

SHELTER PLUS CARE

REFERRAL/APPLICATION PACKET



Applicant's Name: _____

Date: _____

Referral Source: _____

Received Date: _____

Staff: _____

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.

**SHELTER PLUS CARE
REFERRAL/ADMISSION PACKET
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Introduction

Thank you for your interest in Fairview Recovery Services' Shelter Plus Care Program. The Shelter Plus Care Program is a HUD funded subsidized housing program that assists homeless people with disabilities. In order to participate in the Shelter Plus Care Program, the client must meet the HUD definition of homelessness, have a disability documented by a qualified health professional and participate in supportive services that are equal to or greater in value to the yearly costs of the rental subsidy they receive. The overall goals of the Shelter Plus Care Program are: 1) to increase housing stability; 2) to increase skills and/or income; and 3) to gain greater self-sufficiency.

In order to expedite your application please complete and provide the following:

1. Shelter Plus Care Application Form
2. Shelter Plus Care Resident Agreement
3. Shelter Plus Care Medication Policy
4. Shelter Plus Care Vocational Policy
5. Shelter Plus Care Overnight Visitor Policy
6. Current Psychosocial Evaluation
7. Provide Documentation of Homelessness
8. Copy of Birth Certificate
9. Copy of Social Security Card
10. Consent for Release of Information

After we receive the items listed above, your client will be scheduled with an interview with the Shelter Plus Care Case Manager to determine eligibility.

If you have questions, please contact the Shelter Plus Care Case Manager at (607) 722-8987 extension 240.

Again, thank you for interest in Fairview Recovery Services.

FAIRVIEW RECOVERY SERVICES, INC.
Fairview and Merrick Community Residences
Supportive Living
Addictions Crisis Center
5 Merrick Street, Binghamton, NY 13904

Consent for Release of Information Concerning Alcoholism/Drug Abuse Patient

Instructions: Prepare one (1) copy for patient's case record. If this form is used for billing purposes, prepare additional copy for Patient Resources Office. If this form is sent to another agency for information, prepare a second copy for patient's case record.

Patient Name: _____
Last First MI

DISCLOSURE WITH PATIENT'S CONSENT

Extent or nature of information to be disclosed:

Purpose or need for the disclosure: **Continuity of Care**

Between name of person or organization disclosing information:

And name of the person or organization to which the disclosure is being made: _____

Fairview Recovery Services, Inc.

I, the undersigned, have read the above 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, event 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: *6 months following date of discharge*

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 Date Signature of Parent/Guardian when required Date

Patient Name (Printed) Date Parent/Guardian Name (Printed) Date

FAIRVIEW RECOVERY SERVICES, INC.
Fairview and Merrick Community Residences
Supportive Living
Addictions Crisis Center
5 Merrick Street, Binghamton, NY 13904

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Patient Signature	Date	Signature of Parent/Guardian when required	Date
-------------------	------	--	------

Patient Name (Printed)	Date	Parent/Guardian Name (Printed)	Date
------------------------	------	--------------------------------	------

Date: _____

APPLICATION
Shelter Plus Care Program (S+C)

I. APPLICANT INFORMATION

Please check the size of the unit you are applying for:
Efficiency 1Bedroom 2 Bedroom 3 Bedroom

Name _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ How long have you lived at this address? _____

Type of Housing currently living in (emergency or transitional housing, with friends, own apartment, etc) _____

Are you presently involved in outpatient treatment?: yes no If yes, which type of treatment?
Outpatient Drug and/or Alcohol: Where: _____ Frequency: _____
Outpatient Mental Health: Where: _____ Frequency: _____

II. HOUSEHOLD COMPOSITION

List the Head of Household and all other members who will be living in the unit. Give the relation of each member to the head

Participant Name	Relationship to Head of Household	Birthdate	Age	Sex	Social Security #

Do you expect a change in your household composition? Yes No

If yes, please explain:

Please explain any special housing needs your would need:

Are you or anyone in your household subject to state lifetime registration requirement for sex offenders?
yes no If yes, identify household member

Have you or anyone in your household ever been convicted of a crime?
yes no If yes, identify household member

III. HOUSING HISTORY

Have you ever been evicted? yes no If yes, please explain reason(s):

How many times have you been homeless in the last four years?

IV. FINANCIAL INFORMATION

Present Source of Income	Monthly Amount
Health Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Medicare <input type="checkbox"/> Other (specify):	Food Stamps: <input type="checkbox"/> yes <input type="checkbox"/> no Amount:

Do you owe any utility balances?: yes no

V. APPLICANT CERTIFICATION

I/we certify that if selected to receive assistance, the unit I/we occupy will be my/our only residence. I/we understand that the above information is being collected to determine my/our eligibility. I/we certify that the statements made in this application are true and complete to the best of my/our knowledge and belief.

Signature of Applicant

Date

**SHELTER PLUS CARE PROGRAM
CERTIFICATION OF HOMELESSNESS**

Participant Name: _____ Date: _____

Other Household Members: _____

I certify that the person(s) listed above qualify as "homeless" under the definition used in the HUD-funded Shelter Plus Care Program because they meet one of the following criteria:
(Please review the attached Homeless Eligibility and Documentation Guide before checking the appropriate response):

__1. Living on the street or in a place not meant for human habitation (please explain):

__2. Living in an emergency shelter (please give details):

__3. Living in transitional housing after having been homeless (Please attach letter providing details):

__4. Living in an institution (such as a substance abuse / mental health treatment facility) less than thirty days after having met criteria #1 or #2 above. (Please attach letter providing details.):

I certify the information above to be true.

Agency: _____

Agency Representative (Please print name): _____

Signature: _____ Date: _____

**SHELTER PLUS CARE
HOMELESSNESS ELIGIBILITY AND DOCUMENTATION GUIDE**

If your S+ C program serves...	Then you need to...	This means...
Persons living on the street or places not meant for human habitation	Document their homeless status	You must verify that an individual is coming from the street through a certification from an outreach worker or organization that the person was living on the street. If you are unable to verify in this manner, the participant or a staff member may prepare a short written statement about the participant's previous living place and have the participant sign the statement and date it.
Persons coming from an Emergency shelter	Verify from the emergency shelter staff that the participant has been residing at the emergency shelter.	You need to obtain from the referring agency a written, signed, and dated verification that the individual has been a resident of the emergency shelter.
Persons coming from transitional housing for Homeless persons	Verify with the transitional housing staff that the participant has been residing at the transitional housing.	You should obtain: 1) a signed statement from the transitional housing staff indicating that the individual is a resident there; and 2) the referring agency's signed and dated verification as to the individual's homeless status when he/she entered their program.
Persons from a short-term stay (up to 30 days) in an institution who previously resided on the street or in an emergency shelter	Verify from the institution staff that the participant has been residing at the institution and was homeless before entering the institution.	You must obtain: 1) written verification from the institution's staff that the participant has been residing in the institution for less than 31 days; and 2) information on the previous living situation. Preferably, this will be the institution's written signed, and dated verification on the individual's homeless status when he/she entered the institution.

SHELTER PLUS CARE QUESTIONNAIRE

CLIENT NAME: _____

DATE: _____

TO BE FILLED OUT BY APPLICANT

What do you wish to accomplish while in the Shelter Plus Care Program?

What is your primary source of income? DSS SSI/SSD OTHER NONE

Which support services are you currently involved in?

- Case Management
- Intensive Day Treatment
- Alcohol/Substance Abuse Services
- Mental Health Services
- Health Care
- Probation/Parole
- Education
- Other: (Explain)

Do you owe past utility bills? Yes No

Have you ever been evicted from an apartment? Yes No

If so, who was the landlord? _____

I understand that, in order to participate in the Shelter Plus Care Program, I must participate in supportive services that are equal to, or greater in value, to the yearly costs of the rental subsidy I receive. I am aware that the overall goals of the Shelter Plus Care Program are: 1) to increase housing stability; 2) to increase skills and/or income; and 3) to gain greater self-sufficiency.

Signature

Medication Policy

On admission to Shelter Plus Care Residents will review the medications that have been prescribed to them with their case manager. Residents must demonstrate they ability to manage their own medications before admission.

Residents must inform staff when any of the following occurs:

1. Changes in Prescriptions
2. Beginning a new medication
3. Experiencing adverse reactions or side effects to medications
4. Questions regarding medications

I agree to take my medication as prescribed by the doctor, and agree not to abuse my medication.

Resident's Signature _____ Date _____

Counselor's Signature _____ Date _____

Overnight Visitor Policy

1. I understand that I may use my discretion in allowing when I invite an overnight guest(s).
2. I agree that all guests will be alcohol and/o drug free.
3. I agree to assume full responsibility for my children.
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 Fairview staff to be inappropriate will not be allowed in my residence.
6. I agree that there will not be guests in my residence when I am not at home (except with prior FRS staff approval)
7. I agree that no one but me will have keys to my residence.

Client Signature

Date

FRS Staff Signature

Date

Shelter Plus Care
Relapse Policy

I understand and agree to the following procedure for termination from the program:

1. I agree to follow all rules and regulations outlined within the Occupancy Agreement.
2. I agree to remain free from alcohol and substance use.
3. I agree to follow all staff recommendations in the event I relapse, which will include going to the Addiction Crisis Center. If a bed is unavailable, I will call the ACC every two hours until a bed is available. Once a bed is available, I will accept it and immediately report to the ACC.
4. Once at the ACC, I understand a meeting will be held with my primary S+C case manager. This will be for the purpose of gathering facts and information regarding the events leading to the relapse.
5. The next step will include a team meeting, which will include all providers involved with my care. I understand, I will be given an opportunity to present the team with any information I feel is important in the decision making of my continued care and recovery.
6. The team will make a recommendation based on the individual needs of the client and present it to the client. The individual must follow through with the team's recommendation to maintain residency.
7. I will be given an opportunity to make objections to the decision in writing or by appointment to Fairview Recovery Services' Executive Director.
8. Prompt written notice of the final decision will be given to the client.

Client signature _____ Date _____

SHELTER PLUS CARE VOCATIONAL POLICY

As a participant of the Shelter Plus Care Program, I agree to the following Voc/Ed policy:

- 1) I agree upon admission to meet with a Career Choices Unlimited case-manager to do:
 - a) create and or update Vocational Educational plan.
 - b) inform of residency changes.

- 2) I agree to be a participant in one of the following: Employment, volunteer work, GED classes, or college.

- 3) I agree to follow through with all goals agreed upon with the CCU case-manager until completion of the Voc/ED program.

Residents Signature _____ Date: _____

Counselor's Signature _____ Date: _____

Fairview Recovery Services, Inc.
Resident Contract
Shelter Plus Care 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 rehabilitation goals.

Client Expectations: As a resident of Fairview Recovery Services, Inc. Community residence, I agree:

1. To treat all community members (other residence and staff) with dignity, and to respect their 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 participate in the development and carrying out of the activities of my individualized rehabilitation program to include:
 - Maintain sobriety and abstinence from non-prescribed drugs.
 - Meeting with Fairview Recovery Services, Inc. staff on a regularly scheduled 1:1 monthly 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, rehabilitation, work and/ or training, for at least 20 hours a week.Maintaining regular contact with my primary therapist/ counselor.
3. 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.
 - Maintenance and cleaning of the apartments.
 - Assuming responsibility of apartment 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 Clinical Director.
4. To give 30 days written notice of my intent to leave Fairview Recovery Services, Inc.
5. To insure my physical and emotional well-being and that of the community member
 - Supporting fire prevention activities by using smoking materials (candles, incense etc.) only in designated areas and in a safe responsible way.
 - Learning the fire evacuation plan and participating in fire drills.
 - Refraining from the storage and use of weapons in or around the apartment.
 - As a client with a history of alcohol or other substance abuse or dependence, complete abstinence from all non-prescribed, mood-altering substances is expected in accordance with my individualized rehabilitation 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.

- Informing staff of all prescribed and over-the-counter medications I am taking and immediately reporting changes in dose and frequency, and then taking these medications only as approved by my physician.
 - 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 from my apartment for longer than two days at a time.
 - Welcoming guests within the following guidelines: children need to be carefully supervised during their visit; occasional overnight visitation is permitted All guests must be clean and sober.
 - Agreeing that the staff may enter my apartment 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 am not complying with the program expectations.
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 who leaves, will be held for a period of (30) days. After that time, all belongings will be considered forfeited and will be disposed of at the discretion of Fairview Recovery Services, Inc.

Fairview Recovery Services, Inc. Responsibilities: To further your rehabilitation the staff of Fairview Recovery Services, Inc. agree:

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 counseling or other appropriate interventions)
 - f) Medication Management
2. To assist you in:
 - a) Identifying and defining your needs.
 - b) Developing and individualized rehabilitation 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 rehabilitation plan, as appropriate, through regularly scheduled meetings with your primary counselor.
 - g) Dealing with difficult situations through crisis counseling or other appropriate interventions
3. To treat you and your fellow clients with dignity and 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 make and receive phone calls
- e) Right to receive visitors
- f) Right to send and receive mail unopened
- g) Right to voice grievances or complaints about the programs, staff and facility, in an appropriate manner, without fear of reprisal
- h) Right to exercise all other rights guaranteed to citizens of the community

4. To provide your family members/ significant others with an orientation to the program and ongoing consultation, education and support with the primary purpose of helping them understand and support you while you are in the program.

I understand that Fairview Recovery Services, Inc. staff is responsible for helping me find ways to make my stay a growth experience and to help me address situations with which I am not satisfied.

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. A safe environment will be provided and my views will be taken seriously.

Resident's Signature _____ Date _____

Counselor's Signature _____ Date _____

____ Chart Copy

____ Client Copy

FAIRVIEW RECOVERY SERVICES, INC.

Michele Napolitano, MEd, CRC, CASAC

FAIRVIEW COMMUNITY RESIDENCE
MERRICK COMMUNITY RESIDENCE
SUPPORTIVE LIVING

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

August 31, 2011

Dear Referring Agency,

As a requirement of HUD, we are adding a new form to our referral packet titled "***Client Homeless Status: Eligibility Documentation***". If the individual you are referring is not homeless, please indicate that next to the client's name on the form and sign below.

If the individual is homeless please check the box that describes the individual's situation and attach supporting documentation to the form.

Examples of supporting documentation can be found in the second column on the form. If you are in need of additional assistance, or have any questions regarding this new referral requirement, please feel free to contact Jessica Meade, Shelter Plus Care Case Manager (607) 722-8987 ext. 240 or jmeade@frsinc.org.

Thank you in advance for your cooperation with this new referral requirement.

Sincerely,



Michele Napolitano, MEd, CRC, CASAC
Executive Director

CLIENT HOMELESS STATUS: ELIGIBILITY DOCUMENTATION

Client Name: _____

Date of Intake: _____

Check the current housing status and attach the appropriate documentation to verify homelessness eligibility.

Homeless Status	Type of Documentation	Documentation Attached
Living on the street	A signed and dated general certification from an outreach worker verifying that the services are going to homeless persons, and indicates where the persons served reside.	
Persons living on the street Persons coming from living on the street (and into a place meant for human habitation)	Staff should provide written information obtained from third party regarding the participant's whereabouts, and, then sign and date the statement.	
Persons coming from an emergency shelter for homeless persons	Written referral from the agency.	
Persons coming from transitional housing for homeless persons	Written verifications to include program residency and homeless status prior to program entry.	
Persons being evicted from a private dwelling	Documentation of income, efforts to obtain housing, why participant would be on street, and either documentation of formal eviction proceedings or statement from family evicting participant. (Not eligible for acceptance directly into PH from 2005 awards onward.)	
Persons from a short-term stay in an institution who previously resided on the street or in an emergency shelter	Written verification from the institution's staff that the participant has been residing in the institution for less than 31 days, and information on the previous living situation.	
Persons being discharged from a longer stay in an institution	Written verification from the institution of discharge within one week of accepting client into SHP/S+C program AND documentation of income, efforts to obtain housing, and why person would be homeless without assistance.	
Persons fleeing domestic violence	Written, signed, and dated verification from the participant.	
Other:	Written verification from client or referring agency	
CHRONIC HOMELESSNESS Single, disabled Adult + Continuously homeless for 1 yr or more OR.. 4 episodes of homelessness in the past 3 yrs (streets/shelters)	Written verification from outreach workers, shelters AND brief, written statement regarding previous shelter/street stays (dates, locations) AND - documentation of disability	

NOTES:

STAFF MEMBER: _____

Date: _____

CLIENT: I verify this information is true & accurate. I confirm that I have been or am about to be homeless.

Signature of Client

Date: _____