TWIN OAKS REFERRAL

Twin Oaks is an OASAS Part 820 Reintegration 20-bed community residential program providing 24/7 on-site support for men recovering from alcohol and other substance use disorders. Participation can range from six months or more and focuses on one's recovery and reintegration back into the community. supportive services are available in the community and include referrals for outpatient services, educational and vocational, mental health and medical providers. Community support groups are readily available, and clients are encouraged to attend both onsite and offsite services to help with the transition.

Eligibility Requirements:

- Must have a primary substance use disorder diagnosis
- Meet the appropriate level of care based on the OASAS Level of Care Determination Tool.
- Must be males 18 years or older

Determination Process: *In order to determine if a referral is appropriate for Twin Oaks, the following process occurs to determine eligibility.*

- Completed referral form and all accompanying documentation is received and reviewed
- The prescreen referral form completed in its entirety.
- Once the referral is reviewed, applicants and/or referral sources will be contacted by Twin Oaks to schedule a phone screening with the client to determine if this is the correct level of care.
- Upon completion of the phone screening, The application will be reviewed and discussed by the clinical team and applicant/referral source will be notified of decision.
- Twin Oaks is committed to assisting all applicants and referral sources identify and secure appropriate services until applicant is able to be admitted.

Documentation to be included with the referral:

- Recent physical examination.
- Blood work results including CBC, US, Comp, and PPD.
- Current list of all prescribed medications.
- A complete comprehensive assessment, psychosocial evaluation, or other alcohol and other drug history review.
- Psychiatric evaluation *(if applicable)*.
- *If applicable,* a list of all legal information such as: Probation reports, pending charges, designation of mandate for treatment, or any relevant information required to ensure compliance with a legal mandate to treatment.

All referrals should be sent *Via Email* to:

Keith Ritchie, Program Supervisor
Phone: 518-901-4689, Fax 518-907-8104
KRitchie@BHSN.org

AMANDA HANSEN, Sr. Addictions Counselor
Phone: 518-562- 8119, fax: 518-907-8104
AHansen@BHSN.org

Please contact Keith Ritchie or Amanda Hansen at the numbers listed above should you have questions.

Twin Oaks Community Residence Pre-Admissions Screening INSTRUCTIONS: Complete prior to admission. Please include copy of all required documentation listed prior.	**Name (Last, First, MI)**		**Date of Referral**
	Social Security No	**Date of Birth**	**Gender**
	(Ph): 518-901-4689 (F): 518-907-8104 - email: KRitchie@bhsn.org (Ph): 518-562-8119 (F): 518-907-8104 - email: AHansen@bhsn.org		

Street Address: _____ County: _____

City, State, Zip: _____

Phone: _____ Marital Status: _____ Lives With: _____

Referred by:_____

Agency of Referral: _____ Phone: _____

Email Address: _____

Reason for Referral:

Employer: _____

Address: _____

Insurance Information

Medical Insurance: Yes ☐ No ☐ | Carrier: _____ | ID Number: _____

Public Assistance: Yes ☐ No ☐ | County of Residence:_____

Medicaid: Yes ☐ No ☐ | Medicaid (CIN) #:_____ | Preauthorization Required? Yes ☐ No ☐

Legal Involvement (check all that apply): None ☐

Parole ☐ Probation ☐ DWI ☐ Drug Court ☐ Family Court Referred ☐ Charges Pending ☐

Supervising Officer: _____ Phone: _____

Court Name: _____ Phone: _____

Registered Sex Offender: Yes ☐ No ☐ If so, What Level: 1 ☐, 2 ☐, or 3 ☐

If so, are there any housing restrictions in place and what are they?

Does the client meet any of the following *(check all that apply):*

Pregnant IV User Yes ☐ No ☐

Other Pregnant Substance Abuser Yes ☐ No ☐

Other Injecting Drug User? Yes ☐ No ☐

Are there children placed in or in jeopardy of being placed Foster Care? Yes ☐ No ☐

Substance Use History

How long has substance use been problematic? _____

Substances used: _____

Frequency of use: _____

Last use: _____ Is client in active withdrawal? Yes ☐ No ☐

Treatment History

☐ Inpatient: _____

☐ Outpatient: _____

☐ Detox: _____

☐ Medication Assisted Treatment (if so, provider/contact?): _____

Medical History (*Please send summary and recommendations for any pertinent current or past medical conditions)*

Current Physical Ailments: _____

PPD Test Date: _____ Results: ☐ Positive or ☐ Negative

Chest X-Ray Date: _____ Results: _____

Please list any current medications:

Psychiatric History

☐ Hospitalized: _____

☐ Outpatient:_____

☐ History of Suicidal ideation or attempts:_____

Currently Psychiatric Status:

If patient is currently symptomatic, has had suicide intent in the past twelve months, or is currently on psychotropic, anti-anxiety, or antidepressant medication, please provide a psychiatric evaluation with medication recommendations.

Summary of Recommendations (including diagnosis and treatment recommendations)

Name and Title of Person Completing Referral: _____

Date Completed: _____

Please attach the appropriate clinical documentation, PSYCHES consent and a signed HIPAA Release

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

PSYCKES Consent Form

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is an administrative database maintained by the New York State Office of Mental Health (OMH). It contains health information from the NYS Medicaid claims database, health information from the clinical records of persons who have received care from State operated psychiatric centers, and health information from other NYS health databases. This administrative data includes identifying information (such as name, date of birth), information about health services that have been paid for by Medicaid, and information about a person's health care history (such as treatment for illnesses or injuries a person has had, test results, and lists of medication a person has taken). For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

The health information in PSYCKES can help your provider provide you with good care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I give consent"** box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the **"I deny consent"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," this does not mean your provider is completely barred from accessing your medical information in any way. For example, if the Medicaid program has a quality concern about your healthcare, then under federal and state regulations your provider may be given access to your data to address the quality concern. There are also exceptions to the confidentiality laws that may permit your provider to obtain necessary information directly from another provider for treatment purposes under state and federal laws and regulations.

Please carefully read the information on this form before making your decision. Your Consent

Choices. You have two choices:

- ☐ **I give consent for this provider to access all** of my electronic health information that is in PSYCKES in connection with providing me any health care services.
- ☐ **I deny consent for this provider to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number

Signature of Patient or Patient's Legal Representative	Date

Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to patient (if applicable)

Signature of Witness	Print Name of Witness