Catholic Charities of Cortland County
OASAS Program Referral

Date: __________

Referral to: (Please check one)
☐ Charles Street Community Residence
☐ Recovery Apartment Program

Referral Source

Referring Agency, if applicable: ______________________________

Contact Name: ______________________________ Referral Source Phone: ______________________________

Referral Source E-mail: ______________________________ Admission Date: ______________________________

QHP Signature: ______________________________ Anticipated Discharge Date: ______________________________

Applicant Information

Name: ______________________________ Phone: ______________________________

Address: ______________________________

Current living situation: ______________________________

Social Security Number: ______________________________ Date of Birth: ______________________________

☐ Female ☐ Male ☐ Non-Binary ☐ Transgender

Has the applicant been referred to us before? ☐ No ☐ Yes

If yes, please provide details:

Financial Information

☐ Medicaid Number: ______________________________

☐ Medicaid MCO: ______________________________

☐ Private Insurance Company: ______________________________

☐ County of Origin: ______________________________

☐ Public Assistance Amount: ______________________________

☐ SSI/SSD Amount: ______________________________

☐ Unemployment Amount: ______________________________

☐ Other Income: ______________________________

Is the applicant currently sanctioned by DSS? ☐ No ☐ Yes

If yes, please provide details:

Has the applicant ever been sanctioned by DSS? ☐ No ☐ Yes

If yes, please provide details:

MEDICAL HISTORY

The applicant has the following medical conditions:

☐ Allergies; details:

☐ Seizures; details:

Date of most recent PPD Test: _____________

Result of PPD: _________________________________

Date of most recent History & Physical: ___________

Please attach H&P to this completed referral.

Is the applicant currently pregnant? ☐ No ☐ Yes

Is the applicant currently breastfeeding? ☐ No ☐ Yes

BEHAVIORAL HEALTH *(Substance Use and/or Mental Health)*

Principle Diagnosis

____

ICD Code

____

The applicant has the following additional behavioral health conditions.

(Please include all substance use and mental health information.)

Date of most recent psychosocial assessment: ___________

Please attach psychosocial assessment to this completed referral.

Is the applicant capable of self-preservation (evacuation from facility) in case of an emergency?

☐ No ☐ Yes

Is the applicant capable of self-administration of medications?

☐ No ☐ Yes

Recommendation(s) regarding treatment focus and why you, as the referral source, feel this level of care may be appropriate for the applicant.

JUSTICE INVOLVEMENT

Probation

☐ Never

☐ Current Involvement
Probation Officer: ____________________________

☐ Past Involvement
Dates: ________________

Parole

☐ Never

☐ Current Involvement
Parole Officer: ____________________________

☐ Past Involvement
Dates: _______________

Conviction of a Crime

☐ Never

☐ In past 90 days; provide details

☐ More than 90 days ago; provide details

Charges Pending

☐ No

☐ Yes; provide details

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Include the following with this completed referral:

- Referrals made by a clinical professional must include a QHP signature. (In red on page 1 of this referral form)
- Current medication list
- Current History & Physical (H&P)
- Current Psychosocial Assessment
- Documentation of PPD test completed within 12 mos.
- Current laboratory reports, including CBC and drug screen results
- Documentation supporting the requested level of care

PLEASE SEND REFERRALS VIA ONE OF THE FOLLOWING METHODS:

Fax: (607) 756-7214

Mail:
Catholic Charities
ATTN: CSR/RAP Program Manager
33-35 Central Avenue
Cortland, New York 13045
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NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

CONSENT FOR RELEASE OF INFORMATION REGARDING PERSONS WITH SUBSTANCE USE DISORDER

REVOKED ON__________Staff Sig_____________

PATIENT'S LAST NAME	FIRST	M.I.
Charles Street Residence	Recovery Apartment Program	

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.

[DISCLOSURE] / [RELEASE] WITH PATIENT'S CONSENT

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED (CIRCLE)	
PURPOSE OR NEED FOR DISCLOSURE/RELEASE (CIRCLE)	
NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION Between:	NAME OR TITLE OF PERSON OR ORGANIZATION TO WHICH THE DISCLOSURE/RELEASE IS TO BE MADE And:

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. 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 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/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of patient records for persons with substance use disorder, as well as the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to aparty other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above:____

____

____

NOTE:	Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Regarding Persons with Substance Use Disorder (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, as recognized by my signature below.

_______________________________ (Signature of Patient)

_______________________________ (Signature of Parent/Guardian, when required)

_______________________________ (Print Name of Patient)

_______________________________ (Print Name of Parent/Guardian)

_________________ (Date)

_________________ (Date)

State of New York
OFFICE OF ADDICTION SERVICES AND SUPPORTS

NOTE: This form must be attached to all disclosures/releases of information regarding persons with substance use disorder.

PROHIBITION ON REDISCLOSURE OF INFORMATION REGARDING PERSONS WITH SUBSTANCE USE DISORDER

(To accompany disclosure of information made with consent for persons with substance use disorder)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2 and HIPAA). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whomit pertains or as otherwise permitted by 42 CFR Part 2 and/or HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any person with substance use disorder.

Authorization for Release of Information (Consent Form)	**Name (Last, First, M.I.)** ________	**Medicaid CIN** ________
	Sex ________	**Date of Birth** ________
	Catholic Charities of Cortland County **Agency**	☐ CSR ☐ RAP **Program**

This authorization must be completed by the client or their personal representative to use/disclose protected health information (for reasons other than treatment, payment, or health care operations), in accordance with State and Federal laws and regulations.
A separate authorization is required to use or disclose confidential HIV related information.

Part 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

☐ Characteristics/Photograph ☐ Contact Information ☐ Current Medications ☐ Current Services ☐ Daily Living Skills
☐ Diagnosis ☐ Education ☐ Entitlements ☐ Electronic Files ☐ Emergency Contact
☐ Functional Abilities ☐ Mental Health ☐ Psychosocial information
☐ Other; specify: ________

Purpose or Need for Information:

1. This information is being requested:
   - ☐ by the individual or his/her personal representative; or
   - ☐ Other (please describe) Catholic Charities of Cortland County (CCOCC)
2. The purpose of the disclosure is (please describe)

☐ Bill Insurance ☐ Coordinate Services ☐ Electronic Database ☐ Emergency Contact
☐ Emergency Services ☐ Establish Entitlements ☐ Establish Services ☐ Housing
☐ Other; specify: ________

Exchange of Information, in either direction, between the parties below
(Include: Name, Address, Title of person/Organization/Facility/Program)

Catholic Charities of Cortland County (CCOCC) Charles Street Residence & Recovery Apartment Program Mailing Address: 33-35 Central Avenue Physical Address: 29 Charles Street Cortland, New York 13045 Phone: (607) 756-9313 Fax: (607) 756-4697	(Two Way) ⇔	**Admissions Committee** Cortland County Mental Health Clinic; Family & Children's Counseling Services; Guthrie Cortland Medical Center; Helio Health; Syracuse Recovery Services; Cortland County Offices including DSS, Probation, and Sheriff; Cortland City Police; and other Catholic Charities programs and departments

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above.
I understand that:
   1. Only this information may be used and/or disclosed as a result of this authorization.
   2. This information is confidential and cannot legally be disclosed without my permission.
   3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
   4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by Catholic Charities of Cortland County (CCOCC) shown below. I am aware that my revocation will not be effective if the person(s) I have authorized to use and/or disclose my protected health information has/have already taken action because of my earlier authorization.
   5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Addiction Services and Supports (NYS OASAS), nor will it affect my eligibility for benefits.
   6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524).

B-1. One-Time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above between the person(s)/organization(s)/facility(s)/program(s) identified above.
My authorization will expire:

☐ When acted upon;
☐ 90 Days from this Date;
☐ Other; specify: ________

Agency	Name (Last, First, M.I.)	Medicaid CIN
Catholic Charities of Cortland County		

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above between the person(s)/organization(s)/facility(s)/program(s) identified above as often as necessary to fulfill the purpose identified above.

☐ My authorization will expire: ______________________

☐ When I am no longer receiving services from: ☐ CSR ☐ RAP

☐ One year from this date ☐ Other; specify: ______________________

C. Client Signature: I certify that I authorize the use of my health information as set forth in this document.

Signature of Client or Client's Personal Representative ______________________ Date ____________

Client's Name (Printed) ______________________

Personal Representative's Name (Printed) ______________________

Description of Personal Representative's Authority to Act for the Client (*required if Personal Representative signs Authorization)*

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was offered to the client and/or the client's personal representative.

WITNESSED BY: ______________________
Staff person's name and title

Authorization Provided to: ______________________

Date: ______________________

To be Completed by Facility:

Signature of Staff Person Using/Disclosing Information ______________________

Title ____________ Date Release ____________

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:

I hereby refuse to authorize the use/disclosure indicated in Part 1, between the Person(s)/Organization(s)/Facility(s)/Program(s) whose name and address is:

Signature of Client or Client's Personal Representative ______________________ Date ____________

Client's Name (Printed) ______________________

Personal Representative's Name (Printed) ______________________

Description of Personal Representative's Authority to Act for the Client *(required if Personal Representative signs Revocation of Authorization)*

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 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)