SHELTER PLUS CARE

REFERRAL/APPLICATION PACKET

Updated August 2016

Applicant's Name: ____

Date: ____

Referral Source: ____

Received Date: ____

Staff: ____

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.

SHELTER PLUS CARE
REFERRAL/ADMISSION PACKET
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Introduction

Thank you for your interest in Fairview Recovery Services' Shelter Plus Care Program. The Shelter Plus Care Program is a HUD funded subsidized housing program that assists homeless people with disabilities. In order to participate in the Shelter Plus Care Program, the client must meet the HUD definition of homelessness, have a disability documented by a qualified health professional and participate in supportive services that are equal to or greater in value to the yearly costs of the rental subsidy they receive. The overall goals of the Shelter Plus Care Program are: 1) to increase housing stability; 2) to increase skills and/or income; and 3) to gain greater self-sufficiency.

In order to expedite your application please complete and provide the following:

1. Shelter Plus Care Application Form
2. Shelter Plus Care Resident Agreement
3. Shelter Plus Care Medication Policy
4. Shelter Plus Care Vocational Policy
5. Shelter Plus Care Overnight Visitor Policy
6. Current Psychosocial Evaluation
7. Provide Documentation of Homelessness
8. Copy of Birth Certificate
9. Copy of Social Security Card
10. Consent for Release of Information

After we receive the items listed above, your client will be scheduled with an interview with the Shelter Plus Care Case Manager to determine eligibility.

If you have questions, please contact the Shelter Plus Care Case Manager at (607) 722-8987 extension 240.

Again, thank you for interest in Fairview Recovery Services.

FAIRVIEW RECOVERY SERVICES, INC.
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:
____

Purpose or need for the disclosure: **Continuity of Care**
____
____

Between name of person or organization disclosing information:
____

And name of the person or organization to which the disclosure is being made: ____________________
Fairview Recovery Services, Inc.

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 above: ***6 months following 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

FAIRVIEW RECOVERY SERVICES, INC.
Fairview and Merrick Community Residences
Supportive Living
Addictions Crisis Center
5 Merrick Street, Binghamton, NY 13904

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

Date:_________________

APPLICATION
Shelter Plus Care Program (S+C)

I. APPLICANT INFORMATION

Please check the size of the unit you are applying for:
Efficiency 1Bedroom 2 Bedroom 3 Bedroom

Name

Address City State Zip

Phone Number | How long have you lived at this address?

Type of Housing currently living in (emergency or transitional housing, with friends, own apartment, etc

Are you presently involved in outpatient treatment?: yes no If yes, which type of treatment?

Outpatient Drug and/or Alcohol: Where:_______________________ Frequency:_________________
Outpatient Mental Health: Where:_______________________ Frequency:_________________

II. HOUSEHOLD COMPOSITION

List the Head of Household and all other members who will be living in the unit. Give the relation of each member to the head

Participant Name	Relationship to Head of Household	Birth Date	Age	Sex	Social Security #

Do you expect a change in your household composition? Yes No

If yes, please explain:

Please explain any special housing needs you would need:

Are you or anyone in your household subject to state lifetime registration requirement for sex offenders?
yes no If yes, identify household member

Have you or anyone in your household ever been convicted of a crime?
yes no If yes, identify household member

III. HOUSING HISTORY

Have you ever been evicted? yes no If yes, please explain reason(s)::

How many times have you been homeless in the last four years?

IV. FINANCIAL INFORMATION

Present Source of Income	Monthly Amount
Health Insurance: Medicaid None Medicare Other (specify):	Food Stamps: yes no Amount:

Have you contacted NYSEG within the past 30 days, about potentially setting up services? yes no
Who did you speak with at NYSEG? ____
Do you owe any utility balances? yes no
If yes, how much is your back balance: ____
What is your plan for repayment? ____

V. APPLICANT CERTIFICATION

I/we certify that if selected to receive assistance, the unit I/we occupy will be my/our only residence. I/we understand that the above information is being collected to determine my/our eligibility. I/we certify that the statements made in this application are true and complete to the best of my/our knowledge and belief.

Signature of Applicant Date

FAIRVIEW RECOVERY SERVICES, INC.

Michele Napolitano, Executive Director

FAIRVIEW COMMUNITY RESIDENCE
MERRICK COMMUNITY RESIDENCE
SUPPORTIVE LIVING
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

Dear Referring Agency,

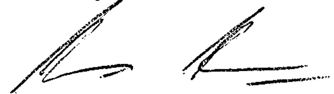
As a requirement of HUD, the "***Client Homeless Status: Eligibility Documentation***" form has been added to our referral packet. If the individual you are referring is not homeless, please indicate that next to the client's name on the form and sign it.

If the individual is homeless, please check the box that describes the individual's situation and attach supporting documentation to the form.

Examples of supporting documentation can be found in the second column on the form. If you are in need of additional assistance, or have any questions regarding this referral requirement, please feel free to contact our Shelter Plus Care Coordinator at (607) 722-8987 ext. 240.

Thank you for your cooperation with this HUD requirement.

Sincerely,



Michele Napolitano, MSEd, CRC, CASAC
Executive Director

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

SHELTER PLUS CARE QUESTIONNAIRE

CLIENT NAME: ______________________________

DATE: ______________________________

TO BE FILLED OUT BY APPLICANT

What do you wish to accomplish while in the Shelter Plus Care Program?

____
____
____
____

What is your primary source of income? _____DSS _____SSI/SSD _____OTHER _____NONE

Which support services are you currently involved in?

___Case Management
___Intensive Day Treatment
___Alcohol/Substance Abuse Services
___Mental Health Services
___Health Care
___Probation/Parole
___Education
___Other: (Explain)

____
____

Do you owe past utility bills? _____Yes _____No

Have you ever been evicted from an apartment? _____Yes _____No
If so, who was the landlord? ____

I understand that, in order to participate in the Shelter Plus Care Program, I must participate in supportive services that are equal to, or greater in value, to the yearly costs of the rental subsidy I receive. I am aware that the overall goals of the Shelter Plus Care Program are: 1) to increase housing stability; 2) to increase skills and/or income; and 3) to gain greater self-sufficiency.

____

Signature

Medication Policy

On admission to Shelter Plus Care Residents will review the medications that have been prescribed to them with their case manager. Residents must demonstrate they ability to manage their own medications before admission.

Residents must inform staff when any of the following occurs:

1. Changes in Prescriptions
2. Beginning a new medication
3. Experiencing adverse reactions or side effects to medications
4. Questions regarding medications

I agree to take my medication as prescribed by the doctor, and agree not to abuse my medication.

Resident's Signature ________________________ Date ______________

Counselor's Signature _______________________ Date _____________

Fairview Recovery Services
Shelter Plus Care

Overnight Visitor Policy

1. I understand that I may use my discretion in allowing when I invite an overnight guest(s).
2. I agree that all guests will be alcohol and/o drug free.
3. I agree to assume full responsibility for my children.
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 Fairview staff to be inappropriate will not be allowed in my residence.
6. I agree that there will not be guests in my residence when I am not at home (except with prior FRS staff approval)
7. I agree that no one but me will have keys to my residence.

______________________________ ____________________
Client Signature Date

______________________________ ____________________
FRS Staff Signature Date

Shelter Plus Care
Relapse Policy

1. We will treat all clients' relapses on an individualized basis.

2. Upon notification of relapse, I understand a meeting will be held with my primary S+C case manager. This will be for the purpose of gathering facts and information regarding the events leading to the relapse.

3. The next step will include a team meeting, which will include all providers involved with my care. I understand, I will be given an opportunity to present the team with any information I feel is important in the decision making of my continued care and recovery.

4. The team will make a recommendation based on the individual needs of the client and present it to the client.

5. Following presentation to the client the service plan will be amended to reflect new treatment plan.

Client signature______________________________ Date _______________________

SHELTER PLUS CARE VOCATIONAL POLICY

As a participant of the Shelter Plus Care Program, I agree to the following Voc/Ed policy:

1) I agree upon admission to met with a Career Choices Unlimited case-manager to do:
   a) create and or update Vocational Educational plan.
   b) inform of residency changes.

2) I agree to be a participant in one of the following: Employment, volunteer work, GED classes, or college.

3) I agree to follow through with all goals agreed upon with the CCU case-manager until completion of the Voc/ED program.

Residents Signature ____________________________ Date: _____________________

Counselor's Signature___________________________Date:_____________________

Fairview Recovery Services, Inc.
Resident Contract
Shelter Plus Care 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 rehabilitation goals.

Client Expectations: As a resident of Fairview Recovery Services, Inc. Community residence, I agree:

1. To treat all community members (other residence and staff) with dignity, and to respect their 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 participate in the development and carrying out of the activities of my individualized rehabilitation program to include:

- Maintain sobriety and abstinence from non-prescribed drugs.
- Meeting with Fairview Recovery Services, Inc. staff on a regularly scheduled 1:1 monthly 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, rehabilitation, work and/ or training, for at least 20 hours a week.

  Maintaining regular contact with my primary therapist/ counselor.

3. 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.
- Maintenance and cleaning of the apartments.
- Assuming responsibility of apartment 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 Clinical Director.

4. To give 30 days written notice of my intent to leave Fairview Recovery Services, Inc.

5. To insure my physical and emotional well-being and that of the community member

- Supporting fire prevention activities by using smoking materials (candles, incense etc.) only in designated areas and in a safe responsible way.
- Learning the fire evacuation plan and participating in fire drills.
- Refraining from the storage and use of weapons in or around the apartment.
- As a client with a history of alcohol or other substance abuse or dependence, complete abstinence from all non-prescribed, mood-altering substances is expected in accordance with my individualized rehabilitation 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.

- Informing staff of all prescribed and over-the-counter medications I am taking and immediately reporting changes in dose and frequency, and then taking these medications only as approved by my physician.
- 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.
- Informing staff when I will be away from my apartment for longer than two days at a time.
- Welcoming guests within the following guidelines: children need to be carefully supervised during their visit; occasional overnight visitation is permitted All guests must be clean and sober.
- Agreeing that the staff may enter my apartment without my prior permission to make routine maintenance checks and at any other time, there is a concern for any health or safety issue or when there is a concern that I am not complying with the program expectations.

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 who leaves, will be held for a period of (30) days. After that time, all belongings will be considered forfeited and will be disposed of at the discretion of Fairview Recovery Services, Inc.

Fairview Recovery Services, Inc. Responsibilities: To further your rehabilitation the staff of Fairview Recovery Services, Inc. agree:

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 counseling or other appropriate interventions)
f) Medication Management

2. To assist you in:

a) Identifying and defining your needs.
b) Developing and individualized rehabilitation 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 rehabilitation plan, as appropriate, through regularly scheduled meetings with your primary counselor.
g) Dealing with difficult situations through crisis counseling or other appropriate interventions

3. To treat you and your fellow clients with dignity and 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 make and receive phone calls
e) Right to receive visitors
f) Right to send and receive mail unopened
g) Right to voice grievances or complaints about the programs, staff and facility, in an appropriate manner, without fear of reprisal
h) Right to exercise all other rights guaranteed to citizens of the community

4. To provide your family members/ significant others with an orientation to the program and ongoing consultation, education and support with the primary purpose of helping them understand and support you while you are in the program.

I understand that Fairview Recovery Services, Inc. staff is responsible for helping me find ways to make my stay a growth experience and to help me address situations with which I am not satisfied.

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. A safe environment will be provided and my views will be taken seriously.

Resident's Signature ______________________ **Date** ____________

Counselor's Signature ______________________ **Date** ____________

_____ **Chart Copy**

_____ **Client Copy**

Revoked On: ___________ Staff Initials: __________

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

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

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 between, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the OASAS-Certified treatment facility identified above 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 and the OASAS treatment facility 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)