C.A.R.S.
CAYUGA ADDICTION RECOVERY SERVICES
RESIDENTIAL CENTER

6621 Route 227, Trumansburg, NY
14886 Phone: 607-273-5500
Fax: 607-387-5793

2025 Cayuga Addiction Recovery Services Application

(Please use this application starting July 24, 2025)

Application for Admission – Men's Residential Program

Fax: 607-387-5793 or scan/email: carsadmissions@cayugahealth.org

Please call 607-275-5678 with any questions

The following information must be attached with this application packet for this to be considered a complete application.

PLEASE NOTE: PLEASE REVIEW THE APPLICATION BEFORE SUBMITTING. You must include all information on the consents, including printed names and signatures as indicated throughout the application. If not completed your application review will be delayed.

- ☐ PSYCKES Consent
- ☐ Release of Information for CARS and the Referral
- ☐ Release of Information for CARS and Medicaid Managed Care or Private Insurance
- ☐ Signatures on "What to Bring to Treatment"
- ☐ Signatures on "Program Rules and Expectations"

- ☐ LOCADTR Report
- ☐ Copy of Insurance card (If available)
- ☐ Physical Exam
- ☐ PPD results with chest x-ray when PPD is positive (if available)

Please be advised that:
Applications that are not completed fully, legibly, and accurately WILL delay the review process.

Client Demographics

Full Name: _____ DOB: _____ Sex: _____

Last Name at Birth: _____ FULL SSN: _____

County of Residence: _____ Address: _____

Ethnicity/Race: _____

Emergency Contact Person (Name and Relationship): _____ Phone: _____

Current Housing Situation: _____ Jail _____ Program _____ Temporarily Safe _____ Homeless

Are you mandated to Attend treatment? Yes _____ No _____

Copy of Court Mandate Letter Attached? Yes _____ No _____

Have you been on Public Assistance within the past 5 years?

If yes, When? _____ What county? _____

Substance Use Information

Total Number of prior treatment episodes: _____

Substance Use Diagnosis: _____

Have you ever overdosed? _____ If yes, did you receive Narcan? _____

Primary Substance

Substance Used: _____ Age First Used: _____

Date of Last Use: _____ Frequency: _____

Amount per Day: _____ Admission: _____

Secondary Substance

Substance Used: _____ Age First Used: _____

Date of Last Use: _____ Frequency: _____

Amount per Day: _____ Admission: _____

Tertiary Substance

Substance Used: _____ Age First Used: _____

Date of Last Use: _____ Frequency: _____

Amount per Day: _____ Admission: _____

Client Name: _____ Date of Birth: _____

Financial Information:

Insurance Provider: _____

Policy Number: _____

Medicaid ID: _____

If you do not have insurance, how will you be paying for medication while in treatment (If Applicable)?

_____

_____

Referral Source Information

Who Is Referring You to Treatment? _____

Address and Phone of Agency Referring You to Treatment (If Applicable):

Address: _____

Phone: _____ Fax: _____

Email: _____

Legal Information

Please check YES or NO for the following– Please add comments where applicable

	Yes	No	Comments:
Arson:			
Perpetrator of physical/emotional/ sexual abuse:			
Stalking:			
Violence:			
Pending charges:			
Legal History? (Arrests, charges, convictions, sentences)			

Do You Have A Pending Court Appearance? Yes_____ No _____

Date of Appearance _____ County _____

Are you on Probation/Parole? Yes _____ No _____

Probation/Parole Officer Name: _____ Phone: _____

Client Name:_____ Date of Birth:_____

Medical Information

Please check YES or NO for the following– Please add comments where applicable.

	Yes	No	Comments
Diabetes:			Type:
Asthma:			
Eating Disorders:			
COPD:			
COVID: (history/current)			
Heart/Cardiac:			
High Blood Pressure:			
Nicotine Use:			
Pregnant:			Due Date:
Allergies:			
Digestion Issues:			
Blood Disorders:			
Liver Disorders:			
Hepatitis C, B, A:			
HIV/AIDS:			
Menstrual Disorders:			
Emphysema:			
Hearing Loss:			
Acute or Chronic Pain:			
Mobility Issues:			❑ Wheelchair ⌊Elevator ⌊Respiratory Equipment
Infections:			
Scabies:			
Open Wounds:			
MRSA (history/current):			
Visual Impairments:			
Dental Issues:			
Recent Surgeries:			
Cancer History:			Current Status:

Client Name:_____ Date of Birth: _____

Please List Current Medications:

_____

_____

Are you currently vaccinated for COVID-19? Yes_____ No _____

Have You Been Hospitalized for Medical Reasons Within the Past Year? Yes_____ No _____

If Yes, Please Explain: _____

Have You Ever Been Prescribed Medication Assisted Treatment? Yes_____ No _____

If Yes, What Medication? _____

Dates MAT Was Used: _____

Are You Currently Prescribed MAT? If Yes, What Medication? _____

Please Provide When Possible

- Physical Exam
- PPD Results with Chest X-Ray When Positive

Mental Health Information

Have You Ever Been Diagnosed with A Mental Illness? Yes_____ No _____

Mental Health Diagnosis: _____

Please check Yes or No for the following – Please add comments where applicable.

	Yes	No	Comments:
Suicidal Attempts:			
Suicidal Ideation:			
Homicidal Attempts:			
Homicidal Ideation:			
Anger/Rage:			

Have you experienced physical/emotional abuse or victimization? Yes_____ No _____

Comments: _____

_____

Have You Been Hospitalized for Mental Illness?

Yes_____ No _____

If Yes, When Was Your Last Hospitalization? _____

Referral Source Signature: _____ **Date:** _____

Client Name: _____ **Date of Birth:** _____

TO BE COMPLETED BY APPLICANT

Please provide all information requested.

What is your primary substance choice? _____

In a 12-month period have you: (mark all that apply)

- ❑ Taken a substance in larger amounts or over a longer period of time that you had intended
- ❑ Had persistent desire or unsuccessful efforts to cut down or control substanceuse
- ❑ Spent a great deal of time in activities necessary to obtain the substance, use substance, or recover from its effects
- ❑ Had cravings or strong desire to use the substance
- ❑ Had recurrent use resulting in failure to fulfill major role obligations at work, school, home
- ❑ Had continued substance use despite having persistent or recurrent social or interpersonal problems
- ❑ Given up or reduced important social, occupational, or recreational activities because of substanceuse
- ❑ Had recurrent substance use in situations in which it is physically hazardous
- ❑ Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
- ❑ A need for markedly increased amounts of the substance to achieve intoxication or desiredeffect **Define your current tolerance to thesubstance:** _____]
- ❑ Characteristic withdrawal syndrome for the substance
- ❑ A markedly diminished effect with continued use of the same amount of substance

Define withdrawal that is specific to you:

_____

- ❑ Use of the substance or closely related substance is taken to relieve or avoid withdrawal symptoms

Please Complete the Following Questions Related to Treatment and Discharge:

1. What would you hope to gain from treatment at CARS?

   _____

   _____

2. Do you have a safe place to live upon your completion/discharge from CARS? If yes, where? Please include county where you hope to return.

   _____

   _____

3. Upon completion/discharge from cars, will you need step-down housing arranged? (half-way house, supportive living).

   _____

   _____

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

PSYCKES Consent Form

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is an administrative database maintained by the New York State Office of Mental Health (OMH). It contains health information from the NYS Medicaid claims database, health information from the clinical records of persons who have received care from State operated psychiatric centers, and health information from other NYS health databases. This administrative data includes identifying information (such as name, date of birth), information about health services that have been paid for by Medicaid, and information about a person's health care history (such as treatment for illnesses or injuries a person has had, test results, and lists of medication a person has taken). For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

The health information in PSYCKES can help your provider provide you with good care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I give consent"** box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the **"I deny consent"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," this does not mean your provider is completely barred from accessing your medical information in any way. For example, if the Medicaid program has a quality concern about your healthcare, then under federal and state regulations your provider may be given access to your data to address the quality concern. There are also exceptions to the confidentiality laws that may permit your provider to obtain necessary information directly from another provider for treatment purposes under state and federal laws and regulations.

Please carefully read the information on this form before making your decision. Your Consent

Choices. You have two choices:

- ☐ **I give consent for this provider to access all** of my electronic health information that is in PSYCKES in connection with providing me any health care services.
- ☐ **I deny consent for this provider to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number

Signature of Patient or Patient's Legal Representative	Date

Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to patient (if applicable)

Signature of Witness	Print Name of Witness

NEW YORK STATE

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME	FIRST	M.I.
DATE OF BIRTH	CASE NO.	
FACILITY **Cayuga Addiction Recovery Services**	UNIT **Residential Services Unit**	

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 (Circle One)

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

Presence in treatment, Diagnosis, participation in individual and/or group therapy, treatment notes, treatment progress, treatment planning, medication records and other information relevant to ongoing treatment and discharge from treatment

PURPOSE OR NEED FOR DISCLOSURE/RELEASE ***Coordinate and facilitate the client's admission, ongoing treatment,* and discharge from Intensive Residential Treatment.**

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION
Between: (Referral Source) **Name:** **Facility:** **Address:** **Phone:**	**And:** **Facility: Cayuga Addiction Recovery Services** **Address: 6621 Rt. 227, PO Box 724 Trumansburg, NY 14886** **Phone 607-275-5678 Fax 607-387-5793**

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 alcohol and drug abuse patient records, 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 a party 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 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, 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)

NEW YORK STATE

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME	FIRST	M.I.
DATE OF BIRTH	CASE NO.	
FACILITY **Cayuga Addiction Recovery Services**	UNIT **Residential Services Unit**	

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 (Circle One)

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED
Diagnosis, participation in individual and/or group therapy, treatment notes, treatment progress, treatment planning, and other information relevant to ongoing treatment and discharge from treatment.

PURPOSE OR NEED FOR DISCLOSURE/RELEASE
Coordinate payment, benefit certification.

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION
Between: (Insurance Provider) **Name:** **Facility:** **Address:** **Phone:** **Fax:**	**And:** **Facility: Cayuga Addiction Recovery Services** **Address: 6621 Rt. 227, PO Box 724 Trumansburg, NY 14886** **Phone 607-275-5678** **Fax 607-387-5793**

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 alcohol and drug abuse patient records, 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 a party 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 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, 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)	

Clients name: _____ Date of birth: _____

What to bring to treatment?

Please refer to the following list for what should and should not be brought for your stay at Cayuga Addictions Recover Services residential center.

CARS is not responsible for lost or damaged property. Please DO NOT bring valuables with you!
All clothing and other items if needed, will be heat treated on admission. Bring **ONLY** 7 to 10 days of weather appropriate clothing. You will be responsible for washing your own clothing at CARS in the facilities machines. Allergen free detergent is provided by CARS.

Items to bring:

-Insurance card and photo ID

-MP3 player and headphones, your MP3 player cannot have Internet connection OR video recording capability, picture taking capability, including storage of photos / videos.

-Stamps and envelopes (if you desire)

-Hygiene products, (all hygiene products including makeup and cosmetics must arrive at admission brand new and factory sealed in the original packaging).

-Alcohol may **not** be any of the first 3 ingredients in any product, please check carefully for this

-Mouthwash must be **alcohol free!**

-Grooming tools CANNOT have sharp edges or pointed edges, except for personal use razors, (no straight razors are allowed), client may bring hair clippers

-Shower caps and flip flops
-No scissors of any kind
-No aerosol products
-No perfume, cologne, or heavily scented products
-No nail Polish or nail Polish remover
***All hygiene products must be in reasonable amounts as space is limited**

Excessive amounts of clothing and/or other personal belonging not able to remain with the client, will be placed in storage. We have limited storage space, and we emphasize not bringing (more than recommended) excessive amounts of personal belongings. Again, Cayuga Addiction Recovery Services (CARS) is **not** responsible for lost or damaged items either in the client's possession or the facilities possession. Inventory will take place on admission of all items brought with the client.

After admission items are only approved if they are shipped from an online store and they meet all guidelines, this means no drop offs of products and no packages sent from home.

Note: the decision to allow a product or not is at staff discretion. All unapproved products will be stored in contraband until the time of discharge.

Items not allowed:

- Cigarettes and vapes/vaping accessories
- Any medication not in original prescription containers
- Over the counter medications
- Laundry soap and other cleaning products
- Blankets, pillows, towels, stuffed animals
- Cell phones, cell phone chargers, pagers
- Laptops and/or tablets
- Food or beverages
- scissors of any kind
- aerosol products
- perfume, cologne, or heavily scented products
- nail Polish or nail Polish remover

Reminder: do not bring excessive amounts of clothing and/or personal items, as we are limited on storage space.

By signing this, the client has read and understands what to bring or not bring to CARS, and the client acknowledges this notice. This document will be retained as part of the admission packet.

X_____ **Date: _____**
Client Signature

X_____
Client printed name

X_____ **Date: _____**
Witness Signature

X_____
Witness printed name

Programs rules and expectations: (limited, complete list in the client handbook)

Clients who accept admission for our residential program understand and will adhere to the following:

- Acknowledges that our program is progression based and can be **UP** to six (6) months long
- We do **NOT** allow smoking/vaping or tobacco products of any kind – in the building or on campus NO SMOKING ALLOWED while in our program
- We do **NOT** allow cell phones/pagers or electronic devices (except MP3 music players that DO NOT have video capabilities)
- Clients may need to be quarantined on arrival until Covid test is complete, can be up to 48 hours, pending your results, you may then be released to the general community
- Dorm rooms at any given time may host up to FOUR (4) clients in one dorm
- While in our program you are required to attend a **minimum** of FOUR (4) groups per day, FOUR (4) days per week, and one (1) session with your primary counselor
- While in our program you are **NOT** allowed to leave campus, unless for a medical reason
- Phone calls can be made at scheduled times only, two (2) calls per week
- Visitation can be granted after thirty days (30) with counselor approval, one (1) visit two (2) times per month
- We have specific time the television will be on, it is **not** on all day
- We do **NOT** tolerate VIOLENCE or DISRESPECTFULNESS of any kind to staff and/or clients
- When a client chooses to leave our program unsuccessfully or against medical advice (AMA), Cayuga Addiction Recovery Services (CARS) does not provide or pay for transportation, the client will be responsible for this.

These are a portion of the rules and expectations we have, you will find a complete list in the client handbook. However, these are most stated that clients were not made aware of prior to coming to our program, by signing this you are signing you understand and agree to these upon admission to our program.

Client printed name: _____ Date: _____

Client signature: _____ Date: _____ Witness

printed name: _____ Date: _____

Witness signature: _____ Date: _____

This will be retained by CARS as part of your application packet.