CARES

APPLICATION & REFERRAL FORM

COMPREHENSIVE ADOLESCENT REHABILITATION AND EDUCATION SERVICES
MOUNT SINAI MORNINGSIDE
411 WEST 114TH STREET, 2ND FLOOR
NEW YORK, NY 10025
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COMPLETED APPLICATION & REFERRAL FORMS CAN BE SUBMITTED VIA FAX, E-MAIL, OR IN PERSON.

CARES
APPLICATION: APPLICANT FORM

APPLICANT NAME: _____ DATE OF BIRTH: _/_____/_____ TODAY'S DATE: ___/_____/_____

1. WHAT NAME DO YOU PREFER TO BE CALLED? _____

2. GENDER:_____PREFERRED PRONOUNS: _____

3. HOW DID YOU HEAR ABOUT CARES? _____

4. CARES HAS AN ON-SITE, ALTERNATIVE HIGH SCHOOL PROGRAM. ARE YOU CURRENTLY SEEKING A NEW ACADEMIC PLACEMENT? (Please circle one) **YES** or **NO**

5. APPLICANT EXPRESSED INTEREST IN THE FOLLOWING REFERRALS/PROGRAMS:
   - □ CARES Academy (SCHOOL AND TREATMENT, 5 DAYS PER WEEK)
   - □ FuTuReS/CAPA (FAMILY AND TEEN RECOVERY SERICES; TREATMENT, 2-5 DAYS PER WEEK)
   - □ UPRISE (FOR JSK & COOP TECH STUDENTS; TREATMENT, 1-5 DAYS PER WEEK)

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP US BETTER UNDERSTAND WHAT YOU MAY WANT, NEED, AND EXPECT FROM TREATMENT.

1. ON A SCALE OF 0–10, PLEASE RATE HOW MUCH CONCERN YOU HAVE ABOUT:

A) YOUR CURRENT ACADEMIC PERFORMANCE:	0	1	2	3	4	5	6	7	8	9	10	N/A
B) YOUR CURRENT MENTAL HEALTH FUNCTIONING:	0	1	2	3	4	5	6	7	8	9	10	N/A
C) YOUR CURRENT SUBSTANCE USE:	0	1	2	3	4	5	6	7	8	9	10	N/A
D) YOUR CURRENT ALCOHOL USE	0	1	2	3	4	5	6	7	8	9	10	N/A
E) YOUR CURRENT NICOTINE USE	0	1	2	3	4	5	6	7	8	9	10	N/A

2. ON A SCALE OF 0–10, PLEASE RATE HOW MUCH CONCERN YOUR FAMILY (PARENT, CAREGIVER, OTHER) HAS ABOUT:

A) YOUR CURRENT ACADEMIC PERFORMANCE:	0	1	2	3	4	5	6	7	8	9	10	N/A
B) YOUR CURRENT MENTAL HEALTH FUNCTIONING:	0	1	2	3	4	5	6	7	8	9	10	N/A
C) YOUR CURRENT SUBSTANCE USE:	0	1	2	3	4	5	6	7	8	9	10	N/A
D) YOUR CURRENT ALCOHOL USE	0	1	2	3	4	5	6	7	8	9	10	N/A
E) YOUR CURRENT NICOTINE USE	0	1	2	3	4	5	6	7	8	9	10	N/A

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PLEASE NOTE HOW MUCH YOU WOULD LIKE FOR THIS TO BE A PART OF YOUR TREATMENT BY CIRCLING ONE NUMBER FOR EACH ITEM.

0 = NO MEANS THAT YOU DEFINITELY **DO NOT WANT** OR NEED THIS FROM TREATMENT
1 = MAYBE MEANS THAT YOU ARE **UNSURE. MAYBE** YOU WANT THIS FROM TREATMENT
2 = YES MEANS THAT YOU **DO WANT** OR NEED THIS FROM TREATMENT
3 = YES! MEANS THAT YOU **DEFINITELY WANT** OR NEED THIS FROM TREATMENT

DO YOU WANT THIS FROM TREATMENT?	NO	MAYBE	YES	YES!
I want to find out for sure if I have a problem with alcohol or other drugs.	0	1	2	3
I want help to stop using alcohol, substances, and/or nicotine completely.	0	1	2	3
I want to help decrease my use of alcohol, substances, and/or nicotine.	0	1	2	3
I want to learn more about alcohol/drug problems.	0	1	2	3
I want to learn some skills to keep from returning to alcohol/drug use.	0	1	2	3
I would like to learn more about peer support programs, like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or SMART Recovery.	0	1	2	3
I want help to decrease my stress and tension.	0	1	2	3
I want help with depression or moodiness.	0	1	2	3
I want help with personal fears or anxiety.	0	1	2	3
I want help with feelings of loneliness.	0	1	2	3
I want help with sleep problems.	0	1	2	3
I want to discuss having been hurt physically, sexually, emotionally, or psychologically.	0	1	2	3
Someone close to me has died or left, and I would like to talk about it.	0	1	2	3
I want to have healthier relationships.	0	1	2	3
I want help in getting motivated to change.	0	1	2	3
I'm struggling to participate in school or work.	0	1	2	3
I want help to meet my goals in school/at work.	0	1	2	3
I am having difficulty adjusting to the changes that came with COVID-19.	0	1	2	3

IS THERE ANYTHING ELSE YOU WOULD LIKE FROM TREATMENT THAT HAS NOT BEEN ASKED? IF SO, PLEASE DESCRIBE.

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APPLICATION: REFERRAL FORM

1. APPLICANT INFORMATION

NAME:_____DATE OF BIRTH:_____/_____/_____GENDER:_____

ADDRESS:_____

PHONE #: _____

2. PARENT OR LEGAL GUARDIAN

NAME:_____RELATIONSHIP TO APPLICANT:_____

ADDRESS:_____

PHONE #: _____

3. DESCRIBE THE EMOTIONAL AND BEHAVIORAL PROBLEMS OF THE APPLICANT, INCLUDING A HISTORY OF PAST TREATMENTS AND DIAGNOSES.

4. DOES THE APPLICANT CURRENTLY USE OR HAVE A HISTORY OF ALCOHOL AND/OR DRUG USE? IF SO, PLEASE SPECIFY.

5. DOES THE APPLICANT HAVE A HISTORY OF PSYCHIATRIC HOSPITALIZATION OR INPATIENT REHABILITATION? IF SO, PLEASE SPECIFY.

6. HAS THE APPLICANT HAD NEUROPSYCHOLOGICAL OR PSYCHOLOGICAL TESTING? IF SO, PLEASE INCLUDE A COPY.

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MENTAL HEALTH INFORMATION

7. CURRENT PSYCHOTHERAPIST, IF ANY

NAME: _: _____

AGENCY: _: _____

ADDRESS: _____

PHONE #: _____

8. PSYCHIATRIST OR MEDICATION PRESCRIBER, IF ANY

NAME: _: _____

AGENCY: _: _____

ADDRESS: _____

PHONE #: _____

9. CURRENT MEDICATIONS, IF ANY (NAME, DOSAGE, FREQUENCY)

A. _____

B. _____

C. _____

10. DOES THE APPLICANT CURRENTLY HAVE ANY CASE MANAGEMENT SERVICES (E.G. SCM, HEALTH HOME, PREVENTIVE, ACS)? IF SO, PLEASE PROVIDE CONTACT INFORMATION.

NAME (AGENCY & WORKER): _____

ADDRESS: _____

PHONE # _____

TYPE OF SERVICE: _____

MEDICAL INFORMATION

11. PRIMARY CARE PROVIDER

NAME: _: _____

ADDRESS: _____

PHONE #: _____

12. OTHER / SPECIALTY PROVIDER

NAME: _: _____

ADDRESS: _____

PHONE #: _____

13. DESCRIBE THE APPLICANTS MEDICAL PROBLEMS, IF ANY, INCLUDING ANY MEDICATIONS TAKEN.

_____

_____

_____

_____

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14. THE APPLICANT'S LAST PHYSICAL EXAM WAS ON: / / (MM/DD/YY)

ACADEMIC/VOCATIONAL INFORMATION

15. MOST RECENT SCHOOL

NAME: _____

ADDRESS: _____

PHONE #: _____

16. HIGHEST GRADE COMPLETED: _____

17. HIGH SCHOOL CREDIT EARNED: _____

18. DOES THE APPLICANT HAVE A HISTORY OF ACADEMIC DIFFICULTIES, INCLUDING LEARNING DISORDERS? IF SO, PLEASE SPECIFY.

_____

_____

_____

_____

19. DOES THE APPLICANT HAVE AN INDIVIDUALIZED EDUCATION PLAN (IEP) THROUGH THE DEPARTMENT OF EDUCATION? *IF YES, PLEASE ATTACH. _____-

20. DAYS OF WORK/SCHOOL MISSED IN PAST 6 MONTHS (ESTIMATE # or %) _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ GROUP # _____

NAME OF PERSON INSURED: _____ ID# _____

IS THERE A SECONDARY INSURANCE? IF SO, PLEASE LIST THIS HERE. _____

DOCUMENTATION REQUIRED AT INTAKE APPOINTMENT

The following documents need to be brought to the intake appointment or may be submitted with this application:

- □ COPY OF PARENT/GUARDIAN'S PHOTO IDENTIFICATION
- □ COPY OF APPLICANT'S BIRTH CERTIFICATE
- □ COPY OF SOCIAL SECURITY CARD
- □ APPLICANT'S IMMUNIZATION RECORD
- □ WRITTERN RECORD OF APPLICANT'S PHYSICAL EXAM WITHIN PAST 6 MONTHS OR PLAN TO OBTAIN PHYSICAL EXAM
- □ COPY OF APPLICANT'S INDIVIDUALIZED EDUCATION PLAN (IEP) IF APPLICABLE ***(CARES ACADEMY)***
- □ APPLICANT'S SCHOOL TRANSCRIPTS OR REPORT CARDS ***(CARES ACADEMY)***