Referral/Admission Packet
Fairview Recovery Services, Inc.
820 Residential Services

Fairview Recovery Services helps people with the disease of alcoholism, chemical dependency, and co-occurring conditions live independent, healthy, and productive lives by providing a continuum of individualized services and care.

Updated 3.2023

Fairview Recovery Services, Inc.
Referral/Admission Packet Checklist

APPLICANT NAME: ___________________________________ **DATE:** ____________________

Please check all that apply: ☐Pregnant Intravenous Substance User ☐Pregnant Substance User
☐ Other who injects drugs ☐Parent/Guardian of child(s)in risk of entering foster care
☐Recently released from criminal justice setting ☐Other substance user

Referring Agency: _______________________________________

Staff Name: ____

Contact Email: ______________________________________ Phone: _______________________

820 Residential Reintegration-(similar to 819 CR/HWH)

Please complete and sign the following documents before faxing/email the Referral/Admissions Packet back to Fairview Recovery Services, Inc:

- ☐ Referral/ Admissions Application
- ☐ Psycho-social assessment
- ☐ Mental health evaluation, if applicable
- ☐ Medical history, physical, UA, CBC (within last 12 months) medical clearance for communicable diseases, if available.
- ☐ PPD Test and verification/results
- ☐ Current Medication List
- ☐ Confirmations from Social Services or Social Security
- ☐ Copy of Benefit Card & Copy of Health Insurance Card
- ☐ Consent/Release forms fo r:
  referring agency, DSS LOCADTR, emergency contact,managed care, PSYCKES
- ☐ Verified Documentation of Homelessness (see eligibility document attached)

Please return this form to Fairview Recovery Services, Inc. with all completed information

Thank you

Referral Application: Fairview 820 Residential Reintegration

INTRODUCTION

Thank you for your interest in Fairview Recovery Services. We look forward to assisting you in your continued recovery.

Please complete the application and fax to Admissions at 607-352-4777. You may also send in a secure email to admissions@frsinc.org

APPLICANT INFORMATION

Name: ______________________________ Phone: ______________________

Street address (prior to treatment, if applicable): ______________________________________

City:____________________County:______________State:___________Zip: __________

What are the reasons why the applicant cannot return to the above address?

____

Is the applicant homeless or at risk for homelessness? ☐Yes ☐No If yes, please explain:

____

____

____

D.O.B. ___________ S.S.N. ________________ Medicaid Number ________________

SUBSTANCE HISTORY

Does the applicant have a substance use disorder diagnosis? ☐Yes ☐No If yes, list DSM / ICD Code:

Code	Description

Substance Type	Onset	Frequency	Route of Ingestion	Date of Last Use

MENTAL HEALTH

Does the applicant have a mental health diagnosis? ☐Yes ☐No If yes, please explain below:

____

____

____

Diagnosed by: ______________________________ Date of Diagnosis: ____________________

Medications: ______________________________ Prescribed by: ____________________

Is the applicant currently receiving mental health treatment? ☐Yes ☐No If yes, who is the provider?

____

____

Does the applicant have previous mental health treatment, including hospitalization? ☐Yes ☐No

If yes, please answer the following:

Events leading to mental health treatment	Program	Dates/Length of Stay

MEDICAL

Does the applicant have a Primary Physician? ____________________

Date of last physical exam / lab / blood work: ____________________ Date of last TB test: ____________________

List any physical disabilities or limitations:

____

____

Is the applicant currently being treated for any communicable disease? ☐Yes ☐No
If yes, explain below:

____

____

If the applicant is female, is she pregnant? ☐Yes ☐No ☐ N/A If yes, please answer the following:

When is her due date? ____________________ Is she receiving prenatal care? ☐Yes ☐No

If she is receiving prenatal care, where? ____

____

MEDICATION

(Please attach current Medication List or write in below)

Current Medication	Dosage	Prescribing Doctor	Reason for Medication

Has the applicant been prescribed any Medication-Assisted Treatment medications? ☐Yes ☐No
If yes, please complete the following:

Current Medication	Dosage	Prescribing Doctor	Phone Number

MEDICAL INFORMATION

Please check YES or NO for the following medical issues:
(If Yes to any of the following please elaborate in the comments section)

	Yes	*No*	*Comments*
Diabetes			
Asthma			
Eating Disorder			
COPD			
Heart/Cardiac			
High Blood Pressure			
Nicotine Use			
Pregnant			
Allergies			
Digestion Issues			
Blood Disorder			
Nicotine Use			
Liver Disorder			
Hepatitis C, B, A			
HIV/AIDS			
Menstrual Disorder			
Emphysema			
Hearing Loss			
Acute or Chronic Pain			
Mobility Issues			
Infections			
Scabies			
Open Wounds			
MRSA (history/current)			
Visual Impairments			
Dental Issues			
Attention Deficit Disorder			
Cancer History			
History of Medication Assisted Treatment			
OTHER			

LEGAL

Is the applicant mandated to this level of care? ☐Yes ☐No If yes, by whom: ___________________________

Please provide any legal entities with which the applicant has involvement:

Entity (Drug Court* Probation, etc.)	Jurisdiction	Contact Person	Contact Number

Does the applicant have any pending court appearances? ☐Yes ☐No If yes, please describe below:

Date	Time	Location	Reason for Appearance

Does the applicant have outstanding warrants? ☐Yes ☐No ☐Unknown If yes, explain:

____

____

Does the applicant have a history of assault? ☐Yes ☐No ☐Unknown If yes, explain:

____

____

Has the applicant been arrested for or convicted of arson? ☐Yes ☐No ☐Unknown If yes, explain:

____

____

Does the applicant have any history of rape, sexual abuse, or violent crimes against a person? ☐Yes ☐No
If yes, please explain below: ____

____

FINANCIAL

Does the applicant currently receive Social Service benefits? ☐Yes ☐No If yes, please provide:

From which county? ___________________________ Current monthly amount: $_________________

Does the applicant currently receive SSI / SSD benefits? ☐Yes ☐No If yes, please provide:

☐ Self-Payee ☐ Rep Payee Payee Name: ___________________________ Phone No.: ___________________

Payee Address: ____

Current monthly income received from SSI / SSD: ____

____

Has the applicant ever been sanctioned/refused Social Services or Social Security ☐Yes ☐No
benefits? If yes, please explain: ____

____

Does the applicant have current Broome County Food Stamps? ☐Yes ☐No Other County Food Stamps? ☐Yes ☐No

Does the applicant have any other sources of income? ☐Yes ☐No If yes, please explain:

____

*****Please submit proof of income with the application***

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	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

Dates of residency, Progress in treatment, treatment planning, discharge planning, discharge summary.

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

Coordination of Funding

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION
Between: **Name: Patrick Haleyor designee** **Facility: Fairview Recovery Services** **Address: 5 Merrick Street Binghamton NY 13904** **Phone: (607) 722-8987 Fax: (607)** 352-4777	**And:** **Name:** **Facility: Broome County Department of Social Services** **Address: 36-42 Main St. Binghamton, NY 13905**

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: _______1 year_____________________________

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)

______________________________ (Print Name of Patient)

______________________________ (Signature of Parent /Guardian when required)

______________ (Date)

______________ (Date)

TRS-2 (5/03)

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	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

Dates of residency, Progress in treatment, treatment planning, discharge planning, discharge summary.

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

Coordination of Funding

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION
Between: **Name: Patrick Haley or designee** **Facility: Fairview Recovery Services** **Address: 5 Merrick Street Binghamton NY 13904 Phone: (607) 722-8987 Fax: (607)** 352-4777	**And:** **Name:** **Facility:** **Address:**

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above:_______1 year ____

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)

______________________________ (Print Name of Patient)

______________________________ (Signature of Parent /Guardian when required)

____________________ (Date)

____________________ (Date)

TRS-2 (5/03)

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	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

Dates of residency, Progress in treatment, treatment planning, discharge planning, discharge summary.

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

Coordination of Care

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING/RELEASING INFORMATION
Between: **Name: Patrick Haley or designee** **Facility: Fairview Recovery Services** **Address: 5 Merrick Street Binghamton NY 13904** **Phone: (607) 722-8987 Fax: (607) 352-4777**	**And:** **Name:** **Facility:** **Address:**

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above:_______1 year ____

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)

_______________________________ (Print Name of Patient)

_______________________________ (Signature of Parent /Guardian when required)

________________ (Date)

________________ (Date)

TRS-2 (5/03)

Revoked On: ___________ Staff Initials: __________

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT
LOCADTR ASSESSMENT

Patient's Last Name First M.I.	
Case Number	
Facility	Unit

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED:

All information necessary to complete a personalized Level of Care for Alcohol and Drug Treatment Referral "LOCADTR" assessment.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION:

I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the OASAS-Certified treatment facility identified above, and Payer / Managed Care Plan ____________________ ___________ of my clinical treatment including information from the OASAS Client Data System (CDS) and my Social Security Number.

I understand that the level of care determination assessment will only be shared with me, the OASAS treatment facility, and Payer / Plan identified above. Unless I have given written permission to share the information with other agencies, programs or payers.

I further understand that non-personal identifying information may be evaluated so that the effectiveness of the LOCADTR assessment tool can be evaluated.

I, the undersigned, have read the above and authorize the New York State Office of Alcoholism and Substance Abuse Services and the staff of the OASAS-certified treatment facility named above to disclose and obtain such information as herein specified.

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 within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, 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. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE: Any information released through this form **MUST** 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.

(Signature of Patient)	(Signature of Parent/Guardian)
(Print Name of Patient)	(Print Name of Parent/Guardian)
(Date)	(Date)

PATIENT HOMELESS STATUS: ELIGIBILITY DOCUMENTATION

Patient 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 that 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:

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

STAFF MEMBER: ____ Date: _____________

PATIENT: ____ Date: ______________

REVOKED ON__________ Staff sig_____________

MULTIPARTY CONSENT FORM FOR THE RELEASE OF CONFIDENTIAL INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME, FIRST, M.I.	
DOB	
FACILITY **Broome County Dept. Social Services**	UNIT **Chemical Dependency Services Unit** **Phone: 607-778-1251/1253**

I, ___________________________________, authorize the following Broome County OASAS/OMH licensed programs
(NAME OF PATIENT)

Addiction Center of Broome County programs, UHS/New Horizons Chemical Dependency Treatment programs, UHS Outpatient Mental Health Clinic, Fairview Recovery Services programs, Family & Children's Society/Family Counseling Services programs, and Helio Health/Binghamton Evaluation Center, Cornerstone Family Healthcare

To disclose the following information to Broome County Social Services at 36-42 Main St Binghamton, NY 13905:

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED
Evaluation results and recommendations, dates of service, diagnosis/brief description of progress/prognosis, medical history, medical tests and procedures to include urine drug screen results, psychiatric/psychological consults, psychosocial/diagnostic summary, legal history, and discharge summary.
PURPOSE OR NEED FOR DISCLOSURE/RELEASE
To monitor compliance with Chemical Dependency treatment for Temporary Assistance Applicants/Recipients as a NYS Office of Temporary and Disability Assistance mandate.

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure 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: 2 years

NOTE: Any information released through this form will be accompanied by the form prohibition on Re-disclosure 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.

X_____________________________________ (Signature of Patient)

_____________________________________ (Signature of Witness)

_____________________________________ (Print Name of Patient)

_____________________________________ (Signature of Parent /Guardian when required)

X_____________________ (Date)

_____________________ (Date)

FAIRVIEW RESIDENTIAL

WHAT TO PACK FOR YOUR STAY

For your convenience, please use this checklist as you prepare for your stay at our facility.
Please bring only items identified on the list below.
Upon Admission all Clients are provided the following, if they do not bring their own: ●Linens ● Towels ● Personal Hygiene

***** 3 BAG LIMIT PER PATIENT *****

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The amount of clothing is to not exceed **3** bags; all other items must fit into 3rd bag. Please have weather appropriate clothing and plan to switch out clothing as the seasons change. Bedding and toiletries are provided on admission. If a patient chooses to add new items within the duration of their stay to exceed listed amounts, items **must be traded out first**.

Maximum Number of Items Allowed Per Patient

Clothing: 8 Shirts/Blouses, **8** Pairs Jeans/Pants/Skirts in Combination, **10** pairs of Underwear/Socks/Bras, **7** Pajamas/Robe/Slippers, **2** Outer Set (coat/jacket, gloves, hat, boots), **3** Sneakers/flats/shower shoes

Toiletries: 1 set bedding, **2** Shampoo, **2** Deodorant, **2** Pillowcases, **2** Soaps (bar or bottle), **2** Pillows, **2** Toothbrushes, **2** Toothpastes, **1** Blanket, **1** Comforter, **1** Washcloth, **1** Towel, **1** Laundry detergent

Other: 3 Notebooks, **1** Planner, Stamps, envelopes, Pens/Gel Pens/Colored Pencils, Appropriate Books, Novels and Magazines, Family Photo (again, must fit within the 3-bag limit)

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*Deliveries are permitted within the duration of your stay with **staff approval for essential items only**. This includes personal hygiene products and essential seasonal clothing if listed within the above guideline. Nonessential items are **not** approved for delivery and will need to be returned or removed from FRS property.*

Fairview Recovery Services provides basic cleaning supplies, furniture, basic hygiene products, snacks and meals

Residential is a *temporary* living situation. Clients are NOT permitted to bring in: iPads/Tablets, Laptops, Gaming Systems, Perfume/Cologne, Aerosol Spray, Snacks/Drinks or Meals

Only the above items are permitted to be brought into the Facility.