Application for Admission

This application is being completed for admission to:

- ❑ Medically Supervised Detox (Part 816)
- ❑ Stabilization in a Residential Setting (Part 820)

Fax or email completed application with required documentation:

Fax to: (607) 274 – 6280 or scan/email to: adcreferral@alcoholdrugcouncil.org

Please call with any questions: (607) 274-6288 ext. 220

The following items must be attached to the completed application. Consent forms are included at the end of this application.

- ❑ Release of Information for Alcohol & Drug Council and the Referral Source
- ❑ Release of Information for Alcohol & Drug Council and the Clients Emergency Contact
- ❑ Release of Information for Alcohol & Drug Council and the Tompkins County DSS
- ❑ Release of Information for Alcohol & Drug Council and Medicaid Managed Care or Private Insurance
- ❑ Release of Information for Alcohol & Drug Council and Cayuga Medical Center *(in the event we need to transport client to Emergency Room before/during admission process)*
- ❑ LOCADTR 3.0 Consent
- ❑ LOCADTR 3.0 Assessment (if one was completed by the referral source)
- ❑ Copy of Photo Identification
- ❑ Copy of Insurance Card and/or Benefits Cards (Medicaid, Medicare, Private Insurance)

Please be Advised:

Applications that are not completed fully, and legibly WILL delay the admission process. To process your referral please complete the application in its entirety including attachments so we may process your application as soon as possible.

Client Name: _____ **Date of Birth:** _____

Referral Source Information:

Referral Agency: _____
Referral Contact Name: _____
Referral Address: _____
Referral Phone: _____ Fax: _____
Referral Email: _____

Client Demographics:

Full Name: _____ Date of Birth: _____
Last Name at Birth: _____ SS#: _____
Sex at Birth: _____ Race: _____
Legal Sex: _____ Ethnicity: _____
Gender Expression: _____ Preferred Language: _____
Phone #: _____
County of Residence: _____
Legal Address: _____
Are you mandated to attend treatment? Yes___ ___ No _____
Copy of Court Mandate Letter Attached? Yes _____ No _____
Have you been on Public Assistance within the past 5 years?
If yes, When? _____ What County: _____

Financial Information:

Insurance Provider: _____
Name of Policy Holder: _____
Policy Number: _____
Medicaid ID: _____
Secondary Insurance: _____
Secondary Insurance Policy#: _____
Separate Prescription Insurance: _____

If you do not have insurance, how will you be paying for medication while in treatment (if applicable)?

_____

_____

Preferred Pharmacy: _____

Client Name: _____ **Date of Birth:** _____

Substance Use Information:

Any history of IV Drug use: ❑ YES ❑ NO If yes, last use: _____

Have you ever overdosed? ❑ YES ❑ NO If yes, did you receive Narcan? ❑ YES ❑ NO

Current Dependency Diagnosis(s): _____

R/O Diagnosis(s): _____

Substance Used:	First Use:	Last Use:	Frequency:	Route of Admission:

Chemical Dependency Treatment History:

(Please include outpatient treatments and the past 3 years of services)

Location/Agency:	Date of Admission:	Length of Stay:	Outcome:

Total Number of Treatment Episodes: _____

Legal Information:

Please check YES or NO for the following– Please add comments where applicable.

	Yes	No	Comments:
Arson:			
Perpetrator of physical/emotional/sexual abuse:			
Stalking:			
Violence:			
Pending Charges:			
Legal History? (Arrests, charges, convictions, sentences)			

Do You Have A Pending Court Appearance? Yes _____ No _____

Date of Appearance: _____ County: _____

Are You on Probation/Parole? Yes ___ ___ No ___ ___

Probation/Parole Officer Name: _____ Phone: _____

Client Name: _____ Date of Birth: _____

Medical Information:

Please check YES or NO for the following – Please add comments where applicable.

	YES	NO	Comments:
Diabetes:			**Type:**
Asthma:			
Eating Disorders:			
COPD:			
COVID (history/current)			
Heart/Cardiac:			
High Blood Pressure:			
Nicotine Use:			
Pregnant:			**Due Date:**
Allergies:			
Digestion Issues:			
Blood Disorders:			
Liver Disorders:			
Hepatitis C, B, A:			
HIV/AIDS:			
Menstrual Disorders:			
Emphysema:			
Hearing Loss:			
Acute or Chronic Pain:			
Mobility Issues:			❑ **Wheelchair** ❑ **Elevator** ❑ **Resp. Equipment**
Infections:			
Scabies:			
Open Wounds:			
MRSA (history/current):			
Visual Impairments			
Dental Issues:			
Recent Surgeries:			
Cancer History:			**Current Status:**
Other:			

Please List Current Medications:

_____

Allergies to Medications: _____ ❑ NKDA

Are you currently vaccinated for COVID-19? ❑ YES ❑ NO

Have You Been Hospitalized for Medical Reasons Within the Past Year? ❑ YES ❑ NO

If Yes, Please Explain: _____

Client Name: _____ **Date of Birth:** _____

Medication Assisted Treatment Information:

Have You Ever Been Prescribed Medication Assisted Treatment? ❑ YES ❑ NO

If Yes, What Medication? _____

Dates MAT Was Used: _____

Are You Currently Prescribed MAT? ❑ YES ❑ NO

If Yes, What Medication? _____

Please Provide When Possible

- Physical Exam
- PPD Results with Chest X-Ray When Positive
- PPD or Quantiferon Gold

Mental Health Treatment Information:

Have You Ever Been Diagnosed with A Mental Illness? ❑ YES ❑ NO

Mental Health Diagnosis: _____

Please check Yes or No for the following – Please add comments where applicable.

Any history or current of:	YES	NO	Comments:
Suicidal Ideation:			
Suicidal Attempts:			
Homicidal Ideation:			
Homicidal Attempts:			
Anger/Rage:			

Have you experienced physical/emotional abuse or victimization? ❑ YES ❑ NO

Comments_____

_____

Have You Been Hospitalized for Mental Illness? ❑ YES ❑ NO

If Yes, When Was Your Last Hospitalization? _____

Referral Source Signature: _____ **Date:** _____

Alcohol & Drug Council of Tompkins County

Client Name: _____ **Date of Birth:** _____

TO BE COMPLETED BY APPLICANT

Please provide all information requested.

What is your primary substance choice? _____

In a 12-month period have you: (mark all that apply)

- ❑ Taken a substance in larger amounts or over a longer period of time that you had intended
- ❑ Had persistent desire or unsuccessful efforts to cut down or control substance use
- ❑ Spent a great deal of time in activities necessary to obtain the substance, use substance, or recover from its effects
- ❑ Had cravings or strong desire to use the substance
- ❑ Had recurrent use resulting in failure to fulfill major role obligations at work, school, home
- ❑ Had continued substance use despite having persistent or recurrent social or interpersonal problems
- ❑ Given up or reduced important social, occupational, or recreational activities because of substance use
- ❑ Had recurrent substance use in situations in which it is physically hazardous
- ❑ Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
- ❑ A need for markedly increased amounts of the substance to achieve intoxication or desired effect

Define your current tolerance to the substance:

_____

- ❑ Characteristic withdrawal syndrome for the substance
- ❑ A markedly diminished effect with continued use of the same amount of substance

Define withdrawal that is specific to you:

_____

- ❑ Use of the substance or closely related substance is taken to relieve or avoid withdrawal symptoms

_____ _____

Client Signature **Date**

NEW YORK STATE

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME	FIRST	M.I.
DATE OF BIRTH	CASE NO.	
FACILITY **Alcohol & Drug Council of TC**	UNIT **Detox & Stabilization**	

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.**

[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT (Circle One)

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

Presence in treatment, Diagnosis, participation in individual and/or group therapy, treatment notes, treatment progress, treatment planning, medication records and other information relevant to ongoing treatment and discharge from treatment

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

Coordinate and facilitate the client's admission, ongoing treatment, and discharge from treatment at the Alcohol & Drug Council

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION
Between: (Referral Source) **Name:** **Facility:** **Address:** **Phone:**	**And:** **Facility: Alcohol & Drug Council of Tompkins County** **Address: 2353 N. Triphammer Rd** **Ithaca, NY 14850** **Phone 607-274-6288 Fax 607-274-6280**

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: _____

NOTE:	Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____	_____
(Signature of Patient)	(Signature of Parent/Guardian, when required)
_____	_____
(Print Name of Patient)	(Print name of Parent/Guardian)
_____	_____
(Date	(Date)

NEW YORK STATE

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME	FIRST	M.I.
DATE OF BIRTH	CASE NO.	
FACILITY **Alcohol & Drug Council of TC**	UNIT **Detox & Stabilization**	

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.**

[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT (Circle One)

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

Status in treatment

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

Coordinate care and/or discharge planning in case of an emergency

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION
Between: (Emergency Contact) **Name:** **Facility:** **Address:** **Phone:**	**And:** **Facility: Alcohol & Drug Council of Tompkins County** **Address: 2353 N. Triphammer Rd** **Ithaca, NY 14850** **Phone 607-274-6288 Fax 607-274-6280**

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: _____

NOTE:	Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Signature of Patient)	_____ (Signature of Parent/Guardian, when required)
_____ (Print Name of Patient)	_____ (Print name of Parent/Guardian)
_____ (Date	_____ (Date)

NEW YORK STATE

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME	FIRST	M.I.
DATE OF BIRTH	CASE NO.	
FACILITY **Alcohol & Drug Council of TC**	UNIT **Detox & Stabilization**	

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.**

[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT (Circle One)

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

Presence in treatment

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

Coordinate payment, benefit certification, and food stamp eligibility determination

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION
Between: **Name: Tompkins County -**	**And:**
Facility: Department of Social Services	**Facility: Alcohol & Drug Council of Tompkins County**
Address: 320 West State Street Ithaca, NY 14850	**Address: 2353 N. Triphammer Rd Ithaca, NY 14850**
Phone: 607-274-5252 Fax: 607-274-5227	**Phone 607-274-6288 Fax 607-274-6280**

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: _____

NOTE:	Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Signature of Patient)	_____ (Signature of Parent/Guardian, when required)
_____ (Print Name of Patient)	_____ (Print name of Parent/Guardian)
_____ (Date	_____ (Date)

NEW YORK STATE

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME	FIRST	M.I.
DATE OF BIRTH	CASE NO.	
FACILITY **Alcohol & Drug Council of TC**	UNIT **Detox & Stabilization**	

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.**

[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT (Circle One)

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

Diagnosis, participation in individual and/or group therapy, treatment notes, treatment process, treatment planning, and other information releveant to ongoing treatment and discharge from treatment

PURPOSE OR NEED FOR DISCLOSURE/RELEASE
Coordinate payment, benefit certification

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION
Between: (Insurance Provider) **Name:** **Facility:** **Address:** **Phone:**	**And:** **Facility: Alcohol & Drug Council of Tompkins County** **Address: 2353 N. Triphammer Rd** **Ithaca, NY 14850** **Phone 607-274-6288 Fax 607-274-6280**

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: _____

NOTE:	Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____	_____
(Signature of Patient)	(Signature of Parent/Guardian, when required)
_____	_____
(Print Name of Patient)	(Print name of Parent/Guardian)
_____	_____
(Date	(Date)

NEW YORK STATE

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

PATIENT'S LAST NAME	FIRST	M.I.
DATE OF BIRTH	CASE NO.	
FACILITY **Alcohol & Drug Council of TC**	UNIT **Detox & Stabilization**	

INSTRUCTIONS:	**GIVE A COPY OF THE FORM TO THE PATIENT! Prepare one (1) copy for the Patient's Case Record. If this form is used for billing purposes, prepare an additional copy for the Resource and Reimbursement Agent. If this form is sent to another agency with a request for information, prepare an additional copy for the Patient's Case Record.**

[DISCLOSURE]/ [RELEASE] WITH PATIENT'S CONSENT (Circle One)

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

Presence in treatment, diagnosis, and other information releveant to coordinating care in the event of an emergency

PURPOSE OR NEED FOR DISCLOSURE/RELEASE

Coordination of emergency care

NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION	NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING AND/OR RECEIVING INFORMATION
Between: **Name: Cayuga Medical Center** **Facility:** Cayuga Medical Center **Address:** 101 Dates Dr. Ithaca, NY 14850 **Phone:** 607-274-4411 Fax:	**And:** **Facility: Alcohol & Drug Council of Tompkins County** **Address: 2353 N. Triphammer Rd** **Ithaca, NY 14850** **Phone 607-274-6288 Fax 607-274-6280**

I, the undersigned, have read the above and authorize the staff of the disclosing/releasing facility named to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Time period, event or condition replacing period specified above: _____

NOTE:	Any information released through this form will be accompanied by the form prohibition on Redisclosure of Information Concerning Alcoholism/Drug Abuse Patient (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

_____ (Signature of Patient)	_____ (Signature of Parent/Guardian, when required)
_____ (Print Name of Patient)	_____ (Print name of Parent/Guardian)
_____ (Date	_____ (Date)

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

CONSENT TO RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT
LOCADTR ASSESSMENT

Revoked On: _____ Staff Initials: _____

Patient's Last Name	First	M.I.
Case Number		
Facility: Alcohol & Drug Council of TC	Unit: Detox & Stabilization	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED:

All information necessary to complete a personalized Level of Care for Alcohol and Drug Treatment Referral "LOCADTR" assessment.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION:

I consent to the disclosure of confidential information to, and among, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the OASAS-Certified treatment facility identified above, and Payer / Managed Care Plan _____ _____ of my clinical treatment including information from the OASAS Client Data System (CDS) and my Social Security Number.

I understand that the level of care determination assessment will only be shared with me, the OASAS treatment facility, and Payer / Plan identified above. Unless I have given written permission to share the information with other agencies, programs or payers.

I further understand that non-personal identifying information may be evaluated so that the effectiveness of the LOCADTR assessment tool can be evaluated.

I, the undersigned, have read the above and authorize the New York State Office of Alcoholism and Substance Abuse Services and the staff of the OASAS-certified treatment facility named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164; and that redisclosure of this additional information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

_____ (Signature of Patient)	_____ (Signature of Parent/Guardian)
_____ (Print Name of Patient)	_____ (Print Name of Parent/Guardian)
_____ (Date)	_____ (Date)

What to Bring to Treatment?

Below is a list of items that can and cannot be brought with you during your stay at the Alcohol & Drug Council.

The Alcohol & Drug Council is not responsible for lost or damaged property. Please do not bring valuables with you to the Alcohol & Drug Council.

All clothing and other appropriate items will be heat treated at admission.

Please Bring:

- 5 days of weather appropriate clothing. You will be responsible for washing your own clothing while at the Alcohol & Drug Council in the facility washing machines. Allergen free detergent will be provided.
- 1 pair of weather appropriate shoes. A pair of winter boots will also be permitted during winter months
- Flip Flops for showers
- Insurance/ID Cards
- Medications that you are currently taking. Medications ***MUST*** be in the original prescription containers
- MP3 Player/Headphones (if you desire). Your MP3 player ***MUST NOT*** have internet connectivity capabilities, recording capabilities, picture taking capabilities, storage of photo/video capabilities
- Stamps/Envelopes (if you desire)

Excessive amounts of clothing and other items will be sent, at the client's expense, to a home address at the time of admission.

Hygiene products:

- All hygiene products including makeup and cosmetics must arrive at admission brand new and factory sealed in the original packaging.
- After admission items are only approved if they are shipped from an online store and if they meet all guidelines (this means no drop offs of products and no packages sent from home)
- Alcohol may not be any of the first 3 ingredients in any product. Please check carefully for this.
- Mouthwash must be alcohol free
- Grooming tools may not have sharp edges or pointed edges except for personal use razors. No straight razors
- No scissors of any kind
- No aerosol products
- No perfume, cologne or heavily scented products
- No nail polish or nail polish remover
- All products must be in reasonable amounts as space is limited

Note that the decision to allow a product or not is at staff discretion. All unapproved products will be stored in contraband until the time of discharge.

the council
Alcohol & Drug Council of Tompkins County

Items *NOT* Allowed:

- Any medication not in original prescription containers
- Over the counter medication
- Loose medications
- Non-prescribed medications
- Laundry soap and other cleaning products
- Blankets, pillows, towels, stuffed animals
- Cell phones/chargers, cameras, pagers
- Food or beverages
- Hats are not allowed inside the building (hoods cannot be worn up)
- Nail polish, nail polish remover
- Q-tips, cotton balls
- Revealing clothing/clothing with inappropriate language, images or reference to drugs, alcohol or tobacco
- Scissors
- Weapons (or anything that may be interpreted as a weapon)
- Pornographic material
- Perfume/cologne/scented oils
- Cash
- Radios or music devices other than single person devices
- Any electronic device that has video or recording capabilities (including laptops and tablets)

Items that will be destroyed upon Admission:

- Cigarettes/chewing Tobacco
- Lighters/Matches
- E-Cigarettes/ E-Cigarette Batteries/any vaping materials
- Drug paraphernalia

All belongings including any stored items must be taken at the time of the successful discharge. Any items left behind will be discarded. If the discharge is unplanned or unsuccessful all belongings will be stored for 30 days. It is the responsibility of the individual to contact the Alcohol & Drug Council with a plan for pick-up of the belongings. The Alcohol & Drug Council is not obligated or responsible for shipping client belongings. You will not have access to stored items during your treatment stay.