COLORADO COALITION FOR THE HOMELESS

Sage Ridge

Referral to Sage Ridge Supportive Residential Community
email completed application to: sageridgereferrals@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 or Sage Ridge Programs?

Yes, FL ☐ Yes, SR ☐ No ☐

How long have you been in Colorado? _____

DOB: _____ Gender: _____

Have your served in the Armed Forces? Yes ☐ No ☐

Previous Substance Use 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 receiving treatment? _____

Are you receiving Medication Assisted Treatment?

☐ Suboxone ☐ Methadone ☐ Naltrexone ☐ Vivitrol ☐ other

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.

Will you need transportation to Sage Ridge? Yes ☐ No ☐

Pickup locations include: Fort Lyon (Las Animas) and 2130 Stout Street (Denver)

EMERGENCY CONTACT FOR CLIENT:

NAME _____PHONE:_____

NEEDS ASSESSMENT

This form is intended to help Sage Ridge staff prepare for any requirements if the applicant is approved and is ready to arrive.

Current Home Life

☐ Detox/Treatment ☐ Street ☐ Couch Surfing ☐ Hospital ☐ Mental Health Facility

☐ Other, please list:

Physical Abilities and Equipment

Can you ambulate independently?

☐ Yes, Max. Distance _____

☐ No

Are any of the following needed?

☐ Cane ☐ Crutches ☐ Walker ☐ Portable Oxygen ☐ Service Animal

☐ Electric Wheelchair ☐ Manual Wheelchair

If manual wheelchair is needed, can you self-propel? ☐ Yes ☐ No Can you self-transfer? ☐ Yes ☐ No

Do you have any problems with any of the following? If yes, click the checkbox with a rating for each category, with 1 being mild impairment and 5 being severe impairment.

Alertness ☐ No ☐ Yes ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Memory Loss ☐ No ☐ Yes ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Confusion ☐ No ☐ Yes ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Able to remove self from unsafe situation: ☐ No ☐ Yes

Sensory Abilities

Vision: ☐ Cataracts ☐ Legally Blind

Speech & Hearing: Deaf ☐ No ☐ Yes

Able to communicate needs: ☐ No ☐ Yes

MRN:_____DOB: _____

CATEGORY: ROI

COLORADO COALITION FOR THE HOMELESS

Sage Ridge

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 __X__ To
Name: CCH Sage Ridge
Address: 28101 East Quincy Ave.
City, State, Zip: Watkins, CO
Phone Number: _____
Fax Number: _____
Email: sageridgereferrals@coloradocoalition.org

_____

__x__From____To **(please select)**
Name or Organization: _____
Relationship to Client: _____
Address: _____
City, State Zip: _____
Phone Number: _____
Fax Number: _____
Email: _____

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

__x__ Continuity of Care
____ Legal
__x__ Obtain/Maintain Housing
____ Insurance
____ Worker's Compensation
____ Personal/Other _____
____Obtain Benefits
__x__Referral

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

____ Paper Copy
____ Specific Dates of Service: _____
__x__ Verbal Exchange
__x__Electronic Copy

Medical Information:

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

Mental Health Information:

____ Progress Notes
____ Lab Results
____ Discharge Summaries
____ Demographic/Face Sheet
____Psychiatric Notes
____Treatment Plan
____Treatment Status
_____Diagnoses
____Intake/Assessment
____Medication List/History
____Billing Records
____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
____ Lab Results
____ Discharge Summaries
____Assessments
____ Treatment Plan
____Treatment Status
____Medication List/History
____ Billing Records
____ 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

_____ _____

Printed Name of Client or Personal Representative 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: Sage Ridge
Contact Name: Bobby Harr, Intake/Discharge Manager
Phone: 720-373-1040

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 the client's current living situation, including their housing status:

_____

_____

_____

_____

_____

_____

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_____

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: _____

Mental Health Screening Form—Ill (MHSF—III)

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 been hospitalized for mental health issues? If so, when was your most recent discharge date? _____		
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 felt 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: _____

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:

By signing below, I acknowledge the patient is currently medically approved to enter the Sage Ridge Residential Supportive Community and information provided above is correct.

Print Name & Medical Credential: _____

Signature: _____ Date: _____

For more information, please call (719) 662-1162, or visit our website

https://www.coloradocoalition.org/sageridge

Medical Resource and Treatment Information for Sage Ridge

Sage Ridge is located in Bent Unincorporated Arapahoe County. It is a rural area and medical resources are limited. There are some specialists available within 30 miles. 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 Sage Ridge.
- Primary care and behavioral health providers are available in the area and the Sage Ridge Health Center is located on campus.

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 30 Days.

I have read and acknowledge the information above.

Print Client's Name Client's Signature Date

_____ _____

Print Referral Source's Name Referral Source's Signature

_____ _____

Personal Property

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

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

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/Sage Ridge 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 90 days.

    ii. It is the resident's responsibility to collect inventory within 90 days; and

    iii. After ninety 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

_____ _____
Referral Source Signature Date

Sage Ridge Benefits Program Eligibility Notice

As a participant in the program at Sage Ridge, 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 Sage Ridge living in the dorms. 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:

Sage Ridge: (Name) 28101 East Quincy Ave., Watkins, CO 80137

We will help make that change when you arrive.