***If you need assistance or have questions regarding your referral, please contact our Residential PEC Team at (716) 831-1800***

# PLEASE READ BEFORE COMPLETING APPLICATION

Thank you for your referral to the Terrace House Stabilization and/or Horizon Village Campus programs. **Please have a counselor or case manager complete the following application in its entirety**. Please also send with your application:

- HIPAA compliant release between your agency and Horizon Health Services
- Most recent bio-psych-social assessment within the past 6 months
- Completed medical examination
- Results of toxicology screenings, blood labs and PPD results
- LOCADTR
- Complete medication list

**Starting 3/1/25 we will **ONLY** accept and process referrals that:*

- *Include a **completed** "NEW" application (below). Old applications will no longer be accepted.*
- *Are emailed to our NEW referral email groupings (Please mark facility below and send to email):*

- *Terrace House Crisis Stabilization _____ Email: TerraceHouseReferrals@horizon-health.org*
- *Horizon Village Residential Campus _____ Email: HorizonCampusReferrals@horizon-health.org*

*If we receive an incomplete application, old application, or documents without a completed application, the referral we be marked incomplete and not reviewed.*

Referring Agency: _____

Patients Current Level of Care:_____

Person(s) to Contact: _____

Email: _____

Phone: _____ Fax:_____

Patient Name:_____

Social Security Number_____ DOB:_____

Birth Sex: _____ Identified Gender:_____ Preferred Pronouns:_____

Race:_____ Ethnicity:_____

Patient Address: _____

City: _____ State:_____ ZIP:_____

Phone:_____ Is this: Mobile Home/landline

Current or ever have CPS involvement? **YES** **NO**

Legal Marital Status: _____

Military Experience? _____ Branch:_____ Seen Combat? _____

First Responder? _____ If yes, what response type:_____

## Financial Information

**Your patient may unknowingly incur personal responsibility for out-of-pocket costs if this information is inaccurate.**

Primary Insurance Name: _____ Insurance ID:_____

Secondary Insurance Name: _____Insurance ID:_____

Does patient have **any** resources or assets such as, but not limited to, property ownership, bank accounts, income from wages, SSD/I, pension, 401k, alimony, child support, unemployment, marital income or settlements?

**YES** **NO**

If YES, please list source and value amount below:

_____

**Has the patient ever used any substances IV? YES NO**

## Substance Use History:

| Substance | Frequency | Amount | Route | Date of last Use |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Substance Use Treatment History: (Including hospitalizations and outpatient)

| Name of Program | Level of Care | Discharge Status | Dates Attended |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Mental Health Information: (Including hospitalizations and outpatient and any diagnoses)

| Name of Program | Level of Care | Discharge Status | Dates Attended |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Mental health diagnosis, symptoms or concerns:_____

_____

_____

History of lethality including prior attempts, past or present ideations, or self-injurious behavior:

_____

_____

_____

Any history or thoughts, plans or attempts to harm others?

_____

_____

_____

Important psychosocial and contextual factors for patients mental health history:

_____

_____

_____

Has the patient ever acted out violently or ever assaulted others?

_____

_____

_____

## Medical Information:

Please list any current physical health concerns, allergies, diagnoses, conditions and surgeries:

_____

_____

_____

Name of primary care physician:_____

History of seizures? YES NO Explain:_____

Is patient pregnant? YES NO Due Date:_____
OBGYN:_____

Is the patient postpartum in the past 12 months? YES NO Delivery Date:_____

## Current Medications: (Including Suboxone, Subutex, Methadone, Vivitrol etc.)

| Medication | Dosage | Frequency | Reason | Provider |
|---|---|---|---|---|
| | | | | |
| | | | | |
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| | | | | |

## Legal Information:

**Has the patient**

Accidentally or intentionally set fires? YES NO

Been charged or convicted of arson? YES NO

Been charged or convicted of a sexual offense? YES NO

Been placed on any state Sex Offender Registry? YES NO

If YES, please explain:

_____

_____

Does the patient have any current legal involvement, charges or concerns at this time?

_____

_____

**Is/does the patient**

Incarcerated? YES NO

On parole? YES NO
Officer_____

On probation? YES NO

Officer _____

Have any outstanding warrants? YES NO
Where_____

Mandated to our treatment program? YES NO

By Who_____

## Additional Information

Does the patient know of any other person currently attending Terrace House or any program on Horizon Village campus? YES NO

If YES, please explain relation:

_____

_____

What are the patient primary barriers to successful treatment?

_____

_____

_____

What are the patient primary motivations to participate in treatment?

_____

_____

_____

**I attest that all information contained in this application and referral is accurate to the best of my knowledge and understand any discrepancies or inaccurate answers can affect my placement and/or out of pocket cost within Horizon Village Inc programs.**

**Patient Signature: _____**

**Date: _____**
**(If patient is unable to sign, please confirm referral has been discussed and reviewed with them)**