PLEASE READ BEFORE COMPLETING APPLICATION

Thank you for your referral to the Terrace House Stabilization and/or Horizon Village Campus programs. To ensure the most efficient and accurate processing of your patients referral, **please have a counselor or case manager complete the following application in its entirety**. Please also send with your application:

- HIPAA compliant release between your agency and Horizon Health Services
- Most recent bio-psych-social assessment within the past 6 months
- Completed medical or nursing examination
- Results of toxicology screenings, blood labs and PPD results
- LOCADTR

All applications must be faxed to 716-418-8423 to ensure receipt & timely processing

Program you are referring to:

Terrace House Crisis Stabilization _____

Horizon Village Campus _____ (Program to be determined upon review)

Referring Agency: _____

Person(s) to Contact: _____

Email: _____

Phone: _____ Fax:_____

Patient Name:_____ Gender:_____

DOB:_____ Social Security Number_____

Patient Address: _____

City: _____ State:_____ ZIP:_____ Phone:_____

Last County of Permanent Residence:_____

Military Experience? _____ Branch:_____

First Responder? _____ Field of Response:_____

The following financial information must be completed in full and as accurately as possible. Your patient may unknowingly incur personal responsibility for out of pocket costs if this information is inaccurate.

Primary Insurance Name: _____ Insurance ID:_____

Secondary Insurance Name: _____Insurance ID:_____

Does patient have **any** resources or assets such as property ownership, bank accounts, income from wages, pension or settlements? _____

If YES, please list source and value amount below:

_____

_____

Legal Marital Status: _____

Substance Use History:

Substance	Frequency/Amount	Route	Date of Last Use

Has the patient ever used substances IV? _____

Substance Use Treatment History: (Including hospitalizations and outpatient)

Name of Program	Level of Care	Discharge Status	Dates Attended

Medical Information:

Please list any current physical health concerns, allergies, diagnoses, conditions and surgeries

_____

_____

_____

History of seizures? _____ YES/NO _____

Is patient pregnant? _____ Due Date:_____ OBGYN:_____

Current Medications: (Including Methadone, Suboxone, Vivitrol, Sublocade, etc.)

Medication	Dosage	Frequency	Provider

Mental Health Information: (Including hospitalizations and outpatient)

Name of Program	Level of Care	Discharge Status	Dates Attended

Current Mental health diagnosis, history of trauma, disordered eating, history of symptoms or concerns:___

_____

_____

History of lethality including prior attempts, past or present ideations, or self-injurious behavior:_____

_____

_____

Any history or thoughts, plans or attempts to harm others?_____

_____

Important psychosocial and contextual factors for patients mental health history: _____

_____

_____

Has the patient ever acted out violently or ever assaulted others?_____

_____

_____

Has the patient

Accidentally or intentionally set fires? YES NO

Been charged or convicted of arson? YES NO

Been charged or convicted of a sexual offense? YES NO

If YES, please explain: _____

_____

_____

Legal Information

Does the patient have any current legal involvement, charges or concerns at this time?

_____

_____

_____

Is/does the patient

Incarcerated?	YES	NO	
On parole?	YES	NO	Officer_____
On probation?	YES	NO	Officer _____
Have any outstanding warrants?	YES	NO	Where_____
Mandated to treatment?	YES	NO	By Who_____
Have CPS involvement?	YES	NO	
At risk of losing children?	YES	NO	

****Please include a consent for any courts, probation or parole between patient and Horizon Health Services, provided at the end of this packet***

Additional Information

Does the patient know of any other person currently attending Terrace House or any program on Horizon Village campus? YES NO

If YES, please explain relation: _____

_____

What are the patient primary barriers to successful treatment?_____

_____

_____

What are the patients primary motivations to participate in treatment?_____

_____

_____

I attest that all information contained in this application and referral is accurate to the best of my knowledge and understand any discrepancies or inaccurate answers can affect my placement and/or out of pocket cost within Horizon Village Inc programs

Patient Signature: _____

Date: _____

(If patient is unable to sign, please confirm referral has been discussed and reviewed with them)

***If you need assistance or have questions regarding your referral please contact central admissions at**

(716) 831-1800*

THE HORIZON CORPORATIONS

BI-DIRECTIONAL AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, or my authorized representative, request that information regarding my care and treatment be released, as set forth in this form. I understand that:

This authorization includes bidirectional (two-way) disclosure of personal information specified in item 4 below.

Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I understand that I may be denied treatment in some circumstances if I do not sign this consent.

I also understand that I have right to revoke this authorization at any time except to the extent that actions have been taken in reliance upon it by notifying my counselor/doctor or Horizon's Privacy Officer at (716) 831-2700

This authorization includes the release of alcohol/drug treatment and mental health treatment information, and HIV/AIDS-related information unless otherwise specified below. Recipients are prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. Any disclosures of substance abuse service information are protected by Title 42, Part 2 of the Code of Federal Regulations. Substance abuse and mental health service disclosures are also protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 164, and NYS Mental Hygiene Law Section 33.13. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

I understand that I must be provided, upon my written request, both a list of the entities to which my identifying information has been disclosed by Horizon, and a list from those entities to whom they have disclosed my patient information.

1. The person whose information may be used, disclosed, or exchanged is:

Name: (First, MI, Last) _____ _____ _____

DOB: _____

2. Name and address of entities to exchange this information:

The Horizon Corporations

AND

Name (Relationship): _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax (if applicable): _____

Primary Contact, if Applicable:

_____

3. The purpose of gathering and sharing of protected health information is to coordinate treatment efforts. Other purpose(s) if any:

4. I authorize Horizon to obtain/release all of the following information:

Findings of the New York State Prescription Monitoring Registry (I-STOP)

Identifying information (such as name, address, telephone, age, sex, race)

Medical history and physical examination

Diagnosis/prognosis/progress in treatment/Test and Tox results/Treatment Regimen

Medications ordered, administered, dispensed

Billing and payment inquiries

HIV/AIDS-related information

And also the following information if checked:

☐ Other:

I do not authorize Horizon to obtain / release the following information:

5. In signing below, I indicate my authorization for the identified parties to exchange the information specified above.

Effective: / /

Expires: / /

☐ Client was provided with a Spanish translation of this form

Ensure that the expiration date is 10 years in the future unless otherwise instructed by the patient.

Signature of Patient: **Date:**

Signature of Staff Member: **Date:**