

1. *I agree to attend and participate in the vocational/educational institution chosen in conjunction with my vocational/educational plan through Career Choices Unlimited (CCU).*

2. *I agree to be involved in a minimum of 20 hours of volunteer or Workfare per week, unless otherwise negotiated through SLP, CCU and, if applicable, the Department of Social Services (DSS). The volunteer/Workfare component must take place at an FRS approved site.*

   Volunteer site chosen: _____

   Volunteer sites being considered: _____

3. *I understand and agree that the Supportive Living requirements (i.e., house group, meetings, one-on-ones) cannot be compromised due to volunteer or Workfare placement.*

4. *I agree to contact <u>both</u> SLP and CCU Case Managers if there are problems or changes of any nature at my address, educational institution, volunteer and/or Workfare site.*

5. *Consideration of any Educational Program, such as college or vocational, would need to be discussed and approved by staff. Course load cannot exceed part time (6 credits). Clients must be in SL, MRT or S+C in order to be eligible for attending college or vocational classes. Any questions or issues can be discussed with your CCU Case Manager.*

_____ _____
Resident's Signature Date

_____ _____
Supportive Living Case Manager Date

_____ _____
Career Choices Unlimited Case Manager Date

_____ _____
Fairview/Merrick Community Residence Case Manager Date

Fairview Recovery Services, Inc.
CLIENT HOMELESS STATUS: ELIGIBILITY DOCUMENTATION

Client Name:_____ Date of Intake: _____

Check the current status and attach the appropriate documentation to verify homelessness eligibility.

Homeless Status	Type of Documentation	Documentation Attached
Living on the street	A signed and dated general certification from an outreach worker verifying that the services are going to homeless persons, and indicates where the persons served reside.	
Persons living on the street Persons coming from living on the street (and into a place meant for human habitation)	Staff should provide written information obtained from third party regarding the participant's whereabouts, and, then sign and date the statement.	
Persons coming from an emergency Shelter for homeless persons	Written referral from the agency.	
Persons coming from transitional housing for homeless persons	Written verifications to include residency and homeless status prior to program entry.	
Persons being evicted from a private dwelling	Documentation of income, efforts to obtain housing, why participant would be on street, and either documentation of formal eviction proceedings or statement from family evicting participant. (not eligible for acceptance directly into PH from 2005 awards onward.)	
Persons from a short-term stay in an institution who previously resided on the street or in an emergency shelter	Written verification from the institution's staff that the participant has been residing in the institution for less than 31 days, and information on the previous living situation.	
Persons being discharged from a longer stay in an institution	Written verification from the institution of discharge within one week of accepting client into SHP/S+C program AND documentation of income, efforts to obtain housing, and why person would be homeless without assistance.	
Persons fleeing domestic violence	Written, signed and dated verification from the participant.	
Other:	Written verification from client or referring agency.	
CHRONIC HOMELESSNESS Single, disabled Adult + Continuously homeless for 1 yr or more OR.. 4 episodes of homelessness in the past 3 yrs (streets/shelters)	Written verification from outreach workers, shelters AND brief, written statement regarding previous shelter/street stays (dates, locations) AND – documentation of disability	

NOTES:

STAFF MEMBER:_____ Date:_____

CLIENT: I verify this information is true & accurate. I confirm that I have been or am about to be homeless.

_____ Date:_____
Signature of Client

Referral Packet Overview

(Synopsis Records of Treatment, Medical, Physical, Background Check and State Forms)

☐ Psych/Social from Treatment Provider Where: _____ Date: _____

☐ Treatment Plan from Treatment Provider Where: _____ Date: _____

☐ Medical History / Physical Exam Where: _____ Date: _____

☐ Complete Blood Count (within 1 year) Where: _____ Date: _____

☐ PPD / TB Results (within 1 year) Where: _____ Date: _____

☐ Urinalysis (within 1 year) Where: _____ Date: _____

☐ Towne and Country Apartments Background Check APPROVAL / DENIAL Faxed: _____

☐ Community Residence Psych/Social Update

☐ Community Residence Face to Face Mini Mental Health Exam

☐ Community Residence OASAS Admission State Form

☐ Copy of Medicaid Card *(New Request)*

☐ Current Medication List

☐ Client Homeless Status: Eligibility Documentation

Original Date: 5/16/08 Revised Date:

POLICY AND PROCEDURE

PROCEDURE FOR: Addressing tobacco use at Fairview Recovery Services, Inc. programs.

PURPOSE: To reduce addiction, illness and death caused by tobacco products.

Policy Statement:
Fairview Recovery Services programs provide crisis, residential and educational services for adults dealing with chemical dependency. Fairview is dedicated to providing quality services in a healthy, drug free environment.

In 1988 the U.S. Public Health Services, under Surgeon General C. Everett Koop, published the report, The Health Consequences of Smoking: Nicotine Addiction. In this report Dr. Koop states, "Smoking is the chief avoidable cause of death in our society." He indicates that nicotine is the substance in tobacco that causes addiction. Nicotine is a mood altering, psychoactive substance that is highly addictive. Since 1980, DSM (Diagnostic and Statistical Manual of Mental Disorders) has listed both nicotine withdrawal and nicotine dependence as diagnosable conditions.

These facts about tobacco/nicotine impact Fairview Recovery Services programs in several ways. First, Fairview Recovery Services is aware that many of our clients have a history of tobacco use and others began using tobacco while in our care or through relapse. Second, Fairview Recovery Services recognizes that tobacco smoke at this facility is a dangerous pollutant which harms non-smokers and smokers alike. Third, Fairview Recovery Services recognizes that nicotine in tobacco is a psychoactive, mood altering, addictive substance.

Objectives:
1. To provide a healthy environment for staff, clients, volunteers, workfare participants, and visitors; one that is free from tobacco smoke pollution and cues to use tobacco products.

2. To establish a tobacco free program including tobacco free grounds.

3. To provide quality, comprehensive crisis, residential, and educational services to the clients at Fairview Recovery Services.

4. To provide tobacco/ nicotine dependence recovery assistance/options to staff.

5. To integrate tobacco/nicotine dependence within the care offered to the clients of Fairview Recovery Services programs through assessment, education, prevention, and treatment.

1. Establish a Tobacco-Free Facility

A. All clients will be informed of this policy as part of the admission process and will sign a written contract at that time.

B. Effective 6-1-2008, all prospective employees will be notified of this policy in employment announcements, during their first interview, prior to hire, and during orientation.

C. Referral sources will be notified of this policy by 6-1-2008 and will continue to be notified on an ongoing basis thereafter.

D. All current staff, volunteers, and workfare participants will receive a copy of the final policy. All new staff and volunteers will be notified of this policy at orientation.

2. Provide Tobacco/Nicotine Dependence Education and Recovery options for staff

A. All employees will be offered an in-service on the medical complications of tobacco use and nicotine dependence.

B. All clinical staff will be offered training on how to identify nicotine dependence. This will include training on assessing, education, treatment planning, and on-going care for nicotine dependence.

C. All employees will not exhibit any tobacco products including paraphernalia (lighters, tobacco brand specific products, promotional clothing, and rolling papers).

D. All employees who currently use tobacco products will be encouraged to discontinue use and offered the following:

1. Pamphlets, brochures and other reading materials to assist and educate them on the effects of using tobacco/nicotine products.
2. Over-the- counter nicotine replacement when not able to obtain through insurance.
3. Counseling through EAP referral.
4. New York State Tobacco Free Quit Line

3. Provide tobacco/nicotine prevention, education and nicotine replacement treatment for clients

A. During all intakes and reviews, the clinical staff will assess clients for tobacco/nicotine dependence using the Fagerstrom Test for Nicotine Dependence and document their level of dependence.

B. All clients, regardless of the tobacco history, will be offered an educational seminar on the effects of tobacco use.

C. During the admission process, all clients will sign an agreement stating that they have been informed of the tobacco free policy and understand its guidelines. All clients in residence on 6-1-08 will also sign the agreement.

D. Clinical staff will assist the clients in obtaining Nicotine Replacement Therapy upon request.

E. While at the program, clients will not exhibit any tobacco/nicotine products including paraphernalia, lighters, rolling papers, promotional clothing and other tobacco/nicotine brand specific items. If clients are found to have any of these items, the items will be confiscated and destroyed.

F. All clients who are identified as needing tobacco cessation will have this area addressed in their service plan.

MONITORING AND COMPLIANCE:

1. All employees, clients, volunteers, workfare participants and visitors are expected to adhere to this policy.

2. All employees are expected to be familiar with this policy and are responsible for monitoring compliance.

3. Employees who violate this policy will be subject to the same disciplinary procedures used for any other policy violation related to work performance.

4. Violation of this policy by clients will be addressed as a treatment issue first, and as disciplinary issue if violations persist. The clinical staff will address non-compliance with the client. Repeated violations may result in termination guided by the way staff deals with other addictions.

5. Visitors who violate this policy will be informed of the policy and asked to comply. A visitor who persists in violating this policy will be asked to leave.

6. Workfare participants and volunteers who violate this policy will be reminded of the policy and asked to comply. A workfare participant or volunteer who persists in violating the policy will be relieved of duty until that workfare participant or volunteer agrees to comply.

DEFINITIONS:

Tobacco- Free
When tobacco use is not permitted in any form indoors or on the grounds, the facility is tobacco-free. Tobacco-free programs understand that any use of tobacco products is incongruent with a lifestyle free of addictive drugs and recognize the need to assist clients, employees and volunteers at the facility in addressing their own tobacco use behavior.

Fairview Recovery Services, Inc.

To support a tobacco free environment, I agree to the following:

- I will not use any type of tobacco products while on the Fairview Recovery Services premises. I understand this includes the sidewalks surrounding the community residence, crisis center, supportive living apartments, parking lots, and vehicles.

- As a tobacco user I understand treatment goals specific to nicotine dependence will be included in my treatment plan.

- I agree I will not bring tobacco products or paraphernalia including lighters, snuff, chewing tobacco, cigars, cigarettes, etc. to any Fairview Recovery Services site understanding that staff will confiscate and destroy them.

- In the event that I violate such policy I understand that my case will be reviewed with possible revisions to my treatment plan. I understand that if I am found to be smoking in any of Fairview Recovery Services facilities I may be discharged from that program immediately.

- In an effort to support peers who have also agreed to this initiative, I agree to take measures to remove the odor or evidence of smoking from my person before I enter any of Fairview Recovery Services facilities (i.e. washing hands).

- As a non-smoker as part of the Fairview Recovery Services admission process I have been informed of this policy.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

Fairview Recovery Services

SUPPORTIVE LIVING
MANNION HOUSE

PASS REQUEST

In keeping with the philosophy of Supportive Living programming the following residents' pass and curfew policy has been designed. Our goal is to help residents build their individual internal accountability.

1. Pass requests must be approved by your Case Manager or Program Coordinator PRIOR to departure.
2. Residents may receive weekend passes according to the Phase assignment.
3. Upon approval, residents must provide the following information:

    a. Destination and address.
    b. Contact name and phone number (CM must have a release on file for the contact.)
    c. Date leaving.
    d. Date returning.

If an emergency arises and you are unable to return as scheduled, you MUST contact on-call staff. Staff reserve the right to urine drug screen and breathalyze you upon return. This may include reporting to the Addictions Crisis Center (ACC)

CURFEW

1. Residents must observe curfew as stated above.
2. If you determine that you are in a situation that warrants a time extension you will need to follow the procedure stated above.
3. If you plan on attending a special event which will prevent you from returning at curfew; you will need to discuss this with your Case Manager or Program Coordinator **PRIOR** to the event.

Non-compliance with this policy may result in immediate discharge

FRS Community Residence:	722-8987 EXT. 4	
FRS Supportive Living:	Program Coordinator 722-8987	EXT. 233
	Base Case Manager	EXT. 246
	Women's Empowerment Case Manager	EXT. 238
	Mannion Case Manager	EXT. 228

By signing this form, I acknowledge the Pass Request and Curfew policies. I have been given the opportunity to ask questions.

_____ _____

Resident's Signature Date FRS Staff Signature Date

MEDICATION POLICY
COMMUNITY RESIDENCES/SUPPORTIVE LIVING:

It is the policy of Fairview Recovery Services, Inc. Community Residential and Supportive Living programs to provide a supportive alcohol and drug-free environment. Therefore alcohol and/or mood altering drugs are not allowed on the premises. We recognize that there is an individualized need for certain residents to take medications for both their physical and mental health needs. Therefore the only acceptable mood altering drugs that are allowed on the premises are those medications that are prescribed by a physician.

Procedure: On Admission to Supportive Living, Residents will review all the medications that have been prescribed to them with their Case Manager. The resident must demonstrate the ability to manage their medication on their own prior to admission.

Residents must inform staff when any of the following situations occur:

Changes in the prescription
Beginning a new medication
Experiencing adverse reactions or side effects to medications

The Supportive Living staff reserves the right to meet with the client and count the quantity of medication with the client present at any time to ensure that no medications are being abused.

Any issues of non-compliance with medications will be managed as a therapeutic issue with the provider. Ongoing issues of non-compliance may ultimately result in discharge and a referral to an alternative level of care.

_____ _____
Client Signature Date

_____ _____
FRS Staff Signature Date

Fairview Recovery Services, Inc.
Supportive Living Program
Mannion House
Visitors Policy - Child

I, _____ agree to abide by the following policy regarding having overnight visitors at the house that I currently occupy:

I understand that I will not be allowed to have overnight guests/and or children, due to the living situation of Mannion House.

During visitation hours I agree to assume full responsibility for my child.

I recognize the need to be in supervision of my child at all times.

I recognize that my child is not the responsibility of my housemate(s) or Fairview Recovery Services, Inc.

Fairview Staff reserves the rights to implement rules when problems or concerns arise.

_____ _____

Client Signature Date

_____ _____

FRS Staff Signature Date

Supportive Living Program
Mannion House
Visitor Policy

1. I understand that overnight guest(s) will not be allowed due to the living situation of the house.

2. I understand that visitation with my children is allowed throughout the week and on weekends as long as it doesn't interfere with my (and/or) my housemates recovery.

3. I agree that all guests will be alcohol/drug free.

4. I agree that Fairview Employees or clients are not to be responsible for my children at any time.

5. I understand that guests determined by F.R.S. staff to be inappropriate will not be allowed in Mannion House.

6. I agree that there will not be guests in Mannion House when I am not at home. I agree that any deviations from the above policy may result in discharge from Supportive Living.

7. I agree guests must leave by **9:00p.m.** due to the living situation at Mannion House. I understand that special requests for guests to stay until the regular curfew will need to be approved by my case manager 24 hours in advance of visit.

8. I agree that no one but me will have keys to Mannion House and/or my bedroom.

9. I agree guests will visit in common areas only. Bedrooms **are not** common areas.

Staff reserves the right to implement rules when problems or concerns arise.

_____ _____

Client Signature Date

_____ _____

FRS Staff Signature Date

Fairview Recovery Services

Guidelines for Living:
Supportive Living

1. No X-rated movies or material that is sexually explicit throughout the Mannion House. This is a house of recovery and these types of materials have no place here.

2. Verbal or physical threats or acts of violence are not acceptable. Racial and sexual slurs, sexual harassment and vulgarity are not acceptable. Violation of these norms may lead to discharge.

3. There is to be no yelling up or down the stairs for any reason. Disruptive loud noise, music, TV's is not acceptable and may lead to discharge.

4. Residents are responsible for supplying their own phone services. It will be the resident's responsibility to sign financial contract for cable services.

5. Residents are responsible for the cleanliness of the house and outside area of the house.

6. Please be courteous and respectful in all living areas that are shared.

7. You are responsible to supervise **children, friends** and **family members** during visitation. You are not allowed to leave them in the apartment at anytime for any reason during visitation.

8. You have the right and responsibility to confront another resident on their old behaviors. We are not here to judge one another and everyone makes mistakes. It is your responsibility, based on the severity of the behavior, to inform staff.

9. The residents of Supportive Living are ineligible to eat meals at the Residential Halfway House at either lunch or dinner without an invitation from a Halfway House client.

10. NO playing cards unless approved by staff. No betting, gambling, pools on sporting events etc. No scratch off lottery ticket. NO gambling of any kind.

Fairview Recovery Services, Inc.
Resident Contract
Supportive Living Program

Fairview Recovery Services, Inc. is a private, nonprofit agency with the mission to improve the quality of life and health of persons diagnosed with and recovering from alcoholism, substance abuse and other disabling conditions. Providing you with residential, rehabilitation and support services pursues this goal. The purpose of this contract is to outline what is expected of you and the role of staff to ensure that you have a safe, secure supportive setting in which to live and to work on your recovery/rehabilitation goals.

Client Expectations: As a resident of Fairview Recovery Services, Inc. Supportive Living Program, I agree:

1. To treat all community members (other residence and staff) with dignity, and to respect they're personal rights and property, their right to privacy and their right to receive support as a member of Fairview Recovery Services, Inc. community.

2. To be willing to live cooperatively, and respectfully with my housemates.

3. To participate in the development and carrying out of the activities of my individualized recovery/treatment program to include:

- Maintain sobriety and abstinence from non-prescribed drugs.
- Meeting with F.R.S. staff on a regularly scheduled 1:1 basis to discuss my plan, services, progress, and changes in my plan, and any other concerns that need to be shared.
- Being involved in a program of goal-oriented activities, therapy, treatment, and/or training, for at least 20 hours a week.
- Participate regularly in community meetings and case management groups.
- Maintaining regular contact with my treatment counselor and Case Manager.

4. To assume responsibility for my health and hygiene and for the care and safe keeping of Fairview

Recovery Services, Inc. property, personal property, and personal living areas to include:

- Keeping myself in good health and maintaining good personal hygiene.
- Maintain my house/bedroom in a clean and orderly fashion.
- Assuming responsibility of house/bedroom keys by insuring against loaning or duplication, and promptly returning all issued keys upon request.
- Assuming financial responsibility for lost or damaged Fairview Recovery Services, Inc. property at replacement value to be established by the Program Coordinator in conjunction with the Clinical Director.

5. To assume responsibility for fee payment from day of admission and for other financial responsibilities as described in the Financial Contract

6. Fairview Recovery Services, Inc. is not responsible for personal belongings. Fairview Recovery Services, Inc. is not responsible to replace lost or damaged personal property. Personal belongings left behind by a resident will be considered forfeited and will be disposed of at the discretion of Fairview Recovery Services, Inc**.**

7. To insure my physical and emotional well-being and that of the community members by:

- **No smoking** in any area inside Mannion House.

— Use of candles, is limited to designated areas of living room and kitchen.

— Learning the fire evacuation plan.

— Storage and use of weapons in or around the house is strictly prohibited

— Abstinence from all non-prescribed, mood-altering substances is expected in accordance with my individualized service plan. I further understand that any use will result in an evaluation by staff to determine what care and attention is needed to insure my health and safety and to decide about my continued participation in the program.

— Preparing and storing food in a responsible way that insures my safety and that of others, as well as Fairview Recovery Services, Inc. property and to consume food and beverages only in designated areas to insure a clean environment.

— Agreeing that the staff may enter my bedroom and the house without my prior permission to make routine maintenance checks and random searches and at any other time there is a concern for any health or safety issue or when there is a concern that I and not complying with the program expectations.

— I agree not to have any "pets" of any type, which are dependent upon me to sustain its life in my apartment. Pets include dogs, cats, birds, reptiles, fish, amphibious creatures, insects, and small mammals, any and all creatures domesticated or wild.

Fairview Recovery Services, Inc. Responsibilities: Fairview Recovery Services, Inc. agrees to provide the following:

1. To provide you with the following services without regard to your sex, race, religion, national origin, sexual preference and mental, emotional, or physical condition:

a) Admission and Discharge planning
b) Training in activities of daily living.
c) Case management
d) Supportive counseling focusing on relapse prevention and monitoring of sobriety.
e) Crisis management (dealing with difficult situations through appropriate interventions and referrals to community agencies)
f) Room and Board
g) Socialization and Leisure Activities
h) Accessing Transportation
i) Developing appropriate behaviors through effective interventions.

2. To assist you in:

a) Identifying and defining your needs.
b) Developing and individualized service plan.
c) Identifying appropriate agencies and services to meet your needs
d) Recommending and or referring and coordinating services
e) Identifying and clarifying your satisfaction or dissatisfaction about the services you are receiving and helping you to find appropriate methods to express your views.
f) Supporting and reviewing progress and changing your service plan, as appropriate, through regularly scheduled meetings with your case manager and treatment counselors.
g) Dealing with difficult situations through crisis counseling or other appropriate interventions

3. To treat individuals with dignity; ensuring that your personal rights include, but are not limited to, the:
a) Right to reasonable privacy
b) Right to confidentiality
c) Right to access to your records as described in agency policies.
d) Right to receive visitors
e) Right to voice grievances or complaints about the programs, staff and facility, in an appropriate manner, without fear of reprisal
f) Right to exercise all other rights guaranteed to citizens of the community

4. To provide you with a clean, safe sober living environment.

I understand that I have entered this program voluntarily and may leave voluntarily, having given proper notice.

I understand that if I am satisfied or not satisfied with something, I am encouraged to inform staff.

Fairview Recovery Services will make a sincere effort to ensure a safe environment and your views will be taken seriously.

Resident's Signature _____ Date _____

Case Manager's Signature _____ Date _____

Fairview Recovery Services, Inc.
Contract for Cable Service

As part of my residency at Mannion House, I agree to pay ten dollars ($10.00) each month for cable services in my room.

I agree and understand that ten dollars ($10.00) will be automatically taken from my PNA each month for this service.

I agree and understand if I wish to discontinue this service I must notify my Case Manager in writing.

Failure to pay for this service will result in the discontinuation of cable.

Cable prices are subject to change. You will be notified of any change in services or cost. Monthly deductions will be adjusted accordingly.

_____
Signature

_____
Witness

_____
Date

FAIRVIEW RECOVERY SERVICES, INC.
Michele Napolitano, MSEd, CRC, CASAC
Executive Director
5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 722-6767

FAIRVIEW COMMUNITY RESIDENCE
MERRICK COMMUNITY RESIDENCE
SUPPORTIVE LIVING
CAREER CHOICES UNLIMITED
5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 722-6767

ADDICTIONS CRISIS CENTER
247 Court Street
Binghamton, NY 13901
Phone (607) 722-4080
Fax (607) 723-1858

2-WAY CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Social Security Number: _____ Date: _____

I, _____, hereby authorize and consent to

communication **BETWEEN: Fairview Recovery Services, Inc.** and

_____
(Agency Name, Full Address, Phone Number)

_____**(**or his/her successors).
(Name & Title of a Contact Person)

The extent of information to be disclosed: **Dates of residency, progress, service planning, discharge planning**

The purpose of the disclosure authorized herein is to: **Facilitate Funding**

I, the undersigned, have read and authorized the staff of the disclosing facility name to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire 6 months from its signing, unless a different time period, event or condition is specified below, in which case such time period, even or condition shall apply. I also understand that any disclosure is bound by Title 42 of the Code of Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information is forbidden without written authorization on my part.

Time period, event or condition replacing period specified above: 6 months from date of discharge

Note: Any information released through this form will be accompanied by Form A-4400 Prohibition on Re-disclosure of Information Concerning Alcoholism/Drug Abuse Patient.

_____ _____
Patient Signature Witness Signature

_____ _____
Patient Name (Printed) Witness Name (Printed)

_____ _____
Date Date

Fairview Recovery Services

SUPPORTIVE LIVING

What to Pack for Your Stay

For your convenience, please use this checklist as you prepare for your stay at our facility.

Please bring only items identified on the list below.

Upon Admission all Clients are expected to bring:

● Linens ● Towels ● Personal Hygiene & Cleaning Supplies

***** 3 BAG LIMIT PER CLIENT *****

Clothing:

The amount of clothing is to not exceed 2 bags. Please have weather appropriate clothing and plan to switch out clothing as the seasons change. Items FRS suggests having is as follows:

☐Shirts/Blouses
☐ Pairs Jeans/Pants/Skirts in Combination
☐Underwear/Socks/Bras
☐Pajamas/Robe/Slippers
☐Outer Set (coat/jacket, gloves, hat, boots)
☐Sneakers

Toiletries:

☐Shampoo
☐Deodorant
☐Soap
☐Toothbrush
☐Toothpaste
☐Washcloths
☐Towels

Bedding:

☐ (Full-Size Bed in most apartments)
☐Sheets/Pillowcases
☐ Pillows
☐Blanket
☐Comforter

Other:

☐Notebook, Stationary, Stamps, Pens
☐Appropriate Books, Novels and Magazines
☐Family Photo
☐Laundry detergent
☐Basic household cleaning supplies; dish detergent, bathroom cleaner, kitchen cleaner, etc.

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FAIRVIEW RECOVERY SERVICES PROVIDES:
BASIC HOUSEHOLD ITEMS AND FURNITURE.

SUPPORTIVE LIVING IS A TEMPORARY LIVING SITUATION.
CLIENTS ARE NOT PERMITTED TO BRING IN:
FURNITURE AND/OR HOUSEHOLD ITEMS.

ONLY THE ABOVE ITEMS ARE PERMITTED
TO BE BROUGHT INTO THE APARTMENTS.
~~~~~~

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT
LOCADTR ASSESSMENT

Revoked On: _____ Staff Initials: _____

Patient's Last Name	First	M.I.
Case Number		
Facility	Unit	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED:

All information necessary to complete a personalized Level of Care for Alcohol and Drug Treatment Referral "LOCADTR" assessment.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION:

I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the OASAS-Certified treatment facility identified above, and Payer / Managed Care Plan _____ _____ of my clinical treatment including information from the OASAS Client Data System (CDS) and my Social Security Number.

I understand that the level of care determination assessment will only be shared with me, the OASAS treatment facility, and Payer / Plan identified above. Unless I have given written permission to share the information with other agencies, programs or payers.

I further understand that non-personal identifying information may be evaluated so that the effectiveness of the LOCADTR assessment tool can be evaluated.

I, the undersigned, have read the above and authorize the New York State Office of Alcoholism and Substance Abuse Services and the staff of the OASAS-certified treatment facility named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

_____ (Signature of Patient)

_____ (Signature of Parent/Guardian)

_____ (Print Name of Patient)

_____ (Print Name of Parent/Guardian)

_____ (Date)

_____ (Date)

Fairview and Merrick Community Residences
Supportive Living
Addictions Crisis Center
5 Merrick Street, Binghamton, NY 13904

Consent for Release of Information Concerning Alcoholism/Drug Abuse Patient

Instructions: Prepare one (1) copy for patient's case record. If this form is used for billing purposes, prepare additional copy for Patient Resources Office. If this form is sent to another agency for information, prepare a second copy for patient's case record.

Patient Name: _____
Last *First* *MI*

DISCLOSURE WITH PATIENT'S CONSENT

Extent or nature of information to be disclosed:
Dates of residency, progress, service planning, discharge planning

Purpose or need for the disclosure:
To coordinate continuity of care

Between name of person or organization disclosing information:
Fairview Recovery Services

And the name of the Financial/funding source to which the disclosure is being made:
Chemical Dependency Services Unit

I, the undersigned, have read the above and authorized the staff of the disclosing facility name to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire 6 months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure is bound by Title 42 of the Code of Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information is forbidden without written authorization on my part.

Time period, event or condition replacing period specified: 6 months from date of discharge

Note: Any information released through this form will be accompanied by Form A-4400 Prohibition on Re-disclosure of Information Concerning Alcoholism/Drug Abuse Patient.

_____	_____	_____	_____
Patient Signature	Date	Signature of Parent/Guardian when required	Date
_____	_____	_____	_____
Patient Name (Printed)	Date	Parent/Guardian Name (Printed)	Date

Congregate Care Level II Referral Authorization Form (07/2017)

Current Date: _____

Referring Agency: _____

Client Name: _____

Client DOB: _____

Current CCII treatment recommendation:
(Information/Program/Level of Care change regarding the referral your agency is seeking approval for)

Client's History and Diagnosis:
(Include information here regarding the client's condition and specific diagnosis. Also, include the client's history related to their condition)

Treatment Rationale:
(Include information on the treatment up to this point, course of care and why the change in treatment is necessary, how this cannot be accomplished locally, and how you expect that it will help the patient.)

Duration:
(Length of time treatment is necessary)

Name (please print) and Signature of Licensed Provider _____

_____

DSS/CDSU APPROVAL – No payment from DSS will occur unless approval is granted

APPROVAL ☐ **DENIAL ☐**

Colleen O'Neil, BS, CASAC
Program Coordinator/Broome County Chemical Dependency Services Unit at
Broome County Department of Social Services

Signature of CDSU CASAC: _____

Fax to Broome County CDSU @ (607) 778-1254

****Provide FRS Inc. with fax confirmation***