Application for Admission

Please call with any questions: 607-273-5500 x29

Return pages 1-15 completed with first three (3) items below to begin the application review process.

Fax to: (607) 273-1277 or scan/email to: *PWhite@carsny.org*

Referral Source (pages 1-5)
Applicant & Referral Source (pages 6-20)

- ☐ **Most recent Psychosocial Evaluation (from Chemical Dependency Treatment Provider)**
- ☐ **Most recent mental health assessment**
- ☐ **Medical history/physical exam (within last 6 months)**
- ☐ Release of information for Cayuga Addiction Recovery Services and the Department of Social Services, Social Security Administration, or other Funding Source
- ☐ Release of information for Cayuga Addiction Recovery Services and Tompkins County Mental Health (CARS collaborates with the Tompkins County Mental Health Department to screen clients for admission to the residential program, refer clients for mental health assessments and follow-up treatment, and to convene joint treatment planning with weekly interagency case conferences)
- ☐ Release of information for Cayuga Addiction Recovery Services and prior treatment providers (including Chemical Dependency treatment, Mental Health treatment, and Medical treatment providers within the past 2 years)
- ☐ Release of information for Cayuga Addiction Recovery Services and Cayuga Medical Center (In the event we need to transport client to Emergency Room before/during admission process)
- ☐ Release of information for Cayuga Addiction Recovery Services and legal entities (including Probation/Parole Department and any courts within the past 2 years)

The above releases are included in the application, see pages 7 - 14

Client needs to review, understand, and adhere to "Smoking Regulations" (pg 16), "Physical Inventory Acknowledgement" (pg 17), "Client Behavioral Expectations Form" (pgs 18-19), and "Length of Stay Guidelines" (pg 20)

- ☐ Applicant Agreement (page 15)
- ☐ Copy of Photo Identification, Social Security Card and Birth Certificate
- ☐ Copy of Medicaid/Medicare or other insurance card (including Managed Care)
- ☐ Copy of Medicare Part D Card

PART I - TO BE COMPLETED BY REFERRAL SOURCE (pages 1-5)

Client Demographics:

Client Name: ____________________
Date of Birth: ____________________
SS#: ____________________
Gender: ____________________
Ethnicity/Race: ____________________
Phone#: ____________________
County of Residence: ____________________

Legal Address of Residence: ____________________
____
____

Current Address (and type of residence)
____
____
____

Referral Source Information:

Referral Agency: ____________________
Referral Name: ____________________

Address: ____________________
____
____

Hours of Operation: ____________________

Phone #: ____________________
Fax #: ____________________
E-mail: ____________________

Financial Information:

Source of Payment for Services:

- ☐ DSS
- ☐ SSI
- ☐ Value Options
- ☐ Social Security Disability
- ☐ Self
- ☐ Other: (indicate) ____________________

Contact Agency of Payment Source: ____________________
Payment Source Name, Title & Phone #: ____________________
Have you ever been a client of Cayuga Addiction Recovery Services? ____________________
If yes, what facility and when? ____________________
Are you currently in Treatment? ____________________
If yes, where? ____________________

Medical Coverage:

☐ Medicaid MA# ____________________ ☐ Check if Medicaid Managed Care Program
☐ Medicare MA# ____________________ ☐ Other: ____________________
☐ Health Insurance Company: ____________________

Number: ____________________ Group: ____________________

Medical Information:

Primary Care Physician: ______________________

Telephone # : ______________ Fax # : ______________

Recent Physical: YES ☐ NO ☐ Where: ______________

Please have client sign consent to share medical records.

If recently incarcerated, please have client sign consent with that **facility.**

Please check YES or NO for the following medical issues:

	YES	NO	Comments:
Diabetes:			Type:

If diabetic, client must be aware that CARS RSU is a six-nine month program and diabetes can be negatively impacted by a variety of factors including individual choice.

	YES	NO	Comments:
Asthma:			
Eating Disorders:			
COPD:			
Heart/Cardiac:			
High Blood Pressure:			
Nicotine Use:			
Pregnant:			
Allergies:			
Digestion Issues:			
Blood Disorders:			
Liver Disorders:			
Hepatitis C, B, A:			
HIV/AIDS:			
Menstrual Disorders:			
Emphysema:			
Hearing Loss:			
Chronic Pain:			
Mobility Issues:			
Infections:			
Cancer History:			

If there is a history of cancer, you must provide date of last treatment, type of cancer, current status and any other information that would be pertinent to medical needs for the next six to nine months:

____

____

Will this client require the regular use of any physical aids including the following:

Wheelchair: ☐ Elevator: ☐ Respiratory Equipment: ☐

Comments: ______________________

Describe any exercise or day to day living expectations or limitations related to physical conditions:

____

____

Substance Use Information:

(Please include alcohol and other drugs including nicotine and caffeine)

Any history of IV Drug use: ☐ yes ☐ no If yes, last use: ____________

Current Dependency diagnosis(s): ____

R/O Diagnosis(s): ____

Substance Used:	First Use:	Last Use:	Frequency:	Route of Admission:

Additional Comments: (please include other pertinent info related to history of chemical abuse or dependence)

____

____

____

Summary of other addictions: (including gambling, sex, eating, internet, work, pornography, etc.)

____

____

Chemical Dependency Treatment History:

(please include outpatient treatments and the past 3 years of services)

Location/Agency:	Date of Admission:	Length of Stay:	Outcome:

Total Number of Treatment Episodes: ____________

Mental Health Treatment Information:

Any history or current (check yes or no)	Yes	No	please tell us what page(s) information can be found on in psychosocial/clinical report
Suicidal ideation/attempts?			
Homicidal ideation/attempts?			
Anger Rage?			
Physical/emotional/sexual abuse or victimization?			

Comments: ____________________

Current psychiatric medication and dosage	Past psychiatric medication and dosage

History of Mental Health hospitalizations and treatment

Diagnosis	Agency	Date	Length of stay	Reason for Admission

Legal Information:

Any history or current (check yes or no)	Yes	No	please tell us what page(s) information can be found on in psychosocial/clinical report
Arson?			
Perpetrator of physical/emotional/sexual abuse?			
Stalking?			
Violence?			
Pending charges?			
Court Appearances? (Please include Court and Court Contact name and phone #)			
Legal History? (arrests, charges, convictions, sentences)			

Probation/Parole Office ____________________

Probation/Parole Officer ____________________

Phone # ____________________

Fax # ____________________

PART II- TO BE COMPLETED BY APPLICANT (pages 6-20)

Please Provide all information requested.

1 Why do you want to come into our intensive residential facility?

2 Please identify 3 goals that you hope to work on while in treatment.

3 Please identify 3 challenges you will have in participating in our program and complying with program rules.

4 Please describe what you are willing to do in order to be successful.

5 Please describe what you will need from us to successful.

Client Signature ______________________ Date ______________

If you were assissted in the completion of this portion of the admission application please describe the form of assistance. If this page was completed by someone other than the applicant please explain why and sign below:

Signature of person assisting applicant ______________________ Date ______________

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

REVOKED ON __________ Staff sig __________

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME FIRST M.I.	
DOB	
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

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 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:	And:
Name: (Referral Source)	Name: Richard Bennett, Treatment Director or designee
Facility:	Facility: Cayuga Addictions Recovery Svcs
Address:	Address: 6621 Rt. 227, PO Box 724 Trumansburg NY 14886
Phone: **Fax:**	Phone: (607)387-6118 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 one (1) year 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 Witness)

This consent was executed on ____________________

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

REVOKED ON __________ **Staff sig** ______________

PATIENT'S LAST NAME FIRST M.I.	
DOB	
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

Medicaid, Public Assistance, and other payment information	
Coordinate Medicaid, Public Asistance benefits for the purpose of admission and treatment.	
NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION **Between:** **Name: Department of Social Services** **Facility:** **Address:** **Phone:** **Fax:**	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION And: Name: Richard Bennett, Treatment Director, or designee Facility: Cayuga Addiction Recovery Svcs Address: 6621 Rt. 227, PO Box 724 Trumansburg NY 14886 Phone: (607)387-6118 Fax: (607)387-5793

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____________________ ____________________
(Signature of Patient) **(Signature of Witness)**

This consent was executed on ______________

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
Cayuga Addiction Recovery Services	P O Box 724 6621 Route 227 Trumansburg, NY 14886

I want this information released because:

I will be residing at Cayuga Addiction Recovery Services (CARS) Long-term Residential Chemical Dependency Program for a minimum of six (6) months. CARS will coordinate my benefits with Social Security Administration during my treatment at CARS.

Please release the following information:

____ Social Security Number
____ Identifying information (includes date and place of birth, parents' names)
X Monthly Social Security benefit amount
X Monthly Supplemental Security Income payment amount
X Information about benefits/payments I received from ______ to ______
X Information about my Medicare claim/coverage from ______ to ______
(specify) Medical billing issues
____ Medical Records
____ Record(s) from my file (specify) ______

____ Other (specify) ______

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: ______

(Show signatures, names, and addresses of two people if signed by mark.)

Date: ______ Relationship: ______

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

REVOKED ON __________ **Staff sig** __________

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME FIRST M.I.	
DOB	
FACILITY Cayuga Addiction Recovery Services	UNIT Residential Services Unit

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

Intake, evaluation, diagnosis, treatment notes and other information relevation to admission, treatment and discharge	
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 **Between:** **Name: Tompkins County Mental Health** **Facility:** **Address: 201 E. Green Street** **Ithaca, NY 14850** **Phone: Fax:**	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION And: Name: Richard Bennett, Treatment Director, or designee Facility: Cayuga Addiction Recovery Svcs Address: 6621 Rt. 227, PO Box 724 Trumansburg NY 14886 Phone: (607)387-6118 Fax: (607)387-5793

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______________________ (Signature of Witness)

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NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

REVOKED ON ___________ Staff sig ______________

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME FIRST M.I.	
DOB	
FACILITY Cayuga Addiction Recovery Services	UNIT Residential Services Unit

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

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.

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: (Prior Treatment Provider(s) Copy as Needed) **Name:** **Facility:** **Address:** **Phone:** **Fax:**	And: Name: Richard Bennett, Treatment Director, or designee Facility: Cayuga Addiction Recovery Svcs Address: 6621 Rt. 227, PO Box 724 Trumansburg NY 14886 Phone: (607)387-6118 Fax: (607)387-5793

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______________________ (Signature of Witness)

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NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

REVOKED ON ____________ **Staff sig** ________________

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME FIRST M.I	
DOB	
FACILITY Cayuga Addiction Recovery Services	UNIT Residential Services Unit

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

Diagnosis, History & Physical, Laboratory Results, X-ray Reports, Operative Report, Record Abstract, ER/Convenient Care, Consultation, EKG, Discharge Summary

Continuation of care at Cayuga Addiction Recovery Services

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: **Name: Cayuga Medical Center** **Facility:** **Address: 101 Dates Drive** **Ithaca, NY 14850** **Phone: 274-4011** **Fax:**	And: Name: Richard Bennett, Treatment Director, or designee Facility: Cayuga Addiction Recovery Svcs Address: 6621 Rt. 227, PO Box 724 Trumansburg NY 14886 Phone: (607)387-6118 Fax: (607)387-5793

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________________________ (Signature of Patient)

________________________ (Signature of Witness)

This consent was executed on ____________________

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

REVOKED ON ____________ **Staff sig** ____________________

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME FIRST M.I.	
DOB	
FACILITY Cayuga Addiction Recovery Services	UNIT Residential Services Unit

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

Results of evaluations, urine screens, alco-sensors, progress reports, diagnosis, treatment plans and recommendations, discharge summary and collateral information.	
The purpose of and need for this consent is to inform the criminal justice agency identified below of my attendance and progress in treatment.	
NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION **Between:** **Name: (Probation/Parole)** **Facility:** **Address:** **Phone:** **Fax:**	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION And: Name: Richard Bennett, Treatment Director, or designee Facility: Cayuga Addiction Recovery Svcs Address: 6621 Rt. 227, PO Box 724 Trumansburg NY 14886 Phone: (607)387-6118 Fax: (607)387-5793

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____________________ (Signature of Patient)

____________________ (Signature of Witness)

This consent was executed on ____________________

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

REVOKED ON ___________ **Staff sig** ______________

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME FIRST M.I.	
DOB	
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

Results of evaluations, urine screens, alco-sensors, progress reports, diagnosis, treatment plans and recommendations, discharge summary and collateral information.

The purpose of and need for this consent is to inform the criminal justice agency identified below of my attendance and progress in 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:	And:
Name: (Court(s) Copy as needed)	Name: Richard Bennett, Treatment Director, or designee
Facility:	Facility: Cayuga Addiction Recovery Svcs
Address:	Address: 6621 Rt. 227, PO Box 724 Trumansburg NY 14886
Phone: **Fax:**	Phone: (607)387-6118 Fax: (607)387-5793

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______________________________ (Signature of Patient)

______________________________ (Signature of Witness)

This consent was executed on ____________________

Residential Services Unit
6621 Rt. 227
Post Office Box 724
Trumansburg, NY 14886

Phone: (607)387-6118
Fax: (607)387-5793
E-Mail: Residential@carsny.org
Homepage: www.carsny.org

APPLICANT AGREEMENT

I have received copies of the following documents and I understand the meaning and content of the documents:

1 Smoking Regulations

2 Residential Program Physical Inventory Acknowledgement

3 Client Acknowledgment of Behavior Expectations

4 Length of Stay Guidelines

I understand that Cayuga Addiction Recovery Services Residential Unit offers intensive residential services. Under the Mental Hygiene Law Sections 19.07(e), 19.09(b), 19.40, 32..01, 32.07(a) Part 819.2 a1 these services are define as "Intensive residential rehabilitation services requiring twenty-four hours a day, seven days per week treatment in a structured environment for individuals whose potential for independent living in recovery is contingent upon substantial social habilitation or rehabilitation...*These services are appropriate for individuals who require chemical dependency services in a residential setting due to previous non-compliance, or relapse, in outpatient service settings, or their life skills deficits require sustained intensive rehabilitation."*

____________________ Applicant Signature

____________________ Witness Signature

This consent was executed on __________

*Please return this sheet only with application. Original aforementioned documents are to be given to applicant.

Residential Services Unit
6621 Rt. 227
Post Office Box 724
Trumansburg, NY 14886

Phone: (607)387-6118
Fax: (607)387-5793
E-Mail: Residential@carsny.org
Homepage: www.carsny.org

Smoking Regulations

Beginning on July 24, 2008, the smoking policy at CARS RSU will change to comply with OASAS regulations. There is to be no tobacco products on the premises of the Residential Program Unit. This includes in clients' personal effects or on their person.

No tobacco possession or use is allowed in RSU vehicles, or when clients are off premises in situations where RSU staff supervision is in effect.

No tobacco use is allowed on the CARS RSU property by any persons, including people who have arrived for admission, visitors or staff. Visitors who do not cooperate with this policy will be asked to leave CARS RSU property and must leave immediately. Visitors must be approved by CARS RSU staff and uncooperative visitors are at risk of future denied visits.

Clients may not have any tobacco products in their possession. Tobacco and related paraphernalia will be confiscated from clients and held as contraband, unless permission is given for disposal.

If a client has tobacco in their possession, the consequence will be an infraction, and placement on Failure to Progress, which will be handled by the clinical team and presented back to the client.

Tobacco cessation issues have been integrated into addiction education and Matrix treatment and will remain in the curriculum to be addressed as are all substances of dependence.

Nicotine Replacement Therapy is available to all clients through the CARS RSU medical services.

Residential Services Unit
6621 Rt. 227
Post Office Box 724
Trumansburg, NY 14886

Phone: (607)387-6118
Fax: (607)387-5793
E-Mail: Residential@carsny.org
Homepage: www.carsny.org

Cayuga Addiction Recovery Services (CARS)
Residential Program Physical Inventory Acknowledgement

There is limited storage and closet space for each resident at the CARS Residential Facility. Residents are asked to limit their belonging to those that are necessary for treatment. The following is a list of clothing and personal items that each resident is permitted to bring. **All belongings must fit neatly in one small closet space and four drawers.** Clothing that is sexually suggestive or that promotes violence, alcohol or drugs is not allowed. CARS is not responsible for lost, stolen, or damaged items.

Clothing you are allowed to bring:

One week supply of:

Pants, jeans, dresses, skirts, sweatpants, etc.

Shirts (Flannels, Dress Shirts, Crew/Turtlenecks)

T-shirts (Plain) - must have sleeves

Socks

Undergarments

Items only as needed:

Footwear (sporting and casual)

Sweaters and Sweat Shirts

Pajamas (Long Johns/Nightgowns)

Robe

Sweat Jacket or Cover Sweater

Gloves and hats

Lightweight Jacket

Winter Coat

Other items you should bring include:

Your prescription medications

Personal hygiene items (soap, shaving necessities, deodorant, toothpaste, etc.)

Bath, face and hand towels, wash cloths – 2 each

Telephone calling card

Stamps, envelopes, and stationery

Personal listening devices (CD, MP3) - **without** camera, video, or internet capabilities

Note: After 30 days any possessions left behind by a resident who has been discharged will be donated to another organization, disposed of as garbage, or provided to other program clients. Cayuga Addiction Recovery Services will make an effort to notify a resident's legal or emergency contact to make arrangements for pick up of the resident's belongings only if a resident leaves through an administrative discharge and is unable to take their belongings with them when they leave.

Items you may not bring:

Alcohol, drugs including over the counter medications other than prescription

Weapons of any kind

Tools

Cell phones, pagers, and computers

Stereos and musical instruments

Pornographic material

Playing cards

Sleeveless shirts

Perfume, cologne, or scented lotions

Hair clippers

Laundry facilities are provided on site. Laundry time is assigned once per week.

Client Acknowledgement Form of Behavior Expectations

Guiding Principle of Behavior at the CARS Residential Facility:
"There are only two ways to behave, towards recovery or towards relapse."

(All behaviors, actions and choices should support a person's recovery.)

While the Guiding Principle for Behavior is the "golden rule", it is necessary to clearly outline some basic behavioral expectations.

1. All actions are to be legal.

2. Residents are to refrain from sexual contact with other people in the residential program both on the premises and offsite.

3. Residents are to refrain from possession or use of any alcohol or drugs other than medication prescribed/approved by members of the program medical staff.

4. Residents are to respect themselves, the program, property, other residents, staff and visitors.
   - A. The confidentiality of all residents is to be maintained.
   - B. Interactions with residents of the opposite gender is not permitted.
   - C. Only approved displaying of mass-produced posters, pictures, etc.
   - D. Only pictures of friends, family and loved ones fully clothed are to be displayed on the resident's dorm bulletin board.
   - E. The building walls are to only have approved items affixed, taped, or mounted.
   - F. The building is to be respected and maintained without intentional damage and efforts should be taken to avoid unintentional damage.
   - G. Dorm rooms are to be maintained in a clean and orderly manner. Beds are to be made prior to breakfast. No resident personal items are to be stored anyplace other than the dresser and nightstand. The space underneath beds is to contain only shoes or sneakers. Cleaning schedules for dorm rooms are to be arranged so that daily cleaning of the bathroom takes place as well as vacuum of the room every two days.
   - H. No food or candy is to be stored in the dorm rooms.
   - I. Valuable items are not to be stored in the dorm room. Arrangements for obtaining approval to store valuable items elsewhere on site should be made via the primary addiction counselor or the valuable items should be transferred to a trusted family member or friend via transfer arrangements made by the primary addiction counselor.
   - J. Personal privacy is to be respected and residents are to access only their own storage spaces in the dorm room.
   - K. Residents are to only enter their own dorm room, unless otherwise directed or approved by staff.
   - L. Others comfort is to be respected. Clothing appropriately covering from the neck area to two inches above the knees and shoes/sneakers are to be worn outside of the assigned dorm room. Clothing is to be "street" and "drug/alcohol" free" (are not to contain direct or indirect reference).
   - M. Jewelry is to be non-distracting and aligned with the "Guiding Behavior Principle". Acceptable jewelry will be one thin neck chain and or one earring in each ear with positive charms/symbols.
   - N. Heads shall remain free of hats, bandannas, and other items with the exception of approved items for protection from the elements while outdoors.
   - O. Language used will be non-offensive. Terms found to be offensive by the

community and society at large is to be avoided.

P. Visits must be scheduled in advance and visitors may not bring anything to residents without prior approval. Visitors must be respected.

Q. Staff is to be treated in a respectful manner. Disagreement with staff actions is to be addressed via the options in the Comments, Concerns, and Complaints document posted in the great room as well as provided to the client at the time of intake.

R. Only agency owned radios, televisions, CD players, VCRs, computers, and other electronic entertainment systems would be kept on agency premises.

~~5.~~ CARS does not assume responsibility for transporting RSU clients to meet individual commitments including drug court appearances, medical appointments, personal time out, etc. **Transportation arrangements are the responsibility of the individual client.**

6. Engagement in treatment is crucial to increase success in treatment therefore:
   A. Residents will seek approval to be absent from programming.
   B. Residents who are ill will rest, as approved, in a designated area during programming hours.
   C. Residents will actively engage in treatment with a positive attitude.
   D. Off site appointments are to be approved and arranged with the assigned primary addiction counselor or designated staff member.
   E. Residents will keep available Personal Needs Allowance funds as needed to cover individaul transportation costs and other individual expenses.

7. Establishing and maintaining a health community to support treatment and recovery is important. Residents will participate in assigned work activities designed to maintain the facility and therapeutic community while allowing the resident to develop additional skills, provide service to the community, and a forum to utilize healthy interpersonal skills.

8. All packages are to be approved and received either via mail or prescheduled approved delivery.

9. Residents are to keep only approved items and the designated amount at the facility. All other items are to be transferred to family or friend in a manner approved by or disposed of in a manner coordinated with staff. Staff has the right to inspect a resident's personal property at any time to ensure that only approved items are in a resident's possession.

10. Items left by a resident who leaves treatment, either successfully or unsuccessfully will be disposed of after 30 days from the resident's time of departure at the direction of the Clinical Supervisor or designee. Disposal may include donation to another organization, disposal as garbage, providing items to program clients, or other approved method. Arrangements to retrieve belongings post leaving treatment must be approved and coordinated with staff. Agency will not transport, mail, or otherwise facilitate any delivery of property nor incur expenses related to delivery of property.

11. I understand that the successful completion of this program automatically enrolls me in the Cayuga Addiction Recovery Services Alumni Association. I may also be asked to participate in outcome studies.

Residential Program
Length of Stay Guidelines

The length of stay at the Residential Program is based on progress and completion of the treatment plan. The treatment plan will include therapeutic tasks as well as behavioral indicators that will guide the client through the phases of our treatment program.

Phases of Treatment

Phase	**Minimum**	**Maximum***
Orientation Phase	6 weeks	12 weeks
Phase 1	6 weeks	12 weeks
Phase 2	6 weeks	12 weeks
Phase 3	6 weeks	12 weeks
** Discharge Phase	4 weeks	6 weeks

* Clients may remain in a phase longer than this amount of time. Clients may need to repeat a phase or be returned to a lower phase, if determined therapeutically necessary.

** According to progress and discharge planning, a client may be appropriate for successful discharge after Phase 3.