Referral to Ft Lyon. Please fax to 719 456 0109 or email to
fortlyonreferrals@coloradocoalition.org

ALL QUESTIONS/FORMS MUST BE COMPLETED

Name of Referral Source: _____

Phone: _____ Email Address: _____

How long have you, the referral source, known this individual? _____

Name of referral agency: _____

Today's Date: _____

Client Information

Client Name: _____

Have you ever been a resident of the Fort Lyon Program? Yes____ No____

How long have you been in Colorado? _____

DOB: _____ Gender: _____

Have your served in the Armed Forces? _____

Is Detox needed? _____If yes, what is the detox plan? _____

Previous Substance Abuse Treatment? Yes___ No___ Where:_____

Substance(s) used in the last six months: _____

Last Use: _____ Type of use: IV SMK SNT ING _____

Mental Health Diagnosis: Yes ___ No ___ Current Diagnosis? _____

Where are they receiving treatment? _____

Benefits: Medicaid___ Medicare_____ SSI____ SSDI ___ AND____ OAP ___ VA ___

Verification of Benefits? Yes _____ No _____

Any open court or warrants? Yes_____ No ____ **Must be closed before admission**

Currently on parole or probation? Yes___ No___ If yes, please include a release of information for us to speak with the Officer.

Emergency Contact for Client: Name _____
Phone:_____

COLORADO COALITION FOR THE Homeless Creating Lasting Solutions

MRN:_____DOB: _____

CATEGORY: ROI

Authorization to Request / Release Health Information

Client Name:_____Client Date of Birth:_____ Last 4 of SSN: _____

I authorize that information may be exchanged between the following:

____ From____To **(please select)**

Name:_____
Attn:_____
Address: _____
City, State, Zip: _____
Phone Number: _____
Fax Number: _____
Email: _____

____From____To **(please select)**

Name or Organization Name: _____
Relationship to Client: _____
Address: _____
City, State Zip: _____
Phone Number: _____
Fax Number: _____
Email: _____

Please indicate the purpose of this release (check all that apply):

____ Continuity of Care
____ Legal
____ Obtain/Maintain Housing
__ Insurance
__ Worker's Compensation
___Personal/Other _____
____Obtain Benefits
____Referral

Information to be released (please check all that apply):

____ Paper Copy ____ Verbal Exchange ____Electronic Copy
____ Specific Dates of Service: _____

Medical Information:

____ Progress Notes ____Imaging Re[prts ____ Consultant Reports ____Operative Reports
____ Lab Results ____Immunizations ____Medication List/History ____ER Reports
____ AIDS/HIV Information ____ Dental Records ____Billing Records ____Eye Care Records
____ Demographic/Face Sheet_____ Diagnoses ____Hospital Admit/Discharge Summaries

Mental Health Information:

____ Progress Notes ____Psychiatric Notes ____Intake/Assessment
____ Lab Results ____Treatment Plan ____Medication List/History
____ Discharge Summaries ____Treatment Status ____Billing Records
____ Demographic/Face Sheet_____Diagnoses ____Hospital Admit/Discharge Summaries

Housing Information:

____Program Status
____Family/Social Composition
____Notices/Eviction Information
____Case Notes or Housing Advocate Notes
____Voucher/Lease Information
____Demographic/Face Sheet

Case Management Information:

____Program Status
____Family/Social Composition
____Intake/Assessment
____Benefit Information
____Case Notes/Case Management Notes
____Treatment/Care Plan
____Demographic/Face Sheet

Substance Treatment Information:

____ Progress Notes ____Assessments ____Medication List/History
____ Lab Results ____ Treatment Plan ____ Billing Records
____ Discharge Summaries ____Treatment Status ____ Diagnoses

Authorization

I understand that:

- Due to the integrated care provided by CCH, information released may include a diagnosis or reference to the following condition(s): behavioral health/psychiatric care; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV) or substance use disorders.
- Individuals enrolled in CCH licensed substance treatment (Part 2) programs have their substance-specific records protected by 42 CFR Part 2
- I understand that treatment and payment may not be conditioned on signature of this form.
- I understand that authorizing the disclosure of this information is voluntary.
- I understand that I may revoke this authorization at any time by giving written notice to the Colorado Coalition for the Homeless, except to the extent that CCH has already acted on this request.
- I understand that when information is released, it carries with it the potential for unauthorized redisclosure and it may no longer be protected by federal confidentiality rules such as HIPAA.
- I understand that I may make a written request for a list of the entities to which my information has been disclosed over a specified period, not to exceed six years preceding the date of my request.
- I understand that if I request to receive records via unsecured email, unencrypted messages (and any attachments) can be read, and potentially copied and forwarded, by anyone.

Expiration

I understand that this release expires on:_____(not to exceed two years from the date of my signature)

_____ _____

Signature of Client or Personal Representative Date

_____ _____

Client or Personal Representative Printed Name Relationship to Client

NOTICE TO THE RECIPIENT OF THE INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (HIPAA and 42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Revocation of Authorization to Release Protected Health Information

I hereby revoke the authorization to release information that I provided to Colorado Coalition for the Homeless allowing CCH to use and disclose my Protected Health Information as outlined on the authorization form, which I signed on_____. I understand that this revocation does not apply to any action Colorado Coalition for the Homeless has taken in reliance on any authorization I signed earlier.

This revocation does not revoke any and all previous authorizations to release information that I have provided to Colorado Coalition for the Homeless.

Client's signature: _____ Date: _____

RENTAL SERVICES, INC

PH: (303) 420 1212 PH: (800) 628 6414 FAX
(303) 420 1477 FAX (800) 296 9902

Applicant Screening Request
Administrative Information
This information is required to process this application.

Rental Services Customer: Colorado Coalition for the Homeless
Department: Ft Lyon
Contact Name: Referral Liaison
Phone: 719 662 1162
FAX: 719 456 0109
Alternate contact: Lisa Trigilio - Program Director Phone 719 662 1111

Type of Report Requested – please check one:

{ } Eviction and Credit Only
{ } Eviction and Credit Plus National Criminal Check

{X} Denver General Sessions

{X} National criminal only

{X} CO criminal courts

{X} CBI

FULL LEGAL NAME:_____ DOB:_____FULL SS #:_____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

APPLICANT'S CONTACT #:_____ AlT #:_____

Co-Applicant:_____ DOB:_____FULL SS #:_____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

Co-APPLICANT'S CONTACT #:_____ AlT #:_____

I declared that the statements above are true and correct. I authorize verification of my references and credit as they relate to my tenancy AND to future rent collections.

Date:_____Signed:_____Co-Signed:_____

History of Homelessness

Please describe Client's current situation, including their housing status:

Drug Abuse Screening Test (DAST-10)

General Instructions
"Drug use" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin. The questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.
Date of Assessment: _____

These questions refer to drug use in the past 12 months. Please answer No or Yes.

1. **Have you used drugs other than those required for medical reasons?**

   ☐ No ☐ Yes
2. **Do you use more than one drug at a time?**

   ☐ No ☐ Yes
3. **Are you always able to stop using drugs when you want to?**

   ☐ No ☐ Yes
4. **Have you had "blackouts" or "flashbacks" as a result of drug use?**

   ☐ No ☐ Yes
5. **Do you ever feel bad or guilty about your drug use?**

   ☐ No ☐ Yes
6. **Does your spouse (or parents) ever complain about your involvement with drugs?**

   ☐ No ☐ Yes
7. **Have you neglected your family because of your use of drugs?**

   ☐ No ☐ Yes
8. **Have you engaged in illegal activities in order to obtain drugs?**

   ☐ No ☐ Yes
9. **Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?**

   ☐ No ☐ Yes
10. **Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?**

    ☐ No ☐ Yes

Comments: _____

Scoring
Score 1 point for each question answered "Yes", except for question 3 for which a "No" receives 1 point.

DAST Score: _____

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?

   (0) Never {Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

3. How many drinks containing alcohol do you have on a typical day when you are drinking?

   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

4. How often during the last year have you had a feeling of guilt or remorse after drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often do you have six or more drinks on one occasion?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

Skip to Questions 9 and 10 if Total Score of Questions 2 and 3 =0

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you found that you were not able to stop drinking once you had started?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. Have you or someone else been injured as a result of your drinking?

   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

9. How often do you have six or more drinks on one occasion?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Record total score here:

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence except for mandated reporting (abuse of children, elderly, etc.). It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation. This is why each question begins, "Have you ever . . . "
Please circle "yes" or "no" for each question.

	Questions	**Check One**	
		Yes	**No**
1.	Have you ever talked to a psychiatrist, psychologist, therapist, social worker or counselor about an emotional problem?		
2.	Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?		
3.	Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problems?		
4.	Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?		
5.	Have you ever heard voices no one else could hear or seen objects or things which others could not see?		
6.	A. Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?		
	B. Did you ever attempt to kill yourself?		
7.	Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?		
8.	Have you ever experienced any strong fears? For example. of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?		
9.	Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property?		
10.	Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?		
11.	Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?		
12.	Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?		

13.	Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything?		
14.	Have you ever had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or rapidly, you were shaking or faint?		
15.	Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying. or maintaining a very rigid schedule of daily activities from which you could not deviate?		
16.	Have you ever lost considerable sums of money through gambling or had problems at work, in school, or with your family and friends as a result of your gambling?		
17.	Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?		

Print client's name: _____

Program to which client will be assigned: _____

Name of admissions counselor: _____

Reviewer Comments: _____

_____

_____

_____

Medical Approval Information

Patient Name: _____ DOB: _____ Date Of Clearance Evaluation: _____

Allergies. Please include any food allergies/restrictions	Current Medication List:
Current Medical/Psychiatric Problem List:	
Please fill out or attach current treatment information. Treatment Plan:	Medication Directions:

Date of most recent Tuberculosis screening test and results (ideally done within 30 days of program entry).

☐ Patient currently medically approved to enter the Fort Lyon Residential Supportive Community.

Print Name & Medical Credential: _____

Signature: _____ Date: _____

In addition to this Medical Clearance Form please fax a copy of your most recent:

☐ Tuberculosis (TB) test results

☐ COVID-19 test result or vaccination status

to 719-456-0109.For more information, please call (719) 662-1162, or visit our website https://www.coloradocoalition.org/property/fort-lyon-supportive-residential-community

Medical Resource and Treatment Information for Fort Lyon

Fort Lyon is located in Bent County in SE Colorado, it is a rural area and medical resources are limited. There are some specialists available within 40 miles of Fort Lyon, but a majority are in Pueblo or Colorado Springs, which is over 100 miles away, and may only see patients 1-2 days a week or month. Transportation is limited if you need to see a specialist.

This is to inform you that if you have a need to see a specialist, the services may not be available to you, please consider this prior to submitting your application.

- If you have any pending surgeries complete them PRIOR to entering program.
- If you plan to enter into treatment for Hepatitis C, Cancer, or other long-term treatment with a specialist you need to complete your treatment PRIOR to coming to Fort Lyon.
- Primary care and behavioral health providers are available in the area such as Fort Lyon Health Center, Valley Wide Health Systems, and South East Health Group.

Assistance for your initial visit will be provided when you enter the program. Dental and Vision appointments are also available after you have been in the program for 90 Days.

I have read and acknowledge the information above.

Print Client's Name Client's Signature and Date

_____ _____

Print Case Manager's Name Referral Source's Signature

_____ _____

Personal Property

1. At admission, Ft. Lyon will only transport 40 pounds of property in one bag per resident. You are also allowed one small purse/bag on you lap.

2. Residents are responsible for the security of their personal belongings during their stay at Fort Lyon.

3. Residents are expected to take all personal belongings with them upon their departure from the campus on or before their discharge date. Ft. Lyon will transport up to 60 pounds of property. If resident is unable to take all property with them:

    i. The inventory will be placed in storage for no more than 30 days.

    ii. It is the resident's responsibility to collect inventory within 30 days; and

    iii. After thirty days, the items will be recycled into the community via the warehouse.

I acknowledge my understanding of the policy above.

_____
Resident Printed Name

_____ _____
Resident Signature Date

_____ _____
Witness Date

Fort Lyon Benefits Program Eligibility Notice

As a participant in the program at Fort Lyon, there are benefits that you are and are not eligible for. Please note any/all programs that affect you and initial each line:

____ SSDI/SSI payments are not affected and residents receive full benefits.

____ VA disability payments are not affected and residents receive full benefits.

____ Medicaid and Medicare are not affected.

____ OAP payments are subject to state exemption criteria and may be reduced to $79/month.

____ AND payments are subject to state exemption criteria and may be reduced to $79/month.

____ Food assistance program (SNAP) is not available for residents of Fort Lyon living in the dorms. Resident may apply once he/she is living in a transitional housing unit. Special diets are not considered as a part of DHS eligibility for food assistance.

I have read this notice and acknowledge the information regarding benefits.

_____ _____

Name Date

*State benefits will remain in the county where you are currently receiving them. You will need to do a change of **mailing address,** with DHS, leaving your residential address in the county they are currently in.

Social Security (retirement/SSI/SSDI) requires address change to new address.

Your New mailing address will be:

(Name) 30999 County Road 15, Las Animas, CO 81054

We will help make that change when you arrive.