

GCASA Bedded Treatment Program Application

Completed referral packages should be faxed to:
585-815-1815
Attn: Intake Coordinator

Please contact our intake coordinator with any questions you may have at:
Alexis Lukovich
Ph: 585-813-6508 E: alukovich@gcasa.org

Please select which level of care to which the applicant is applying:

Detox (Opioid, Alcohol, Benzodiazepine –
Mild/Moderate withdrawal only)

Community Residence (Requires 10 days
since last use)

Inpatient

Supportive Living

Complete referral packages for Community Residence and Supportive Living MUST include:

Psycho-social assessment
History and Physical
Blood work
PPD
Urinalysis

Indications for Referral (check all that apply):

Opioid Use Disorder
Alcohol Use Disorder
IV User
Pregnant
Homeless
Children in foster care or in jeopardy of being placed in foster care
Referred from a crisis center or looking to go bed to bed

Please explain:

CLIENT INFORMATION

Name: DOB:

Gender: SSN:

Address (prior to treatment):

County of Origin:

Phone: Email:

Does client currently receive benefits through Social Services? Yes No

If yes, what county?

Is client receiving SSI or SSD benefits? Yes No

If yes, complete the following:

Case Number: County:

Case Worker: Amount of benefit:

Has the client ever been refused/sanctioned for Social Services or Social Security Benefits?

Yes No

If yes, explain:

Highest grade level completed:

1 2 3 4 5 6 7 8 9 10 11 12 GED

Some college Bachelors Doctorate
Associates Masters

Please indicate any diplomas, degrees, trade school certificates, etc.:

INSURANCE

Primary Insurance:

Policy number:

Group number:

Subscriber:

Subscriber address:

Secondary Insurance? Yes No

Secondary Insurance (if applicable):

REFERRAL SOURCE

Name:

Relationship:

Agency (if applicable):

Phone number:

Fax:

Email:

Will you be providing ongoing support: Yes No

MEDICAL INFORMATION

Primary Care Provider Name:

Location:

PCP Phone:

PCP Fax:

Medical Diagnoses (i.e. heart disease, thyroid disease, epilepsy, cancer, diabetes, etc.):

If yes, please provide any additional information known:

Mental Health Treatment History:

Events Leading to Treatment	Program	Length of Stay	Dates

SUBSTANCE USE HISTORY

Has a substance use and/or alcohol use diagnosis been assigned to the client? Yes No

If yes, by whom?

When?

Diagnosis:

Primary substance:

Substance Use History:

Substance	Amount	Frequency	Route	Date of Last Use

Substance Abuse Treatment History:

Facility Name	Type of Treatment	Month/Year	Completed	
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

LEGAL

Is the client on probation or parole? Yes No

If yes, please provide probation/parole officer's name, county, and contact info:

Is the client attending treatment court? Yes No

Where?

Is the client mandated for treatment? Yes No

By who?

Has the client ever been arrested? Yes No

If yes, when and what were the charges?

Has the client ever been arrested for assault? Yes No

If yes, explain:

Has the client ever been arrested for arson or sexual assault? Yes No

If yes, explain:

Is the client a registered sex offender? Yes No

Current pending court appearances:

Does client have any outstanding warrants? Yes No

If yes, explain:

OTHER AGENCIES, SUPPORTS, OR INDIVIDUALS INVOLVED

Name	Relationship	Phone Number	Last Seen

COVID-19 VACCINATION STATUS

Has client ever received a dose of COVID-19 Vaccine? Yes No

If yes, which vaccine product did the client receive?

Pfizer-BioTech

Moderna

Johnson & Johnson

Has the client received a complete COVID-19 vaccine series (1 dose Johnson & Johnson or 2 doses of Pfizer-BioTech or Moderna)? Yes No

Has the client received any of the booster shots? Yes No

If yes, what:

ADDITIONAL INFORMATION

Client Signature

Date

Staff Signature and Title

Date

Staff Phone Number