

**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:

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**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 \_\_\_\_\_  Charges Pending
- Parole \_\_\_\_\_  CPL Date \_\_\_\_\_
- Conviction of a Crime

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:** [bvanwinkle@ccocc.org](mailto:bvanwinkle@ccocc.org)

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

<b>AUTHORIZATION FOR RELEASE OF INFORMATION</b>	Patient's Names (Last, First, M.I.) _____	Client Number _____
	Sex _____	Date of Birth _____
	Catholic Charities of Cortland County Facility Name _____	<input type="checkbox"/> CSR <input type="checkbox"/> 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:**

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> Contact Information      | <input type="checkbox"/> Current Medications         | <input type="checkbox"/> Current Services        | <input type="checkbox"/> Daily Living Skills  | <input type="checkbox"/> Diagnosis            |
| <input type="checkbox"/> Education                | <input type="checkbox"/> Entitlements                | <input type="checkbox"/> Emergency Contact Info. | <input type="checkbox"/> Functional Abilities | <input type="checkbox"/> Mental Health Status |
| <input type="checkbox"/> Psychosocial information | <input type="checkbox"/> Characteristics/ Photograph | <input type="checkbox"/> Electronic Files        |   |   |
| <input type="checkbox"/> 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)

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Screening/Assessment   | <input type="checkbox"/> Bill Insurance     | <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Emergency Services    |
| <input type="checkbox"/> Establish Entitlements | <input type="checkbox"/> Establish Services | <input type="checkbox"/> Housing           | <input type="checkbox"/> Coordinating Services |
| <input type="checkbox"/> OTHER: _____           |   |  |  |
| <input type="checkbox"/> Electronic Database    |   |  |  |

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

<b>Catholic Charities of Cortland County</b> Residential & Housing 33-35 Central Avenue Cortland, New York 13045 P: (607) 756-5992 F: (607) 756-7214	(Two Way) 	<b>Admissions Committee:</b> 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
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- 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 Catholic Charities (Cortland County)	Patient's Name (Last, First, M.I.)	Client Number
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**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)*

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

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<b>Catholic Charities of Cortland County</b> 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 _____
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- 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.
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Facility/Agency Name Catholic Charities (Cortland County)	Patient's Name (Last, First, M.I.)	Client Number
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- 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 <i>(required if Personal Representative signs Authorization)</i>	

**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 <i>(required if Personal Representative signs Revocation of Authorization)</i>	

**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)