Catholic Charities of Cortland County
OASAS Program Referral

Check One: ☐Charles Street Community Residence ☐Recovery Apartment Program

Referral Source _____ Phone _____ Date _____

Contact Name _____ QHP Signature _____

Referral Source E-mail _____

CLIENT INFORMATION

Name _____ Date of Birth _____ Soc. Sec. # _____

Address _____ Phone _____

☐Male ☐Female

Has the applicant been referred to us before? ☐ Yes ☐ No
If yes, explain. When, for what services and circumstances:

Current Living Situation: _____

FINANCIAL STATUS
Client Receives: ☐ SSI ☐ SSD ☐ SSI/SSD Pending ☐ VA Benefit ☐ Wages
☐ PA - If yes, County of origin _____
☐ Has the client ever been sanctioned by DSS? If yes, please explain:

MEDICAL STATUS
Does applicant have any medical conditions that should be noted? (i.e. seizures, allergies, special diet, visual impairment, limited impairment, chronic illness, etc.)
☐ Yes ☐ No If yes, explain:

Is applicant capable of self- preservation in case of emergency? (Evacuating housing safely) ☐ Yes ☐ No

MENTAL HEALTH HISTORY

☐Yes. If yes, attach psycho-social assessment.
☐No.

SERVICE UTILIZATION

Check any services used. If checked, give dates and provider.

☐ Inpatient treatment: _____
☐ Outpatient treatment: _____
☐ OPWDD Service: _____
☐ Care Coordination: _____
☐OMH Services: _____
☐ Other: _____

CRIMINAL JUSTICE SYSTEM

Check if current or history of the following - Provide name of Probation/Parole Officer if current.

☐ Probation _____
☐ Parole _____
☐ Conviction of a Crime
☐ Charges Pending
☐ CPL Date _____

Provide Details:

CLINICAL ASSESSMENT

	ICD 10 Code(s)	Diagnosis
Primary	_____	_____

Note any recommendations, or focus of treatment, and why this level of care may be appropriate?

MEDICATIONS

Attach a copy of a current medication list.

Is client capable of self-administration of medications? ☐ Yes ☐ No

Please include the following with the referral information:

- This referral from a clinical professional must be signed by a QHP
- Current medical history & physical& medications list
- Current psycho-social assessment
- Documentation of PPD within 12 mos.
- Current laboratory reports including CBC and drug screen results
- Documentation supporting the level of care

PLEASE SEND REFERRALS VIA ONE OF THE FOLLOWING METHODS:

By Fax: (607) 756-7214

By Secure e-mail: blumley@ccocc.org

By Mail:
Catholic Charities
33-35 Central Avenue
Cortland, New York 13045
ATTN: Charles Street Residence

AUTHORIZATION FOR RELEASE OF INFORMATION	Patient's Names (Last, First, M.I.)	Client Number
	Sex _____	Date of Birth _____
	Catholic Charities of Cortland County Facility Name	☐ CSR ☐ RAP Unit/Ward/Residence No.

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), 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:

☐ Contact Information ☐ Current Medications ☐ Current Services ☐ Daily Living Skills ☐ Diagnosis
☐ Education ☐ Entitlements ☐ Emergency Contact Info. ☐ Functional Abilities ☐ Mental Health Status
☐ Psychosocial information ☐ Characteristics/ Photograph ☐ Electronic Files
☐ OTHER: _____

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 (Cortland County)
2. The purpose of the disclosure is (please describe)

☐ Screening/Assessment ☐ Bill Insurance ☐ Emergency Contact ☐ Emergency Services
☐ Establish Entitlements ☐ Establish Services ☐ Housing ☐ Coordinating Services
☐ Electronic Database
☐ OTHER: _____

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

Catholic Charities of Cortland County Residential & Housing 33-35 Central Avenue Cortland, New York 13045 P: (607) 756-5992 F: (607) 756-7214	(Two Way) ⇔	**Admissions Committee:** Including Representatives from Family & Children's Counseling Services, Cortland County Mental Health, City of Cortland Police Department, Guthrie Cortland Medical Center, Cortland County Probation Department, Catholic Charities of Cortland County

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 shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information 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, 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:

Facility/Agency Name	Patient's Name (Last, First, M.I.)	Client Number
Catholic Charities (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: ☐ Recovery Apartment Program ☐ Charles Street Residence

☐ One year from this date ☐ Other: _____

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

_____ _____

Signature of Patient or Personal Representative Date

_____

Patient's Name (Printed)

_____

Personal Representative's Name (Printed)

_____

Description of Personal Representative's Authority to Act for the Patient (*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 provided to the patient and/or the patient'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 Patient or Personal Representative Date

_____

Patient's Name (Printed)

_____

Personal Representative's Name (Printed)

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

AUTHORIZATION FOR RELEASE OF INFORMATION	Patient's Names (Last, First, M.I.)	Client Number
	Sex _____	Date of Birth _____
	Catholic Charities of Cortland County Facility Name	☐ CSR ☐ RAP Unit/Ward/Residence No.

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☐ OTHER: _____

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 (Cortland County)
2. The purpose of the disclosure is (please describe)

☐ Screening/Assessment ☐ Bill Insurance ☐ Emergency Contact ☐ Emergency Services
☐ Establish Entitlements ☐ Establish Services ☐ Housing ☐ Coordinating Services
☐ Electronic Database
☐ OTHER: _____

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

Catholic Charities of Cortland County Residential & Housing 33-35 Central Avenue Cortland, New York 13045 P: (607) 756-5992 F: (607) 756-7214	(Two Way) ⇔	Department Of Social Services _____ Address Phone Fax

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 shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information 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, nor will it affect my eligibility for benefits.
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My authorization will expire:

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

Facility/Agency Name	Patient's Name (Last, First, M.I.)	Client Number
Catholic Charities (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: ☐ Recovery Apartment Program ☐ Charles Street Residence

☐ One year from this date ☐ Other:

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

Signature of Patient or Personal Representative _____ Date _____

Patient's Name (Printed) _____

Personal Representative's Name (Printed) _____

Description of Personal Representative's Authority to Act for the Patient (*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 provided to the patient and/or the patient'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 Patient or Personal Representative _____ Date _____

Patient's Name (Printed) _____

Personal Representative's Name (Printed) _____

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

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 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)