Application and Referral Form

Comprehensive Adolescent Rehabilitation and Education Services (CARES)

307 West 38th Street | Seventh Floor | New York, NY 10018

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Completed application and referral forms can be submitted via fax, email, 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 Identity: _____ Preferred pronouns: _____

3. Sexual Identity: _____

4. Race/Ethnicity: _____

5. How did you hear about CARES?

6. CARES has an on-site, alternative high school program. Are you currently seeking a new academic placement?
   ☐ Yes ☐ No

7. Applicant expressed interest in the following referrals/programs:
   ☐ **CARES Academy:** School and treatment five days per week
   ☐ **UPRISE:** For JSK and Co-Op Tech students. Treatment one to five 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.

CARES Application Referral Form

1. Applicant Information

Applicant Name | Date of Birth | Gender

Address | Phone Number

2. Parent or Legal Guardian

Parent/Legal Guardian Name | Relationship to Applicant

Address | Phone Number

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 Number _____

8. Psychiatrist or medication prescriber, if any

Name _____ Agency _____

Address _____ Phone Number _____

9. Current medications, if any (please list name, dosage, and frequency)

a. _____

b. _____

_____

10. Does the applicant currently have any case management services (e.g., SCM, Health Home, Preventive, ACS)? If so, please provide their contact information.

Name (Agency and Worker) _____ Type of Service _____

Address _____ Phone Number _____

CARES Application Referral Form

Medical Information

11. Primary Care Provider

Name

Address | Phone Number

12. Other/Specialty Provider

Name

Address | Phone Number

13. Describe the applicants medical problems, if any, including any medications taken.

14. The applicant's last physical exam was on (MM/DD/YY)**:** _____ / _____ / _____

Insurance Information

15. Primary Insurance

Primary Insurance | Name of Person Insured

Group Number | ID Number

16. Secondary Insurance (if applicable)

Secondary Insurance | Name of Person Insured

Group Number | ID Number

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Academic/Vocational Information

17. Most Recent School

Name

Address

Phone Number

18. Highest Grade Completed: _____

19. High School Credit Earned: _____

20. Does the applicant have a history of academic difficulties, including learning disorders? If so, please specify.

21. Does the applicant have an individualized education plan (IEP) through the department of education? If yes, please attach.
☐ Yes ☐ No

22. Days of work/school missed in the past six months (estimate number or percent)**:** _____

Documentation Required

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
- ☐ Written record of applicant's physical exam **within the past six 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)**