CARES

APPLICATION & REFERRAL FORM

COMPREHENSIVE ADOLESCENT REHABILITATION AND EDUCATION SERVICES
MOUNT SINAI MORNINGSIDE

(through summer 2025)
411 WEST 114TH STREET, 2ND FLOOR
NEW YORK, NY 10025

(new location as of fall 2025)
307 West 38th Street, 7th Floor
New York, NY 10018

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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 #: _____

EMAIL: _____

2. PARENT OR LEGAL GUARDIAN

NAME:_____ RELATIONSHIP TO APPLICANT:_____

DATE OF BIRTH:_____/_____/_____ EMAIL: _____

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.

_____

_____

_____

_____

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)***