CARES
APPLICATION & REFERRAL FORM

COMPREHENSIVE ADOLESCENT REHABILITATION AND EDUCATION SERVICES
MOUNT SINAI MORNINGSIDE
411 West 114TH STREET, 2ND FLOOR
New York, NY 10025
Phone: (212) 523-3083
Fax: (212) 523-7547

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 SERVICES; 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
CARES

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

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

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
   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.

________________________________________________________________________
________________________________________________________________________
**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 Applicant's 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
□ WRITTEN 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)