

SUPPORTIVE LIVING Referral Packet

To All Applicants: The Supportive Living VOLUNTEER VOC/ED AGREEMENT must be completed and signed by the Career Choices Unlimited VOC/ED Case Manager, Residential Case Manager and Applicant **Prior** to submitting this packet.



Fairview Recovery Services, Inc. is committed to delivering a continuum of services to individuals with the disease of alcoholism, chemical dependency and co-occurring conditions. These services are designed to provide individuals the opportunity to develop the skills and knowledge to live independent, healthy and productive lives. We strive to deliver high quality care that is respectful of individual differences and needs.

**SUPPORTIVE LIVING
REFERRAL PACKET
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FAIRVIEW RECOVERY SERVICES, INC.

Michele Napolitano, MEd, CRC, CASAC

FAIRVIEW COMMUNITY RESIDENCE
MERRICK COMMUNITY RESIDENCE
SUPPORTIVE LIVING
CAREER CHOICES UNLIMITED
5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 722-6767

Executive Director
5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 722-6767

ADDICTIONS CRISIS CENTER
247 Court Street
Binghamton, NY 13901
Phone (607) 722-4080
Fax (607) 723-1858

2-WAY CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Social Security Number: _____

Date: _____

I, _____, hereby authorize and consent to

communication **BETWEEN Fairview Recovery Services, Inc.** and

Towne and Country Apartments, 100 Roberts Street, Binghamton, NY, 13901

Contact: Office Staff, Property Manager, or his/her successors.

The extent of information to be disclosed: name, date of birth, social security number, current address, and previous address.

The purpose of the disclosure authorized herein is to: share background check information for Towne and Country Apartments regarding potential residency.

I, the undersigned, have read and authorized the staff of the disclosing facility name to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire 6 months from its signing, unless a different time period, event or condition is specified below, in which case such time period, even or condition shall apply. I also understand that any disclosure is bound by Title 42 of the Code of Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information is forbidden without written authorization on my part.

Time period, event or condition replacing period specified above: 6 months from date of discharge

Note: Any information released through this form will be accompanied by Form A-4400 Prohibition on Re-disclosure of Information Concerning Alcoholism/Drug Abuse Patient.

Patient Signature

Witness Signature

Patient Name (Printed)

Witness Name (Printed)

Date

Date

**TOWNE AND COUNTRY APARTMENTS
BACKGROUND CHECK INFORMATION**

TENANT NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

CURRENT ADDRESS: _____

PREVIOUS ADDRESS: _____

PREVIOUS ADDRESS: _____

*Towne and Country Apartments
100 Roberts Street
Binghamton, NY 13901
607-723-1194*

Thank you for your application to Towne & Country Apartments!

Background checks are completed for all applicants over the age of 18. The fee is \$20 per applicant, or \$35 per married couple, and must be paid before your application can be processed.

Please sign below indicating your permission for the background check to be performed at your expense. Please note that if your background check indicates that you have any felonies or misdemeanors involving sexual misconduct, crimes involving controlled substances, or a physical crime against someone else/property, your application will automatically be denied.

Thank you,

Applicant #1 Signature

Date

Applicant #2 Signature

Date



Administration

Fairview & Merrick
Community Residences

Supportive Living

Shelter + Care

Career Choices Unlimited

5 Merrick Street
Binghamton, NY 13904
607-722-8987
Fax: 607-722-6767
fairview@frsinc.org
www.frsinc.org

To the Referred Person and the Referral Source,
**In order for your referral to be accepted and processed
the following MUST be provided to the
Supportive Living Program Coordinator:**

1. An admission packet that has been entirely completed and reviewed by both the referred person and the referral source. This can be found on the Fairview Recovery Services website at: www.frsinc.org or we will be happy to mail one to you. Feel free to make copies to keep on file.
2. A recent psychosocial (within the last year) that must include a chemical dependency diagnosis, and where applicable, a mental health diagnosis.
3. Documentation of a negative PPD/Mantoux test for TB (tuberculosis) within the past month.
4. Whenever possible please provide:
5. A complete history and physical from a health care provider completed within the last year, including lab (blood) work with a CBC Count.
6. Proof of funding from DSS or Social Security.

Referrals that are **not** complete will **not** be processed until the Supportive Living Coordinator has received **all** of the above named components.

Thank you,
Supportive Living Program

Addictions Crisis Center
247 Court Street
Binghamton, NY 13901
607-722-4080
Fax: 607-723-1858

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Fax (607) 723-1858

2-WAY CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Social Security Number: _____ Date: _____

I, _____, hereby authorize and consent to communication **BETWEEN** _____ and

(Agency Name, Full Address, Phone Number)

(Name & Title of a Contact Person) (or his/her successors).

The extent of information to be disclosed **Medical history, laboratory results, physical; psychosocial evaluation & recommendations; psychiatric evaluation; diagnosis; treatment history; progress in treatment; discharge summary & discharge status.**

The purpose of the disclosure authorized herein is to: **Coordinate treatment and share pertinent information for this purpose.**

I, the undersigned, have read and authorized the staff of the disclosing facility name to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire 6 months from its signing, unless a different time period, event or condition is specified below, in which case such time period, even or condition shall apply. I also understand that any disclosure is bound by Title 42 of the Code of Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information is forbidden without 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 Form A-4400 Prohibition on Re-disclosure of Information Concerning Alcoholism/Drug Abuse Patient.

Patient Signature

Witness Signature

Patient Name (Printed)

Witness Name (Printed)

Date

Date

Fairview Recovery Services, Inc.
Counselor Questionnaire

Client Name: _____

Thank you for taking time to help us evaluate your client for placement into Fairview Supportive Living Program. Your answers to all of the following questions are critical to our assessment of your client's appropriateness for admission to our facility.

1. Why do you feel that your client has the ability to remain clean and sober outside of a community residence?

2. Please tell us your impressions of your client's current denial system. Please circle the most appropriate number:

No Denial	Moderate Denial	High Denial	Extreme Denial
1	2	3	4

3. In what areas has your client made the most progress in treatment? _____

4. In what specific areas will your client need the most encouragement and support if admitted to Supportive Living? _____

5. It can be a challenge for people in early recovery to live in close contact and harmony with others. Please describe if your client will benefit from peer support:

6. Please add any additional information that will help us help your client. _____

Thank you for spending the time to help your client through this referral process. Should your client live at Fairview/Merrick Community Residence, we would like to stay in contact with your agency and yourself so that we can all be supportive of this resident. Please let us know the best times to contact you and, if possible, a direct phone line.

REFERRING AGENT

DATE

Client Introduction

Thank you for applying to Fairview Recovery Services Supportive Living Program. Supportive Living is a program for the recovering individual struggling with chemical dependence. Our Supportive Living program is a scattered site apartment setting. Program participants will be sharing a two-bedroom apartment with another individual in Supportive Living. Clients share the responsibility for basic activities of daily living (i.e. housekeeping). Each apartment is furnished with bedroom furniture, living room furniture (including television), kitchen table and chairs, and essential household items. Clients are responsible for providing their own bed linens and bathroom towels. (Emergency 911 phone capability only) (Cable service not included).

We will develop an individualized Recovery Plan (i.e. Alcohol and Drug, Mental Health, Marital/ Family, Social, Educational/Vocational/Employment, Health and Legal), with you within thirty days (30) of admission to Supportive Living, with input from the referral source. Length of stay is based on an individual's progress and need for continued services.

To help us know you better, we ask you to fill out the accompanying forms in a **thorough and honest manner.**

All information will be treated confidentially. If you are accepted into Supportive Living, all information supplied by yourself, your primary counselor, and your current treatment agency will be part of your permanent record and will be referred to throughout your stay at Fairview.

After we receive all of this information, from you and your counselor, your counselor will be notified of your appropriateness as a candidate for our Supportive Living Program. Your admission will be prioritized in conjunction with the waiting list policy in compliance with the NYS OASAS guidelines.

Again, thank you for applying for residence at Fairview Supportive Living Program.

Fairview Recovery Services, Inc.
Client Questionnaire

Client Name: _____

1. Please tell us your impressions of where you are at in treatment at the present time. What have you gained? What do you need to work on in treatment:

2. This Supportive Living provides a safe, sober living environment. Why are you seeking to live in this type of environment at this time? _____

3. There will be other people living in Supportive Living who are also in early recovery. How will you add to the quality of recovery in the Supportive Living Community?

4. What are your personal assets and your personal liabilities in this phase of your recovery?

5. What are you willing to do specifically in the area of self help, continuing treatment and personal growth during the next 4-6 months? _____

6. Do you have a court case pending? _____ If yes, are you facing jail time? _____
If yes, explain _____

7. Have you ever been treated for mental illness? _____ If yes, explain: _____

8. Do you have a learning disability? _____ If yes, explain: _____

9. Have you ever sexually abused a minor? _____
10. Have you ever been convicted of arson? _____
11. Have you ever been in jail or prison? _____ If yes, how many different times? _____
How much total time have you spent in jail or prisons? _____
12. Do you have any medical problems? _____ If yes, explain: _____

13. In the past 12 months has anyone hit, slapped, pushed, punched or kicked you? If yes
who? _____

14. Have you hit, slapped, pushed, punched or kicked anyone in the past 12 months? If yes,
who? _____

15. What is your level of contact or involvement on an on going basis with the person named
above?

16. Do you have a current order of protection in place against someone else or against you? If
yes, against or by whom? Through what court?

17. In the event you relapse, or leave Supportive Living, who can you stay with?
Name: _____
Address: _____
Phone: _____

Signature of Client

Date

Application for FRS Supportive Living Program

Name: _____ Case Manager: _____

Soc. Sec. #: ____ - ____ - _____ Date of Birth: ____ / ____ / _____

Admission Date to Supportive Living: _____

Sobriety Date: _____

Where and when did last relapse occur: _____

Please list all treatment and/or residential placements you have completed in the last 6 months.

Are you presently in treatment? Where? Name of treatment counselor?

Do you currently attend a 12 step program? _____

On average how many meetings do you attend weekly? _____

Do you have a home group? _____

Do you work with a sponsor? _____

Have you developed a sober support system? _____

Do you have Educational goals? _____

Do you have Vocational goals? _____

What have you done so far to achieve these goals? _____

POLICY AND PROCEDURE

PROCEDURE FOR: Addressing tobacco use at Fairview Recovery Services, Inc. programs.

PURPOSE: To reduce addiction, illness and death caused by tobacco products.

Policy Statement:

Fairview Recovery Services programs provide crisis, residential and educational services for adults dealing with chemical dependency. Fairview is dedicated to providing quality services in a healthy, drug free environment.

In 1988 the U.S. Public Health Services, under Surgeon General C. Everett Koop, published the report, The Health Consequences of Smoking: Nicotine Addiction. In this report Dr. Koop states, "Smoking is the chief avoidable cause of death in our society." He indicates that nicotine is the substance in tobacco that causes addiction. Nicotine is a mood altering, psychoactive substance that is highly addictive. Since 1980, DSM (Diagnostic and Statistical Manual of Mental Disorders) has listed both nicotine withdrawal and nicotine dependence as diagnosable conditions.

These facts about tobacco/nicotine impact Fairview Recovery Services programs in several ways. First, Fairview Recovery Services is aware that many of our clients have a history of tobacco use and others began using tobacco while in our care or through relapse. Second, Fairview Recovery Services recognizes that tobacco smoke at this facility is a dangerous pollutant which harms non-smokers and smokers alike. Third, Fairview Recovery Services recognizes that nicotine in tobacco is a psychoactive, mood altering, addictive substance.

Objectives:

1. To provide a healthy environment for staff, clients, volunteers, workfare participants, and visitors; one that is free from tobacco smoke pollution and cues to use tobacco products.
2. To establish a tobacco free program including tobacco free grounds.
3. To provide quality, comprehensive crisis, residential, and educational services to the clients at Fairview Recovery Services.
4. To provide tobacco/ nicotine dependence recovery assistance/options to staff.
5. To integrate tobacco/nicotine dependence within the care offered to the clients of Fairview Recovery Services programs through assessment, education, prevention, and treatment.

1. Establish a Tobacco-Free Facility

- A. All clients will be informed of this policy as part of the admission process and will sign a written contract at that time.

- B. Effective 6-1-2008, all prospective employees will be notified of this policy in employment announcements, during their first interview, prior to hire, and during orientation.
- C. Referral sources will be notified of this policy by 6-1-2008 and will continue to be notified on an ongoing basis thereafter.
- D. All current staff, volunteers, and workfare participants will receive a copy of the final policy. All new staff and volunteers will be notified of this policy at orientation.

2. Provide Tobacco/Nicotine Dependence Education and Recovery options for staff

- A. All employees will be offered an in-service on the medical complications of tobacco use and nicotine dependence.
- B. All clinical staff will be offered training on how to identify nicotine dependence. This will include training on assessing, education, treatment planning, and on-going care for nicotine dependence.
- C. All employees will not exhibit any tobacco products including paraphernalia (lighters, tobacco brand specific products, promotional clothing, and rolling papers).
- D. All employees who currently use tobacco products will be encouraged to discontinue use and offered the following:
 - 1. Pamphlets, brochures and other reading materials to assist and educate them on the effects of using tobacco/nicotine products.
 - 2. Over-the-counter nicotine replacement when not able to obtain through insurance.
 - 3. Counseling through EAP referral.
 - 4. New York State Tobacco Free Quit Line

3. Provide tobacco/nicotine prevention, education and nicotine replacement treatment for clients

- A. During all intakes and reviews, the clinical staff will assess clients for tobacco/nicotine dependence using the Fagerstrom Test for Nicotine Dependence and document their level of dependence.
- B. All clients, regardless of the tobacco history, will be offered an educational seminar on the effects of tobacco use.
- C. During the admission process, all clients will sign an agreement stating that they have been informed of the tobacco free policy and understand its guidelines. All clients in residence on 6-1-08 will also sign the agreement.
- D. Clinical staff will assist the clients in obtaining Nicotine Replacement Therapy upon request.
- E. While at the program, clients will not exhibit any tobacco/nicotine products including paraphernalia, lighters, rolling papers, promotional clothing and other tobacco/nicotine brand specific items. If clients are found to have any of these items, the items will be confiscated and destroyed.
- F. All clients who are identified as needing tobacco cessation will have this area addressed in their service plan.

MONITORING AND COMPLIANCE:

1. All employees, clients, volunteers, workfare participants and visitors are expected to adhere to this policy.
2. All employees are expected to be familiar with this policy and are responsible for monitoring compliance.
3. Employees who violate this policy will be subject to the same disciplinary procedures used for any other policy violation related to work performance.
4. Violation of this policy by clients will be addressed as a treatment issue first, and as disciplinary issue if violations persist. The clinical staff will address non-compliance with the client. Repeated violations may result in termination guided by the way staff deals with other addictions.
5. Visitors who violate this policy will be informed of the policy and asked to comply. A visitor who persists in violating this policy will be asked to leave.
6. Workfare participants and volunteers who violate this policy will be reminded of the policy and asked to comply. A workfare participant or volunteer who persists in violating the policy will be relieved of duty until that workfare participant or volunteer agrees to comply.

DEFINITIONS:

Tobacco- Free

When tobacco use is not permitted in any form indoors or on the grounds, the facility is tobacco-free. Tobacco-free programs understand that any use of tobacco products is incongruent with a lifestyle free of addictive drugs and recognize the need to assist clients, employees and volunteers at the facility in addressing their own tobacco use behavior.

Fairview Recovery Services, Inc.

To support a tobacco free environment, I agree to the following:

- I will not use any type of tobacco products while on the Fairview Recovery Services premises. I understand this includes the sidewalks surrounding the community residence, crisis center, supportive living apartments, parking lots, and vehicles.
- As a tobacco user I understand treatment goals specific to nicotine dependence will be included in my treatment plan.
- I agree I will not bring tobacco products or paraphernalia including lighters, snuff, chewing tobacco, cigars, cigarettes, etc. to any Fairview Recovery Services site understanding that staff will confiscate and destroy them.
- In the event that I violate such policy I understand that my case will be reviewed with possible revisions to my treatment plan. I understand that if I am found to be smoking in any of Fairview Recovery Services facilities I may be discharged from that program immediately.
- In an effort to support peers who have also agreed to this initiative, I agree to take measures to remove the odor or evidence of smoking from my person before I enter any of Fairview Recovery Services facilities (i.e. washing hands).
- As a non-smoker as part of the Fairview Recovery Services admission process I have been informed of this policy.

Client Signature

Date

Staff Signature

Date



SUPPORTIVE LIVING VOLUNTEER & VOC/ED AGREEMENT

As a resident of FRS Supportive Living Program (SLP), I agree to the following guidelines:

- 1. *I agree to attend and participate in the vocational/educational institution chosen in conjunction with my vocational/educational plan through Career Choices Unlimited (CCU).*
- 2. *I agree to be involved in a minimum of 20 hours of volunteer or Workfare per week, unless otherwise negotiated through SLP, CCU and, if applicable, the Department of Social Services (DSS). The volunteer/Workfare component must take place at an FRS approved site.*

Volunteer site chosen: _____

Volunteer sites being considered: _____

- 3. *I understand and agree that the Supportive Living requirements (i.e., house group, meetings, one-on-ones) cannot be compromised due to volunteer or Workfare placement.*
- 4. *I understand that I will begin working as a volunteer or in Workfare within 30 days of my admission to SLP.*
- 5. *I agree to contact both SLP and CCU Case Managers if there are problems or changes of any nature at my address, educational institution, volunteer and/or Workfare site.*

Resident's Signature

Date

Supportive Living Case Manager

Date

Career Choices Unlimited Case Manager

Date

Fairview/Merrick Community Residence Case Manager

Date

MEDICATION POLICY
COMMUNITY RESIDENCES/SUPPORTIVE LIVING:

It is the policy of Fairview Recovery Services, Inc. Community Residential and Supportive Living programs to provide a supportive alcohol and drug-free environment. Therefore alcohol and/or mood altering drugs are not allowed on the premises. We recognize that there is an individualized need for certain residents to take medications for both their physical and mental health needs. Therefore the only acceptable mood altering drugs that are allowed on the premises are those medications that are prescribed by a physician.

Procedure: On Admission to Supportive Living, Residents will review all the medications that have been prescribed to them with their Case Manager. The resident must demonstrate the ability to manage their medication on their own prior to admission.

Residents must inform staff when any of the following situations occur:

- Changes in the prescription
- Beginning a new medication
- Experiencing adverse reactions or side effects to medications

The Supportive Living staff reserves the right to meet with the client and count the quantity of medication with the client present at any time to ensure that no medications are being abused.

Any issues of non-compliance with medications will be managed as a therapeutic issue with the provider. Ongoing issues of non-compliance may ultimately result in discharge and a referral to an alternative level of care.

Client Signature

Date

FRS Staff Signature

Date

Fairview Recovery Services, Inc.
Supportive Living Program

Overnight Visitor Policy-CHILD

I, _____ agree to abide by the following policy regarding having overnight visitors at the apartment that I currently occupy:

I agree to follow Fairview Recovery Services Supportive Living Program overnight visitor's policy.

In addition I agree to assume full responsibility for my child.

I recognize the need to be in supervision of my child at all times.

I recognize that my child is not the responsibility of my roommate or Fairview Recovery Services, Inc.

I understand that I will not be allowed to have overnight visitation with my children until the emergency childcare plan is in place for each child that is visiting.

I understand that any deviation from the policy may jeopardize my residency in Fairview Recovery Services Supportive Living Program.

Client Signature

Date

FRS Staff Signature

Date

Supportive Living Program

Overnight Visitor Policy

1. I understand that overnight guest(s) whether children or adults are allowed via mutual agreement between my roommate and me.
2. I understand that overnight guests are limited to weekends rather than week days due to the potential impact that it may have on my and my roommate(s) recovery.
3. I agree guests will visit in common areas only. Bedrooms **are not** common areas. Overnight guests may **not** sleep in bedroom. An alternate room must be used for this purpose.
4. I agree that all guests will be alcohol/drug free.
5. I agree that Fairview Employees or clients are not to be responsible for my children at any time.
6. I understand that guests determined by Fairview staff to be inappropriate will not be allowed in my residence.
7. I agree that there will not be guests in my residence when I am not at home. I agree that any deviations from the above policy may result in dismissal from Supportive Living.
8. I agree that no one but me will have keys to my residence.

Client Signature

Date

FRS Staff Signature

Date



Guidelines for Living in Supportive Living

1. No X-rated movies or materials that is sexually explicit throughout the apartments. These are apartments of recovery and these types of materials have no place here.
2. Verbal or physical threats or acts of violence are not acceptable. Racial and sexual slurs, sexual harassment and vulgarity are not acceptable. Violation of these norms may lead to discharge.
3. There is to be no yelling up or down the stairs in the apartment complexes for any reason. Disruptive loud noise and music is not acceptable and may lead to discharge.
4. Residents are responsible for supplying their own television / phone services. It will be up to the residents to work out together a payment plan for these services.
5. Residents are responsible for the cleanliness of the apartment hallways and outside area of their buildings. Bicycles and/or other belongings are not allowed in the hallways of the building.
6. Please be courteous and respectful in all living areas that are shared.
7. You are responsible to supervise **children, friends** and **family members** during visitation. You are not allowed to leave them in the apartment at anytime for any reason during visitation.
8. You have the right and responsibility to confront another resident on their old behaviors. We are not here to judge one another and everyone makes mistakes. It is your responsibility, based on the severity of the behavior, to inform staff.
9. The residents of Supportive Living are ineligible to eat meals at the Community Residences at either Lunch or Dinner without an invitation from a Community Residence client.
10. To maintain a safe, sober environment, staff reserves the right to urine drug screen and breathalyze individuals at any time. Failure to submit to either test will result in immediate discharge from the Supportive Living Program.

Fairview Recovery Services, Inc.
Resident Contract
Supportive Living Program

Fairview Recovery Services, Inc. is a private, nonprofit agency with the mission to improve the quality of life and health of persons diagnosed with and recovering from alcoholism, substance abuse and other disabling conditions. Providing you with residential, rehabilitation and support services pursues this goal. The purpose of this contract is to outline what is expected of you and the role of staff to ensure that you have a safe, secure supportive setting in which to live and to work on your recovery/rehabilitation goals.

Client Expectations: As a resident of Fairview Recovery Services, Inc. Supportive Living Program, I agree:

1. To treat all community members (other residence and staff) with dignity, and to respect they're personal rights and property, their right to privacy and their right to receive support as a member of Fairview Recovery Services, Inc. community.
2. To be willing to live cooperatively, and respectfully with my apartment roommates.
3. To participate in the development and carrying out of the activities of my individualized recovery/treatment program to include:
 - Maintain sobriety and abstinence from non-prescribed drugs.
 - Meeting with Fairview Recovery Services, Inc. staff on a regularly scheduled 1:1 basis to discuss my plan, services, progress, and changes in my plan, and any other concerns that need to be shared.
 - Being involved in a program of goal-oriented activities, therapy, treatment, work and/or training, for at least 20 hours a week.
 - Participate regularly in community meetings.
 - Maintaining regular contact with my treatment counselor and Case Manager.
4. To assume responsibility for my health and hygiene and for the care and safe keeping of Fairview Recovery Services, Inc. property, personal property, and personal living areas to include:
 - Keeping myself in good health and maintaining good personal hygiene.
 - Maintain my apartment in a clean and orderly fashion.
 - Assuming responsibility of apartment keys by insuring against loaning or duplication, and promptly returning all issued keys upon request.
 - Assuming financial responsibility for lost or damaged Fairview Recovery Services, Inc. property at replacement value to be established by the Program Coordinator in conjunction with the Clinical Director.
5. To assume responsibility for fee payment from day of admission and for other financial responsibilities as described in the Financial Contract
6. Fairview Recovery Services, Inc. is not responsible for personal belongings. Fairview Recovery Services, Inc. is not responsible to replace lost or damaged personal property. Personal belongings left behind by a resident will be considered forfeited and will be disposed of at the discretion of Fairview Recovery Services, Inc.
7. To insure my physical and emotional well-being and that of the community members by:

- Smoking is prohibited in all apartment bedrooms at all times.
- Use of candles, incense etc. is limited to designated areas of living room and kitchen.
- Learning the fire evacuation plan.
- Storage and use of weapons in or around the apartment is strictly prohibited
- Abstinence from all non-prescribed, mood-altering substances is expected in accordance with my individualized service plan. I further understand that any use will result in an evaluation by staff to determine what care and attention is needed to insure my health and safety and to decide about my continued participation in the program.
- Preparing and storing food in a responsible way that insures my safety and that of others, as well as Fairview Recovery Services, Inc. property and to consume food and beverages only in designated areas to insure a clean environment.
- Informing staff when I will be away from my apartment for a period of time exceeding a normal weekend, and establishing with staff a time to return.
- Agreeing that the staff may enter my apartment without my prior permission to make routine maintenance checks and at any other time there is a concern for any health or safety issue or when there is a concern that I and not complying with the program expectations.
- I agree not to have any “pets” of any type, which are dependent upon me to sustain its life in my apartment. Pets include dogs, cats, birds, reptiles, fish, amphibious creatures, insects, small mammals, any and all creatures domesticated or wild.

Fairview Recovery Services, Inc. Responsibilities: Fairview Recovery Services, Inc. agrees to provide the following:

1. To provide you with the following services without regard to your sex, race, religion, national origin, sexual preference and mental, emotional, or physical condition:
 - a) Admission and Discharge planning
 - b) Training in activities of daily living.
 - c) Case management
 - d) Supportive counseling focusing on relapse prevention and monitoring of sobriety.
 - e) Crisis management (dealing with difficult situations through appropriate interventions and referrals to community agencies)
 - f) Room and Board
 - g) Socialization and Leisure Activities
 - h) Accessing Transportation
 - i) Developing appropriate behaviors through effective interventions.

2. To assist you in:
 - a) Identifying and defining your needs.
 - b) Developing and individualized service plan.
 - c) Identifying appropriate agencies and services to meet your needs
 - d) Recommending and or referring and coordinating services
 - e) Identifying and clarifying your satisfaction or dissatisfaction about the services you are receiving and helping you to find appropriate methods to express your views.
 - f) Supporting and reviewing progress and changing your service plan, as appropriate, through regularly scheduled meetings with your case manager and treatment counselors.
 - g) Dealing with difficult situations through crisis counseling or other appropriate interventions

3. To treat individuals with dignity; ensuring that your personal rights include, but are not limited to, the:
 - a) Right to reasonable privacy

- b) Right to confidentiality
- c) Right to access to your records as described in agency policies.
- d) Right to receive visitors
- e) Right to voice grievances or complaints about the programs, staff and facility, in an appropriate manner, without fear of reprisal
- f) Right to exercise all other rights guaranteed to citizens of the community

4. To provide you with a clean, safe sober living environment.

I understand that I have entered this program voluntarily and may leave voluntarily, having given proper notice.

I understand that if I am satisfied or not satisfied with something, I am encouraged to inform staff.

Fairview Recovery Services will make a sincere effort to ensure a safe environment is provided and your views will be taken seriously.

Resident's Signature _____ **Date** _____

Case Manager's Signature _____ **Date** _____

FAIRVIEW RECOVERY SERVICES, INC.

Michele Napolitano, MEd, CRC, CASAC

FAIRVIEW COMMUNITY RESIDENCE
MERRICK COMMUNITY RESIDENCE
SUPPORTIVE LIVING

5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 722-6767

Executive Director
5 Merrick Street
Binghamton, NY 13904
Phone (607) 722-8987
Fax (607) 722-6767

ADDICTIONS CRISIS CENTER
247 Court Street
Binghamton, NY 13901
Phone (607) 722-4080
Fax (607) 723-1858

August 31, 2011

Dear Referring Agency,

As a requirement of HUD, we are adding a new form to our referral packet titled "***Client Homeless Status: Eligibility Documentation***". If the individual you are referring is not homeless, please indicate that next to the client's name on the form and sign below.

If the individual is homeless please check the box that describes the individual's situation and attach supporting documentation to the form.

Examples of supporting documentation can be found in the second column on the form. If you are in need of additional assistance, or have any questions regarding this new referral requirement, please feel free to contact Ann Crist, Supportive Living Coordinator at:

(607) 722-8987 ext. 228 or acrist@frsinc.org.

Thank you in advance for your cooperation with this new referral requirement.

Sincerely,



Michele Napolitano, MEd, CRC, CASAC
Executive Director

CLIENT HOMELESS STATUS: ELIGIBILITY DOCUMENTATION

Client Name: _____

Date of Intake: _____

Check the current housing status and attach the appropriate documentation to verify homelessness eligibility.

Homeless Status	Type of Documentation	Documentation Attached
Living on the street	A signed and dated general certification from an outreach worker verifying that the services are going to homeless persons, and indicates where the persons served reside.	
Persons living on the street Persons coming from living on the street (and into a place meant for human habitation)	Staff should provide written information obtained from third party regarding the participant's whereabouts, and, then sign and date the statement.	
Persons coming from an emergency shelter for homeless persons	Written referral from the agency.	
Persons coming from transitional housing for homeless persons	Written verifications to include program residency and homeless status prior to program entry.	
Persons being evicted from a private dwelling	Documentation of income, efforts to obtain housing, why participant would be on street, and either documentation of formal eviction proceedings or statement from family evicting participant. (Not eligible for acceptance directly into PH from 2005 awards onward.)	
Persons from a short-term stay in an institution who previously resided on the street or in an emergency shelter	Written verification from the institution's staff that the participant has been residing in the institution for less than 31 days, and information on the previous living situation.	
Persons being discharged from a longer stay in an institution	Written verification from the institution of discharge within one week of accepting client into SHP/S+C program AND documentation of income, efforts to obtain housing, and why person would be homeless without assistance.	
Persons fleeing domestic violence	Written, signed, and dated verification from the participant.	
Other:	Written verification from client or referring agency	
CHRONIC HOMELESSNESS Single, disabled Adult + Continuously homeless for 1 yr or more OR.. 4 episodes of homelessness in the past 3 yrs (streets/shelters)	Written verification from outreach workers, shelters AND brief, written statement regarding previous shelter/street stays (dates, locations) AND - documentation of disability	

NOTES:

STAFF MEMBER: _____

Date: _____

CLIENT: I verify this information is true & accurate. I confirm that I have been or am about to be homeless.

Signature of Client

Date: _____