

SUPPORTIVE LIVING

Referral Packet

Mannion House

To All Applicants: The Supportive Living VOLUNTEER VOC/ED AGREEMENT must be completed and signed by the Career Choices Unlimited VOC/ED Case Manager, Residential Case Manager and Applicant **Prior** to submitting this packet.



Fairview Recovery Services, Inc. is committed to delivering a continuum of services to individuals with the disease of alcoholism, chemical dependency and co-occurring conditions. These services are designed to provide individuals the opportunity to develop the skills and knowledge to live independent, healthy and productive lives. We strive to deliver high quality care that is respectful of individual differences and needs.

**SUPPORTIVE LIVING
MANNION HOUSE
REFERRAL PACKET
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To the Referred Person and the Referral Source,
In order for your referral to be accepted and processed the following MUST be provided to the Supportive Living Program Coordinator:

**Fairview & Merrick
Community Residences**

Supportive Living

Shelter + Care

5 Merrick Street
Binghamton, NY 13904
607-722-8987
Fax: 607-722-6767
fairview@frsinc.org
www.frsinc.org

1. An admission packet that has been entirely completed and reviewed by both the referred person and the referral source. This can be found on the Fairview Recovery Services website at: www.frsinc.org or we will be happy to mail one to you. Feel free to make copies to keep on file.
2. A recent psychosocial (within the last year) that must include a chemical dependency diagnosis and where applicable a mental health diagnosis
3. Documentation of a negative PPD/Mantoux test for TB (tuberculosis) within the past six (6) months
4. Whenever possible please provide: A complete history and physical from a health care provider; completed within last year, including lab (blood) work with CBC Count.
5. Proof of funding from DSS or Social Security

Referrals that are **not** complete will **not** be processed until the Supportive Living Coordinator has received **all** of the above named components.

Thank you,
Supportive Living Program

Addictions Crisis Center
247 Court Street
Binghamton, NY 13901
607-722-4080
Fax: 607-723-1858

**Addictions Case
Management**
247 Court Street
Binghamton, NY 13901

Career Choices Unlimited
10 Mitchell Avenue
Binghamton, NY 13903
607-762-2109
Fax: 607-762-2313

FAIRVIEW RECOVERY SERVICES, INC.

Michele Napolitano, MEd, CRC, CASAC

FAIRVIEW COMMUNITY RESIDENCE
MERRICK COMMUNITY RESIDENCE
SUPPORTIVE LIVING
CAREER CHOICES UNLIMITED
5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 722-6767

Executive Director
5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 722-6767

ADDICTIONS CRISIS CENTER
247 Court Street
Binghamton, NY 13901
Phone (607) 722-4080
Fax (607) 723-1858

2-WAY CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Social Security Number: _____

Date: _____

I, _____, hereby authorize and consent to
communication **BETWEEN** _____ and

(Agency Name, Full Address, Phone Number)

(or his/her successors).

(Name & Title of a Contact Person)

The extent of information to be disclosed **Medical history, laboratory results, physical; psychosocial evaluation & recommendations; psychiatric evaluation; diagnosis; treatment history; progress in treatment; discharge summary & discharge status.**

The purpose of the disclosure authorized herein is to: **Coordinate treatment and share pertinent information for this purpose.**

I, the undersigned, have read and authorized the staff of the disclosing facility name to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire 6 months from its signing, unless a different time period, event or condition is specified below, in which case such time period, even or condition shall apply. I also understand that any disclosure is bound by Title 42 of the Code of Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information is forbidden without written authorization on my part.

Time period, event or condition replacing period specified above: 6months from discharge date

Note: Any information released through this form will be accompanied by Form A-4400 Prohibition on Re-disclosure of Information Concerning Alcoholism/Drug Abuse Patient.

Patient Signature

Witness Signature

Patient Name (Printed)

Witness Name (Printed)

Date

Date

Fairview Recovery Services, Inc.
Counselor Questionnaire

Client Name: _____

Thank you for taking time to help us evaluate your client for placement into Fairview Supportive Living Program. Your answers to all of the following questions are critical to our assessment of your client's appropriateness for admission to our facility.

1. Why do you feel that your client has the ability to remain clean and sober outside of a community residence?

2. Please tell us your impressions of your client's current denial system. Please circle the most appropriate number:

No Denial	Moderate Denial	High Denial	Extreme Denial
1	2	3	4

3. In what areas has your client made the most progress in treatment? _____

4. In what specific areas will your client need the most encouragement and support if admitted to Supportive Living? _____

5. It can be a challenge for people in early recovery to live in close contact and harmony with others. Please describe if your client will benefit from peer support:

6. Please add any additional information that will help us help your client. _____

Thank you for spending the time to help your client through this referral process. Should your client live at Fairview/Merrick Community Residence, we would like to stay in contact with your agency and yourself so that we can all be supportive of this resident. Please let us know the best times to contact you and, if possible, a direct phone line.

REFERRING AGENT

DATE

Client Introduction

Thank you for applying to Fairview Recovery Services Supportive Living Program. Supportive Living is a program for the recovering individual struggling with chemical dependence. Our Supportive Living program is a scattered site apartment setting. We will develop an individualized Recovery Plan (i.e. Alcohol and Drug, Mental Health, Marital/ Family, Social, Educational/Vocational/Employment, Health and Legal), with you within thirty days (30) of admission to Supportive Living, with input from the referral source. Length of stay is based on an individual's progress and need for continued services.

To help us know you better, we ask you to fill out the accompanying forms in a **thorough and honest manner.**

All information will be treated confidentially. If you are accepted into Supportive Living, all information supplied by yourself, your primary counselor, and your current treatment agency will be part of your permanent record and will be referred to throughout your stay at Fairview.

After we receive all of this information, from you and your counselor, your counselor will be notified of your appropriateness as a candidate for our Supportive Living Program. Your admission will be prioritized in conjunction with the waiting list policy in compliance with the NYS OASAS guidelines.

Again, thank you for applying for residence at Fairview Supportive Living Program.

Fairview Recovery Services, Inc.
Client Questionnaire

Client Name: _____

DOB: _____

SS#: _____

1. Please tell us your impressions of where you are at in treatment at the present time. What have you gained? What do you need to work on in treatment:

2. This Supportive Living provides a safe, sober living environment. Why are you seeking to live in this type of environment at this time? _____

3. There will be 5 other people living with you in Supportive Living Mannion House who are also in early recovery. How will you add to the quality of recovery in this setting?

4. What are your personal assets and your personal liabilities in this phase of your recovery?

5. What are you willing to do specifically in the area of self help, continuing treatment and personal growth during the next 4-6 months? _____

6. Do you have a court case pending? _____ If yes, are you facing jail time? _____
If yes, explain _____

7. Have you ever been treated for mental illness? _____ If yes, explain: _____

8. Do you have a learning disability? _____ If yes, explain: _____

9. Have you ever sexually abused a minor? _____

10. Have you ever been convicted of arson? _____

11. Have you ever been in jail or prison? _____ If yes, how many different times? _____
How much total time have you spent in jail or prisons? _____

12. Do you have any medical problems? _____ If yes, explain: _____

13. In the past 12 months has anyone hit, slapped, pushed, punched or kicked you? If yes who?

14. Have you hit, slapped, pushed, punched or kicked anyone in the past 12 months? If yes, who?

15. What is your level of contact or involvement on an on going basis with the person named above?

16. Do you have a current order of protection in place against someone else or against you? If yes,
against or by whom? Through what court?

17. In the event you relapse, or leave Supportive Living, who can you stay with?
Name: _____
Address: _____
Phone #: _____

Signature of Client

Date

Application for F.R.S. Supportive Living Program

Name: _____ Case Manager: _____

Admission Date to Supportive Living: _____

Sobriety Date: _____

Where and when did last relapse occur: _____

Please list all treatment and/or residential placements you have completed in the last 6 months.

_____	_____
_____	_____
_____	_____
_____	_____

Are you presently in treatment? Where? Name of treatment counselor?

Do you currently attend a 12 step program? _____

On average how many meetings do you attend weekly? _____

Do you have a home group? _____

Do you work with a sponsor? _____

Have you developed a sober support system? _____

Do you have Educational goals? _____

Do you have Vocational goals? _____

What have you done so far to achieve these goals? _____



SUPPORTIVE LIVING VOLUNTEER & VOC/ED AGREEMENT

As a resident of FRS Supportive Living Program (SLP), I agree to the following guidelines:

- 1. I agree to attend and participate in the vocational/educational institution chosen in conjunction with my vocational/educational plan through Career Choices Unlimited (CCU).*
- 2. I agree to be involved in a minimum of 20 hours of volunteer or Workfare per week, unless otherwise negotiated through SLP, CCU and, if applicable, the Department of Social Services (DSS). The volunteer/Workfare component must take place at an FRS approved site.*

Volunteer site chosen: _____

Volunteer sites being considered: _____

- 3. I understand and agree that the Supportive Living requirements (i.e., house group, meetings, one-on-ones) cannot be compromised due to volunteer or Workfare placement.*
- 4. I understand that I will begin working as a volunteer or in Workfare within 30 days of my admission to SLP.*
- 5. I agree to contact both SLP and CCU Case Managers if there are problems or changes of any nature at my address, educational institution, volunteer and/or Workfare site.*

Resident's Signature

Date

Supportive Living Case Manager

Date

Career Choices Unlimited Case Manager

Date

Fairview/Merrick Community Residence Case Manager

Date

POLICY AND PROCEDURE

PROCEDURE FOR: Addressing tobacco use at Fairview Recovery Services, Inc. programs.

PURPOSE: To reduce addiction, illness and death caused by tobacco products.

Policy Statement:

Fairview Recovery Services programs provide crisis, residential and educational services for adults dealing with chemical dependency. Fairview is dedicated to providing quality services in a healthy, drug free environment.

In 1988 the U.S. Public Health Services, under Surgeon General C. Everett Koop, published the report, The Health Consequences of Smoking: Nicotine Addiction. In this report Dr. Koop states, "Smoking is the chief avoidable cause of death in our society." He indicates that nicotine is the substance in tobacco that causes addiction. Nicotine is a mood altering, psychoactive substance that is highly addictive. Since 1980, DSM (Diagnostic and Statistical Manual of Mental Disorders) has listed both nicotine withdrawal and nicotine dependence as diagnosable conditions.

These facts about tobacco/nicotine impact Fairview Recovery Services programs in several ways. First, Fairview Recovery Services is aware that many of our clients have a history of tobacco use and others began using tobacco while in our care or through relapse. Second, Fairview Recovery Services recognizes that tobacco smoke at this facility is a dangerous pollutant which harms non-smokers and smokers alike. Third, Fairview Recovery Services recognizes that nicotine in tobacco is a psychoactive, mood altering, addictive substance.

Objectives:

1. To provide a healthy environment for staff, clients, volunteers, workfare participants, and visitors; one that is free from tobacco smoke pollution and cues to use tobacco products.
2. To establish a tobacco free program including tobacco free grounds.
3. To provide quality, comprehensive crisis, residential, and educational services to the clients at Fairview Recovery Services.
4. To provide tobacco/ nicotine dependence recovery assistance/options to staff.
5. To integrate tobacco/nicotine dependence within the care offered to the clients of Fairview Recovery Services programs through assessment, education, prevention, and treatment.

1. Establish a Tobacco-Free Facility

- A. All clients will be informed of this policy as part of the admission process and will sign a written contract at that time.
- B. Effective 6-1-2008, all prospective employees will be notified of this policy in employment announcements, during their first interview, prior to hire, and during orientation.

- C. Referral sources will be notified of this policy by 6-1-2008 and will continue to be notified on an ongoing basis thereafter.
- D. All current staff, volunteers, and workfare participants will receive a copy of the final policy. All new staff and volunteers will be notified of this policy at orientation.

2. Provide Tobacco/Nicotine Dependence Education and Recovery options for staff

- A. All employees will be offered an in-service on the medical complications of tobacco use and nicotine dependence.
- B. All clinical staff will be offered training on how to identify nicotine dependence. This will include training on assessing, education, treatment planning, and on-going care for nicotine dependence.
- C. All employees will not exhibit any tobacco products including paraphernalia (lighters, tobacco brand specific products, promotional clothing, and rolling papers).
- D. All employees who currently use tobacco products will be encouraged to discontinue use and offered the following:
 - 1. Pamphlets, brochures and other reading materials to assist and educate them on the effects of using tobacco/nicotine products.
 - 2. Over-the-counter nicotine replacement when not able to obtain through insurance.
 - 3. Counseling through EAP referral.
 - 4. New York State Tobacco Free Quit Line

3. Provide tobacco/nicotine prevention, education and nicotine replacement treatment for clients

- A. During all intakes and reviews, the clinical staff will assess clients for tobacco/nicotine dependence using the Fagerstrom Test for Nicotine Dependence and document their level of dependence.
- B. All clients, regardless of the tobacco history, will be offered an educational seminar on the effects of tobacco use.
- C. During the admission process, all clients will sign an agreement stating that they have been informed of the tobacco free policy and understand its guidelines. All clients in residence on 6-1-08 will also sign the agreement.
- D. Clinical staff will assist the clients in obtaining Nicotine Replacement Therapy upon request.
- E. While at the program, clients will not exhibit any tobacco/nicotine products including paraphernalia, lighters, rolling papers, promotional clothing and other tobacco/nicotine brand specific items. If clients are found to have any of these items, the items will be confiscated and destroyed.
- F. All clients who are identified as needing tobacco cessation will have this area addressed in their service plan.

MONITORING AND COMPLIANCE:

1. All employees, clients, volunteers, workfare participants and visitors are expected to adhere to this policy.
2. All employees are expected to be familiar with this policy and are responsible for monitoring compliance.
3. Employees who violate this policy will be subject to the same disciplinary procedures used for any other policy violation related to work performance.
4. Violation of this policy by clients will be addressed as a treatment issue first, and as disciplinary issue if violations persist. The clinical staff will address non-compliance with the client. Repeated violations may result in termination guided by the way staff deals with other addictions.
5. Visitors who violate this policy will be informed of the policy and asked to comply. A visitor who persists in violating this policy will be asked to leave.
6. Workfare participants and volunteers who violate this policy will be reminded of the policy and asked to comply. A workfare participant or volunteer who persists in violating the policy will be relieved of duty until that workfare participant or volunteer agrees to comply.

DEFINITIONS:

Tobacco- Free

When tobacco use is not permitted in any form indoors or on the grounds, the facility is tobacco-free. Tobacco-free programs understand that any use of tobacco products is incongruent with a lifestyle free of addictive drugs and recognize the need to assist clients, employees and volunteers at the facility in addressing their own tobacco use behavior.

Fairview Recovery Services, Inc.

To support a tobacco free environment, I agree to the following:

- I will not use any type of tobacco products while on the Fairview Recovery Services premises. I understand this includes the sidewalks surrounding the community residence, crisis center, supportive living apartments, parking lots, and vehicles.
- As a tobacco user I understand treatment goals specific to nicotine dependence will be included in my treatment plan.
- I agree I will not bring tobacco products or paraphernalia including lighters, snuff, chewing tobacco, cigars, cigarettes, etc. to any Fairview Recovery Services site understanding that staff will confiscate and destroy them.
- In the event that I violate such policy I understand that my case will be reviewed with possible revisions to my treatment plan. I understand that if I am found to be smoking in any of Fairview Recovery Services facilities I may be discharged from that program immediately.
- In an effort to support peers who have also agreed to this initiative, I agree to take measures to remove the odor or evidence of smoking from my person before I enter any of Fairview Recovery Services facilities (i.e. washing hands).
- As a non-smoker as part of the Fairview Recovery Services admission process I have been informed of this policy.

Client Signature

Date

Staff Signature

Date

PASS REQUEST

In keeping with the philosophy of Supportive Living programming the following residents pass and curfew policy has been designed. Our goal is to help residents build their individual internal accountability.

1. Pass requests must be approved by your Case Manager or Program Coordinator **PRIOR** to departure.
2. Residents may receive one pass each week, for 48 hours in length.
3. Upon approval, residents must provide the following information:
 - a. Destination and address.
 - b. Contact name and phone number.
 - c. Date leaving.
 - d. Date returning.

If you determine that you are in a situation that warrants an extension of a pass, you must leave a message on your Case Manager's telephone as well as notify Fairview Residential Halfway House staff. The message should include; new date of return and telephone number you can be reached at. Staff numbers provided below.

Staff reserves the right to urine drug screen and breathalize you upon return. This may include reporting to the Addictions Crisis Center (A.C.C.)

CURFEW

1. Residents must observe curfew. Weekday curfew is 11:30 p.m. Weekend and holiday curfew is 12:00 p.m.
2. If you determine that you are in a situation that warrants a time extension you will need to follow the procedure stated above.
3. If you plan on attending a special event which will prevent you from returning at curfew; you will need to discuss this with your Case Manager or Program Coordinator **PRIOR** to the event.

Non-compliance with this policy may result in immediate discharge.

FRS Community Residence: 722-8987 EXT. 5

FRS Supportive Living: Program Coordinator 722-8987 EXT. 228
Base Case Manager EXT. 243
Women's Empowerment Case Manager EXT. 233
Case Manager Mannion House EXT. 238

Resident's Signature: _____ Date: _____

FRS Staff: _____ Date: _____

MEDICATION POLICY
COMMUNITY RESIDENCES/SUPPORTIVE LIVING:

It is the policy of Fairview Recovery Services, Inc. Community Residential and Supportive Living programs to provide a supportive alcohol and drug-free environment. Therefore alcohol and/or mood altering drugs are not allowed on the premises. We recognize that there is an individualized need for certain residents to take medications for both their physical and mental health needs. Therefore the only acceptable mood altering drugs that are allowed on the premises are those medications that are prescribed by a physician.

Procedure: On Admission to Supportive Living, Residents will review all the medications that have been prescribed to them with their Case Manager. The resident must demonstrate the ability to manage their medication on their own prior to admission.

Residents must inform staff when any of the following situations occur:

- Changes in the prescription
- Beginning a new medication
- Experiencing adverse reactions or side effects to medications

The Supportive Living staff reserves the right to meet with the client and count the quantity of medication with the client present at any time to ensure that no medications are being abused.

Any issues of non-compliance with medications will be managed as a therapeutic issue with the provider. Ongoing issues of non-compliance may ultimately result in discharge and a referral to an alternative level of care.

Client Signature

Date

FRS Staff Signature

Date

Fairview Recovery Services, Inc.
Supportive Living Program
Mannion House
Visitors Policy - Child

I, _____ agree to abide by the following policy regarding having overnight visitors at the house that I currently occupy:

I understand that I will not be allowed to have overnight guests/and or children, due to the living situation of Mannion House.

During visitation hours I agree to assume full responsibility for my child.

I recognize the need to be in supervision of my child at all times.

I recognize that my child is not the responsibility of my housemate(s) or Fairview Recovery Services, Inc.

Fairview Staff reserves the rights to implement rules when problems or concerns arise.

Client Signature

Date

FRS Staff Signature

Date

Supportive Living Program
Mannion House
Visitor Policy

1. I understand that overnight guest(s) will not be allowed due to the living situation of the house.
2. I understand that visitation with my children is allowed throughout the week and on weekends as long as it doesn't interfere with my and/or my housemates recovery.
3. I agree that all guests will be alcohol/drug free.
4. I agree that Fairview Employees or clients are not to be responsible for my children at any time.
5. I understand that guests determined by F.R.S. staff to be inappropriate will not be allowed in Mannion House.
6. I agree that there will not be guests in Mannion House when I am not at home. I agree that any deviations from the above policy may result in discharge from Supportive Living.
7. I agree guests must leave by **9:00p.m.** due to the living situation at Mannion House. I understand that special requests for guests to stay until the regular curfew will need to be approved by my case manager 24 hours in advance of visit.
8. I agree that no one but me will have keys to Mannion House and/or my bedroom.
9. I agree guests will visit in common areas only. Bedrooms **are not** common areas.

Staff reserves the right to implement rules when problems or concerns arise.

Client Signature

Date

FRS Staff Signature

Date



Guidelines for Living: Supportive Living

1. No X-rated movies or material that is sexually explicit throughout the Mannion House. This is a house of recovery and these types of materials have no place here.
2. Verbal or physical threats or acts of violence are not acceptable. Racial and sexual slurs, sexual harassment and vulgarity are not acceptable. Violation of these norms may lead to discharge.
3. There is to be no yelling up or down the stairs for any reason. Disruptive loud noise, music, TV's is not acceptable and may lead to discharge.
4. Residents are responsible for supplying their own phone services. It will be the resident's responsibility to sign financial contract for cable services.
5. Residents are responsible for the cleanliness of the house and outside area of the house.
6. Please be courteous and respectful in all living areas that are shared.
7. You are responsible to supervise **children, friends and family members** during visitation. You are not allowed to leave them in the apartment at anytime for any reason during visitation.
8. You have the right and responsibility to confront another resident on their old behaviors. We are not here to judge one another and everyone makes mistakes. It is your responsibility, based on the severity of the behavior, to inform staff.
9. The residents of Supportive Living are ineligible to eat meals at the Residential Halfway House at either lunch or dinner without an invitation from a Halfway House client.

Fairview Recovery Services, Inc.
Resident Contract
Supportive Living Program

Fairview Recovery Services, Inc. is a private, nonprofit agency with the mission to improve the quality of life and health of persons diagnosed with and recovering from alcoholism, substance abuse and other disabling conditions. Providing you with residential, rehabilitation and support services pursues this goal. The purpose of this contract is to outline what is expected of you and the role of staff to ensure that you have a safe, secure supportive setting in which to live and to work on your recovery/rehabilitation goals.

Client Expectations: As a resident of Fairview Recovery Services, Inc. Supportive Living Program, I agree:

1. To treat all community members (other residence and staff) with dignity, and to respect they're personal rights and property, their right to privacy and their right to receive support as a member of Fairview Recovery Services, Inc. community.
2. To be willing to live cooperatively, and respectfully with my housemates.
3. To participate in the development and carrying out of the activities of my individualized recovery/treatment program to include:
 - Maintain sobriety and abstinence from non-prescribed drugs.
 - Meeting with F.R.S. staff on a regularly scheduled 1:1 basis to discuss my plan, services, progress, and changes in my plan, and any other concerns that need to be shared.
 - Being involved in a program of goal-oriented activities, therapy, treatment, work and/or training, for at least 20 hours a week.
 - Participate regularly in community meetings.
 - Maintaining regular contact with my treatment counselor and Case Manager.
4. To assume responsibility for my health and hygiene and for the care and safe keeping of Fairview Recovery Services, Inc. property, personal property, and personal living areas to include:
 - Keeping myself in good health and maintaining good personal hygiene.
 - Maintain my house/bedroom in a clean and orderly fashion.
 - Assuming responsibility of house/bedroom keys by insuring against loaning or duplication, and promptly returning all issued keys upon request.
 - Assuming financial responsibility for lost or damaged Fairview Recovery Services, Inc. property at replacement value to be established by the Program Coordinator in conjunction with the Clinical Director.
5. To assume responsibility for fee payment from day of admission and for other financial responsibilities as described in the Financial Contract
6. Fairview Recovery Services, Inc. is not responsible for personal belongings. Fairview Recovery Services, Inc. is not responsible to replace lost or damaged personal property. Personal belongings left behind by a resident will be considered forfeited and will be disposed of at the discretion of Fairview Recovery Services, Inc.
7. To insure my physical and emotional well-being and that of the community members by:

- **No smoking** in any area inside Mannion House.
- Use of candles, incense etc. is limited to designated areas of living room and kitchen.
- Learning the fire evacuation plan.
- Storage and use of weapons in or around the house is strictly prohibited
- Abstinence from all non-prescribed, mood-altering substances is expected in accordance with my individualized service plan. I further understand that any use will result in an evaluation by staff to determine what care and attention is needed to insure my health and safety and to decide about my continued participation in the program.
- Preparing and storing food in a responsible way that insures my safety and that of others, as well as Fairview Recovery Services, Inc. property and to consume food and beverages only in designated areas to insure a clean environment.
- Informing staff when I will be away for a period of time exceeding a normal weekend, and establishing with staff a time to return.
- Agreeing that the staff may enter my bedroom and the house without my prior permission to make routine maintenance checks and at any other time there is a concern for any health or safety issue or when there is a concern that I and not complying with the program expectations.
- I agree not to have any “pets” of any type, which are dependent upon me to sustain its life in my apartment. Pets include dogs, cats, birds, reptiles, fish, amphibious creatures, insects, and small mammals, any and all creatures domesticated or wild.

Fairview Recovery Services, Inc. Responsibilities: Fairview Recovery Services, Inc. agrees to provide the following:

1. To provide you with the following services without regard to your sex, race, religion, national origin, sexual preference and mental, emotional, or physical condition:
 - a) Admission and Discharge planning
 - b) Training in activities of daily living.
 - c) Case management
 - d) Supportive counseling focusing on relapse prevention and monitoring of sobriety.
 - e) Crisis management (dealing with difficult situations through appropriate interventions and referrals to community agencies)
 - f) Room and Board
 - g) Socialization and Leisure Activities
 - h) Accessing Transportation
 - i) Developing appropriate behaviors through effective interventions.

2. To assist you in:
 - a) Identifying and defining your needs.
 - b) Developing and individualized service plan.
 - c) Identifying appropriate agencies and services to meet your needs
 - d) Recommending and or referring and coordinating services
 - e) Identifying and clarifying your satisfaction or dissatisfaction about the services you are receiving and helping you to find appropriate methods to express your views.
 - f) Supporting and reviewing progress and changing your service plan, as appropriate, through regularly scheduled meetings with your case manager and treatment counselors.
 - g) Dealing with difficult situations through crisis counseling or other appropriate interventions

3. To treat individuals with dignity; ensuring that your personal rights include, but are not limited to, the:
 - a) Right to reasonable privacy

- b) Right to confidentiality
- c) Right to access to your records as described in agency policies.
- d) Right to receive visitors
- e) Right to voice grievances or complaints about the programs, staff and facility, in an appropriate manner, without fear of reprisal
- f) Right to exercise all other rights guaranteed to citizens of the community

4. To provide you with a clean, safe sober living environment.

I understand that I have entered this program voluntarily and may leave voluntarily, having given proper notice.

I understand that if I am satisfied or not satisfied with something, I am encouraged to inform staff.

Fairview Recovery Services will make a sincere effort to ensure a safe environment and your views will be taken seriously.

Resident's Signature _____ **Date** _____

Case Manager's Signature _____ **Date** _____

Fairview Recovery Services, Inc.

Contract for Cable Service

As part of my residency at Mannion House, I agree to pay ten dollars (\$10.00) each month for cable services in my room.

I agree and understand that ten dollars (\$10.00) will be automatically taken from my PNA each month for this service.

I agree and understand if I wish to discontinue this service I must notify my Case Manager in writing.

Failure to pay for this service will result in the discontinuation of cable.

Cable prices are subject to change. You will be notified of any change in services or cost. Monthly deductions will be adjusted accordingly.

Signature

Witness

Date

Referral Paperwork Overview

(Synopsis Records of Treatment, Medical, Physical, Background Check and State Forms)

- Psych/Social from Treatment Provider Where: _____ Date: _____
- Treatment Plan from Treatment Provider Where: _____ Date: _____

- Medical History / Physical Exam Where: _____ Date: _____
- Complete Blood Count (within 1 year) Where: _____ Date: _____
- PPD / TB Results (within 1 year) Where: _____ Date: _____

- Towne and Country Apartments Background Check APPROVAL / DENIAL Faxed: _____

- Community Residence Psych/Social Update
- Community Residence Face to Face Mini Mental Health Exam
- Community Residence OASAS Admission State Form

- Copy of Medicaid Card (*New Request*)