



St. Christopher's Inn
Residential Treatment Services
21 Franciscan Way / PO Box 150 - Graymoor
Garrison, NY 10524

Website: www.stchristophersinn.org

Admissions Referral Form

Office Hours: Monday ~ Friday: 8:00 a.m. to 4:30 p.m.

Phone: 845-335-1020 • **FAX:** 845-424-4537 • **Email:** sciadmissions@atonementfriars.org

Self-Referrals: Please call our Admissions Office at 845-335-1020 for a screening.

Referral Agencies: Complete **ALL** pages; then FAX to Admissions (845-424-4537)

Client Name: _____ Agency Name: _____
Client D.O.B: _____ Contact Name: _____
Social Security No# _____ Phone Number: _____
Insurance Plan: _____ FAX Number# _____
Medicaid CIN# _____ Email: _____
~ or Insurance ID# _____

◆ **Referral Agencies: Please INCLUDE 'ALL' the following info with this referral:**

- | | |
|--|--|
| <input type="checkbox"/> Insurance information | <input type="checkbox"/> List of Medications & Diagnoses |
| <input type="checkbox"/> Bio-Psycho-Social | <input type="checkbox"/> Psych Eval & <input type="checkbox"/> Psyckes Consent (if on psychotropic meds) |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> *Client I.D. if available (Suggestions: Driver's License, Passport, State I.D.) |

- TB Test Results: Any ONE of the following:** PPD -or- Chest X-Ray -or-
 QuantiFERON Gold test

TB Test Results: If “+” PPD history, a negative Chest X-Ray within the past 12-months or a QuantiFERON Gold blood test must be obtained.

◆ **REFERENT, PLEASE ANSWER *ALL* THE FOLLOWING:**

1. Client Discharge Date: _____
2. Date of last TB Test? _____
3. Date of last H & P ? _____ **Note: *If H&P was completed at your facility, it must be signed by an MD or NP and provided with this form.**
4. Registered Sex Offender? NO YES - If 'yes', **which LEVEL?** 1, 2 or 3
5. Any Seizure History? NO YES
6. *Client to bring in a physical I.D. (if available) - Which does he have?
 Drivers' License Passport State I.D. Other (name): _____
7. Client's Preferred Language: _____

~ ****CLINICIAN: Complete Pages 1 & 2 / **CLIENT Reviews & Signs Pages 3, 4 & 5~**



St. Christopher's Inn ~ Admissions Referral Form

◆ **PSYCHIATRIC HISTORY / Diagnoses** ~ Provide psychiatric evaluation if available.

◆ **MEDICAL HISTORY** ~ Provide documentation for any recent hospitalizations (i.e., surgeries, medical conditions, etc.)

◆ **CURRENT MEDICATIONS** ~ Submit a LIST of all your client's current medications.

IMPORTANT:

If client is prescribed medications, you must be E-scribed to our PHARMACY.

****Clients should be made aware that they may be responsible for medication Co-Pays.**



PHARMACY = Prescription Center
296 Route 59 - PO Box 64, Tallman, New York 10982
Phone: (845) 368-9700 / FAX: (845) 368-4056



◆ **PENDING APPOINTMENTS:**

MEDICAL: _____

LEGAL: _____

OTHER: _____

We appreciate your referral to St. Christopher's Inn. Our Admission Staff will contact you upon review of this referral packet. The Admissions Office is open Monday through Friday: 8:00 a.m. to 4:30 p.m.

Please Note:

Medical clearance during pre-admission does not guarantee acceptance into St. Christopher's Inn. Upon arrival: The Admission's nurse will conduct a complete assessment, and final determination will be made regarding the status of admission into our recovery program.

RESIDENT FREQUENTLY ASKED QUESTIONS

St. Christopher's Inn ~ 21 Franciscan Way (PO Box 150), Garrison, N.Y. 10524

Can I have my cellphone while in the program? No cellphones / no Smartwatches / no laptops / and no Tablets. Your cellphone will be securely stored and may be used at the discretion and supervision of your counselor. Residents are permitted three phone calls per week using a phone card (obtained from us for \$5.00). One phone card will provide ten phone calls; any additional calls need counselor approval.

Am I allowed to have visits? We have a family program. Thirty days after admission, your counselor will work with you to set a date for a family visit supervised by your counselor.

How long until I can go out on my own? When you are not in meeting sessions, you have the freedom to go outdoors on our property during 'free' time. You are not permitted to leave the grounds unless you have an approved appointment for which we will provide transportation.

How many people sleep in a room? We have 13 dormitories. Depending which dorm you are in, the number of beds in a dorm range from 7 to 18 men in a room.

Am I allowed to get a job? You are not permitted to obtain an outside job. While here you are assigned a vocational activity on premises as part of your treatment plan.

How many meetings per day? Three meetings: a small group, a lecture, and an evening AA/NA meeting.

Is this a smoking facility? Can I bring my own cigarettes/vape? This is currently a smoking facility with a limited tobacco program (i.e., *designated smoking times and cigarette tapering*). You may bring your own cigarettes (*packs must be sealed and handed to security upon arrival*). NO Vapes/Vaping allowed. If brought with you, ALL vaping devices will be discarded.

How long is this program? The length of your stay depends on your treatment plan, goals, and insurance coverage. Typically, our residential treatment program is about 90 days or longer. Your length of stay ultimately depends on when you meet your individual goals and what your insurance will cover.

Is this facility co-ed? No, we have only MALE residents.

Is transportation provided to outside AA meetings? No, we have an onsite AA meeting each evening.

Do you offer weekend passes? No.

Does this facility have a gym? We have a workout room with exercise machines and weights that can be utilized during your free time.

Do you help with housing? We offer referrals for your aftercare plan and aid in finding sober housing. We do *not* aid in obtaining rentals, applying for Section 8 or that type of housing.

Am I allowed to use a computer/laptop? With permission from your counselor for specific reasons.

Can I attend school? Do you offer any classes or help finding classes or college? Not at this current time, but a program called Access VR is part of your aftercare and they do aid in the education process.

****By signing below, I acknowledge that I have read the above document and understand its contents.**

Client Name (Print)

Signature

Date

Witness Print Name

Witness Signature

Date

**Notice Regarding Department of Social Services/Human Resources Administration Benefits
and NYS OASAS Part 820 Residential Treatment Program (820 Consent)**

1. **There are three levels of benefits typically provided by DSS/HRA:**
 - a. Congregate Care Level II — Room and Board
 - b. SNAP — Supplemental Nutrition Assistance Program
 - c. PNA — Personal Needs Assistance
2. **As a resident of a NYS OASAS approved Part 820 Residential Treatment Program** you will be required, if eligible, to apply for all DSS/HRA benefits as described above.
3. **If you have an active DSS/HRA benefits case** upon admission to St. Christopher’s Inn, DSS/HRA will be notified of your admission, and your budget may be adjusted to include Room & Board and PNA. *Those with active benefits that include family members, your portion will be removed from the total amount provided for the family while you are here at St. Christopher’s and will be restored fully when you complete treatment or if you decide to leave.*
4. **SNAP benefits** will be applied for and provided through Putnam County Department of Social Services.
5. **Room & Board and SNAP benefits** *will be made payable to St. Christopher’s Inn* to support your stay here.
6. **If you are eligible for PNA**, those funds will be provided to you.
7. **If you are a recipient of Supplemental Security Income (SSI) and/or Social Security Disability income (SSDI)**, you will be required to pay St. Christopher’s Inn an amount for Room & Board according to the amounts set annually by the Social Security Administration for Congregate Care Level II settings.
8. **All mail from DSS/HRA and SSA** may be opened by Billing & Client Benefit Services staff so that documentation requests and other matters requiring timely action can be acted upon.

I acknowledge that I have read the above information and understand it, or it has been explained to me. Once I am admitted to St. Christopher’s Inn, I understand that I will be assisted by the Billing and Clients Services Office to help with the process.

Client Name (Print)

Date

Client Signature

St. Christopher's Inn
21 Franciscan Way ♦ (PO Box 150) ♦ Garrison, NY 10524
Admissions: 845-335-1020

PSYCKES Consent Form

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is a web-based application maintained by the New York State (NYS) Office of Mental Health (OMH). It contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES: visit www.psyckes.org and see: "About PSYCKES."

PSYCKES data includes identifying information (such as your name and date of birth), information about health services that have been paid for by Medicaid, information about your health care history (such as treatment for illnesses or injuries, test results, lists of medication you have taken), and information entered by you or your treatment provider into the PSYCKES application (such as a Safety Plan).

The health information in PSYCKES can help your provider deliver better 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. QUALITY CONCERNS HELP HEALTHCARE PROFESSIONALS DETERMINE WHETHER THE RIGHT SERVICES ARE BEING DELIVERED AT THE RIGHT TIME TO THE RIGHT PEOPLE. 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 printed information sheet provided before making your decision. Your Consent Choices:

CHOOSE 'ONE' OF THE FOLLOWING:

- I GIVE CONSENT for this provider to access ALL 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.

CLIENT's Signature: _____

CLIENT NAME (Print): _____

CLIENT / Patient - Date of Birth: _____

Today's Date

Time