COLORADO COALITION FOR THE HOMELESS

Referral to Fort Lyon Supportive Residential Community

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 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 Fort Lyon? Yes ☐ No ☐

Pickup location & Time: ☐ **9:15 AM**, 2130 Stout Street, Denver

☐ **11:15 AM**, 5 W. Las Vegas Street, CO Springs ☐ **11:45 AM** 509 E. 13th St. Pueblo

EMERGENCY CONTACT FOR CLIENT:

NAME _____PHONE:_____

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 __X__ To
Name: CCH Fort Lyon
Address:30999 County Road 15
City, State, Zip: Las Animas, CO
Phone Number: _____
Fax Number: _____
Email: fortlyonreferrals@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: _____

COLORADO
Bureau of Investigation
Department of Public Safety

BIOMETRIC IDENTIFICATION AND RECORDS UNIT | 690 Kipling Street, Suite 3000 | Denver, CO 80215 |
(303) 239-4208 | cdps.cbi.biru.dis@state.co.us | www.cbi.colorado.gov

Public Request for Criminal History Record Information

Please type or print clearly | Reply will be mailed in 3-5 business days

Please call (303) 239-4208 with any inquiries. Discrepancies must be reported within 30 days.

NAME TO BE CHECKED

Last Name: _____

First Name: _____ Middle Name: _____

Date of Birth (required): _____
MM/DD/YYYY

Gender (optional): ☐ Male ☐ Female ☐ Other: _____

Social Security Number: _____
###-##-####

SEND REPLY TO

Colorado Coalition for the Homeless - Fort Lyon
30999 County Road 15, LAS ANIMAS, CO. 81054
PH: (719) 662 - 1162
FAX: (719) 456 - 0109

PURPOSE FOR REQUEST

☐ **Public Request/General Inquiry**

PLEASE READ AND SIGN BELOW

The record you may receive is for lawful use only and summarizes information sent to the Colorado Bureau of Investigation from fingerprint contributors in the state of Colorado. Unless fingerprints accompany your inquiry, the Colorado Bureau of Investigation cannot guarantee this record relates to the person in whom you have an interest. If the disposition is not shown, or further explanation of an arrest charge or disposition is desired, that information may be obtained from the agency who furnished the arrest information. Only the court of jurisdiction or the respective District Attorney's office wherein the final disposition occurred can provide an official copy to any specific disposition. State law governs access to sealed records. Because additions and deletions to a criminal history record may be made at any given time, a new inquiry should be requested when needed for subsequent use. Any report received from the Colorado Bureau of Investigation as the result of this inquiry shall not be used for the direct solicitation of business for pecuniary (monetary) gain.

X _____

Signature of Requesting Party (required per State law)

History of Homelessness

Please describe the client's current living 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: _____

Fort Lyon Residential Community

SELF ASSESSMENT QUESTIONNAIRE

Patient Name:
Date of Birth:
Today's Date:

Please complete this form in its entirety.

Presenting Problem

1. Please describe what brings you in today?
2. How long have you been experiencing this problem?
3. Rate the intensity of this problem (1 being mild and 5 being most severe)
4. How is the problem interfering with your daily functioning?
5. What are your current goals for therapy / treatment?

6. If treatment was successful, how would your life be different?

Current Symptoms

7. Are you currently experiencing any of the following symptoms now or in the last 30 days? (Please check all that apply)

☐ *Angry / Irritable*	☐ *Have Special Powers*	☐ *Reoccurring Nightmares*	☐
☐ *Anxiety*	☐ *Hearing Things*	☐ *Sadness*	☐
☐ *Avoidance*	☐ *Helpless*	☐ *Seeinig Things*	☐
☐ *Can't Be in Crowds*	☐ *Hopeless*	☐ *Self-Esteem Problems*	☐
☐ *Can't Concentrate*	☐ *Impulsive*	☐ *Self-Harm*	☐
☐ *Depression*	☐ *No Motivation*	☐ *Sleep Changes*	☐
☐ *Easily Startled*	☐ *Not Hungry*	☐ *Sleep Too Little*	☐
☐ *Fatigue / No Energy*	☐ *No Need for Sleep*	☐ *Sleep Too Much*	☐
☐ *Feeling Nervous*	☐ *Panic Attacks*	☐ *Stress*	☐
☐ *Feeling Worthless*	☐ *People Out to Get Me*	☐ *Substance Use*	☐
☐ *Fearful*	☐ *People Watching Me*	☐ *Suicidal Thoughts*	☐
☐ *Food or Eating Changes*	☐ *Poor Memory*	☐ *Suspicious*	☐
☐ *Grief and Loss*	☐ *Prefer Being Alone*	☐ *Talk Too Fast*	☐
☐ *Guilt*	☐ *Relationship Problems*	☐ *Thoughts of Dying*	☐
☐ *Lack of Interest*	☐ *Restless*	☐ *Too Much*	☐

8. Do you now or have you ever contemplated committing suicide? ..... ☐ *Yes* ☐ *No* ☐ *N/A*
9. Are you a survivor of trauma? ..... ☐ *Yes* ☐ *No* ☐ *N/A*

10. Are you pregnant now? ☐ *Yes* ☐ *No* ☐ *N/A*

11. If yes, when are you expecting?

12. Are you at risk for HIV/AIDS/Sexually Transmitted Diseases? (Unsafe Sex / Using Needles?) ☐ *Yes* ☐ *No* ☐ *N/A*

13. Please list all of your allergies to foods or medications

14. Has your physical health prevented you from participating in activities? ☐ *Yes* ☐ *No* ☐ *N/A*

Substance Use

15. Have you ever used any form of tobacco, such as cigaretttes, snuff, chewing tobacco, etc.) ☐ *Yes* ☐ *No* ☐ *N/A*

16. Are you a former tobacco user? ☐ *Yes* ☐ *No* ☐ *N/A*

If yes, what form(s) of tobacco have you used in the past? (Please check all that apply)

☐ *Cigarettes* ☐ *Pipes* ☐ *Cigars* ☐ *Chewing Tobacco*
☐ *Snuff* ☐ *Other*

17. Have you been in a program to help you quit using tobacco in the last 30 days? ☐ *Yes* ☐ *No* ☐ *N/A*

Substance Use / Addiction Present

18. Would you or someone you know say you are having a problem with alcohol use / addiction? ☐ *Yes* ☐ *No* ☐ *N/A*

19. Would you or someone you know say you are having a problem with pills or illegal drugs? ☐ *Yes* ☐ *No* ☐ *N/A*

20. Would you or someone you know say you are having problems with other addictions, like gambling, pornography, or shopping? ☐ *Yes* ☐ *No* ☐ *N/A*

21. Have you ever been to a self-help group? ☐ *Yes* ☐ *No* ☐ *N/A*

Substance Use / Addiction Past

22. Would you or someone you know say you had a problem with alcohol use or addiction? ☐ *Yes* ☐ *No* ☐ *N/A*

23. Would you or someone you know say you had a problem with pills or illegal drugs? ☐ *Yes* ☐ *No* ☐ *N/A*

24. Would you or someone you know say you had problems with other addictions, like gambling, pornography, or shopping? ☐ *Yes* ☐ *No* ☐ *N/A*

25. Is there a history in your family of addiction ☐ *Yes* ☐ *No* ☐ *N/A*

26. If yes, please describe in more detail:

Personal, Family, and Relationships

27. Have you ever been arrested? ☐ *Yes* ☐ *No* ☐ *N/A*

28. If yes, did you serve time in prison or a corrections facility? ☐ *Yes* ☐ *No* ☐ *N/A*

29. Please list out your family members (parents, children, brothers, sisters, etc.)

30. Does anyone in your family have a history of mental health disorders? Please describe: ☐ *Yes* ☐ *No* ☐ *N/A*

31. Has a significant person or family member entered into your life or left your life in the last 90 days? ☐ *Yes* ☐ *No* ☐ *N/A*

32. How are the relationships with your family members? Please describe:

33. How are the relationships in your support circle (friends, extended family, etc.)? Please describe:

34. Have there been any problems with your family in the past (abuse, conflicts, stress, loss, etc.)? Please describe:

35. Are there any problems with your family now (abuse, conflicts, stress, loss, etc.)? Please describe:

36. Have there been any problems with your support circle in the past? Please describe:

37. Are there any problems with your support circle now? Please describe:

38. What is your marital status now? (Please check all that apply)

☐ *Single* ☐ *Married* ☐ *In a Relationship* ☐ *Widowed*
☐ *Divorced*

39. Have you ever had problems in your marriage or relationships? ☐ *Yes* ☐ *No* ☐ *N/A*

40. If yes, please check a reason why:

☐ *Abuse* ☐ *Conflict* ☐ *Loss* ☐ *Divorce/Seperated*
☐ *Trust Issues* ☐ *Infidelity/Cheating* ☐ *Other*

41. Do you have any close friends? ☐ *Yes* ☐ *No* ☐ *N/A*

42. Do you have problems being in friendships? ☐ *Yes* ☐ *No* ☐ *N/A*

43. Do you get along well with others (neighbors, co-workers, people around you, etc.)? ☐ *Yes* ☐ *No* ☐ *N/A*

44. What do you like to do for fun / in your spare time? Please explain:

Education

45. Please check the highest level you completed in school:

☐ *No Education* ☐ *K - 5th* ☐ *6th - 8th* ☐ *9th - 12th*
☐ *GED* ☐ *College Degree* ☐ *Masters Degree* ☐ *Advanced Degree*

46. Would you describe your schooling experience as a positive? ..... ☐ *Yes* ☐ *No* ☐ *N/A*
47. Are you currently in school or in a training program? ..... ☐ *Yes* ☐ *No* ☐ *N/A*

Work

48. What is your work history like?

☐ *Good* ☐ *Poor* ☐ *Sporadic* ☐ *Other*

49. How long do you usually stay in your job?

☐ *Weeks* ☐ *Months* ☐ *About a Year* ☐ *Longer than 1 year*

50. Are you retired from working? ..... ☐ *Yes* ☐ *No* ☐ *N/A*
51. If yes, what kind of work did you do before you retired?

52. Do you feel financially secure? ..... ☐ *Yes* ☐ *No* ☐ *N/A*
53. Have you ever served in the military? ..... ☐ *Yes* ☐ *No* ☐ *N/A*
54. If yes, what is your status?

☐ *Active* ☐ *Reserves* ☐ *Retired* ☐ *Other*

Medical

55. Who is your current Primary Care Physician? Phone Number:
56. Past Medical/Surgical Problems:

57. Are you experiencing any medical problems now? Please explain: ..... ☐ *Yes* ☐ *No* ☐ *N/A*

58. Past Medications and Dosages:

59. Are you taking any medications currently and what are the dosages for each? ..... ☐ *Yes* ☐ *No* ☐ *N/A*

60. Have you ever been to a mental health professional before? ..... ☐ *Yes* ☐ *No* ☐ *N/A*
61. If yes, Who: When: Reason for Changing:
62. Current APRN/Psychiatrist, if applicable:

63. Is there anything else you'd like to share with me?

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 Fort Lyon Residential Supportive Community and information provided above is correct.

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 (ideally done within 30 days of program entry)to 719-456-0109.

For more information, please call (719) 662-1162, or visit our website https://www.coloradocoalition.org/fortlyonreferral

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. These locations are over 100 miles away, and may only see patients 1-2 days per week, or even 1-2 days per 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 the Fort Lyon Health Center (on campus), 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 Referral Source'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 your 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 30 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

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. 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:

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

We will help make that change when you arrive.