



Community Residential Services
25 Dies Street
Canton, New York 13617
(315) 379-0139 Fax (315) 379-1004
www.ncfreedomhomes.org

To Start the Referral Process:

Provide the following information by Faxing to: (315)-379-1004, Mailing to: 25 Dies St., Canton, NY 13617, or by calling Angela Hooper at: (315) 379-0139 Ex 8. As soon as we have ALL REQUIRED information the individual will be placed on our waiting list.

Before your candidate can be interviewed: we will need copies of their Psychological and Social History, as well as their Medical Information including the results of BW, UR and a recent TB test.

All information/space must be completed BY PROVIDER, please do not list "see attached", or leave blank.

Admission Date Requested: _____

First Name: _____ **M.I.** _____ **Last** _____ **Sex:** _____ **Age:** _____

Date of Birth: _____ **Soc Sec #:** _____ **County of Residence:** _____

Referred By: _____ **Phone #:** _____ **Extension:** _____

Organization: _____

Financial Information

Medicaid does not pay for Community Residence/Halfway Houses

Is there Managed Care? _____ **If Yes Name of Company:** _____

Managed Care ID #: _____ **Active TA?** _____

Date Applied If Not Active: _____ **Medicaid CIN#** _____

Caseworker's Name: _____ **Phone:** _____ **Extension:** _____

Is There SSI? _____ **Disability?** _____ **Private Payment?** _____

Clinical Information

Diagnosis: _____

Treatment History: _____

MAT History: _____

Current MAT: _____

Last Use Date and Substance: _____

Psychiatric History

******If patient is currently exhibiting psychiatric symptoms, has had a suicide attempt in the last 12 months, or is currently on psychotropic, anti-anxiety or antidepressant medications, you MUST provide a psychiatric report******

Diagnosis: _____

Current Psychiatric Status: _____

Hospitalizations & OP: _____

Suicide Ideations/Attempts: _____

Current Psych Medications: _____

Medical History

Current Medical Issues: _____

Allergies: _____

Previous Medical Issues: _____

PPD Test Date/Results: _____

Current Medications/Dosage: _____

Legal Status

NYSID # _____

Pending Charges: _____

Previous Charges: _____

Previous Incarcerations: _____

Registered Sex Offender? _____

Probation/Parole/Drug Court: _____

Officers Name/Address: _____

Court Name/Address: _____

Signature/Title of Referral Source	
------------------------------------	--