LEGACY TREATMENT SERVICES
OARS (Opiate Addiction Recovery Support) Program

Who We Serve:

- Adults 18 years old and up
- Struggling with Opiate Use Disorder
- Currently homeless or at risk of homelessness

Referrals Methods:

- Referrals can be made to **Lindsay Dragon**, Program Director via
  - Phone at 609-267-5656 ext. 3346
  - Referral forms can be emailed to ldragon@legacytreatment.org

Purpose:
To establish a consumer friendly, comprehensive, and expedient admission's process into the OARS Program to provide case management and supportive housing services to individuals with an opiate use disorder.

Policy:
Consumers deemed appropriate for admission are admitted according to Legacy Treatment Services admission procedures.

Procedures:
Current Atlantic County residents who are currently struggling with opiate use and are currently homeless or at imminent risk of becoming homeless in the next 30 days or less. Consumers cannot be linked with other housing funding.

Process:
Consumers who are self-identified or have been identified as having an opiate use disorder can complete the Referral Form to then send via email/fax/phone to the Program Director. The information needed will include demographics, insurance information (if applicable), referral source, current frequency of substances use, current living situation, current treatment (if applicable), and special needs.

Outreaches will be made within 72 hours by the Recovery Specialist to follow up on the referral and connect with the consumer. The Recovery Specialist will confirm all the information is correct with the consumer and further assess the housing needs.

If the consumer connects with Legacy staff in person, staff will complete the Referral Form for the program with the consumer to assess the housing needs.

Staff will explain the parameters of the program to the consumer and answer any other questions.

The referral will then be provided to the Case Manager who will then review the information to contact the consumer scheduling an initial assessment within 24 hours of receiving the referral.

Legacy Treatment Services
Opiate Addiction Recovery Support (OARS) Referral Form

**** Please fax referral and collateral information to (609) 726-4033 to expedite referral process****

Section 1: Demographic Information

Date of Referral: ____

Consumer Name: ____

Phone and Type (cell/home etc): ________________________________

Street Address: ____

City, State, Zip: ____

Currently Homeless? (circle): YES NO

If No, at Risk of Losing Housing? (circle): YES NO

Birth Date: ____________________ Birth Sex: _____ Religion: _______________________ Race: ____________________ Hispanic Ethnicity: YES NO

Sexual Orientation: _________________ Does Gender Identity Differ from Birth Sex?: YES NO **If yes,** Elaborate: ____________________________

Marital Status (please select one): ( ) Married/Living as Married ( ) Widowed ( ) Divorced ( ) Separated ( ) Never Married ( ) Unknown

Social Security #: ____ **If no** SS#, Explain Why: ____

Current Smoker?: YES NO **If Yes**, How Many Cigarettes a Day?: ____

Primary Language: _______________________________________ Other Language:__________________________ Interpreter Needed? (circle): YES NO

Section 2: Employment/Education/Income Information

Employment Status (please select): ( ) Full Time ( ) Part Time ( ) Armed Services ( ) Unemployed ( ) Not in Labor Force ( )Unknown

Occupation: ____________________________________ Job Title: ____________________________ Days Worked in the Past 30 Days: _________________

Highest Grade Completed: _______________________ Education Type (degree, vocational, etc.)____

Annual Household Income: ______________________ #of Individuals in Household: _____________________ # of Individuals under 18: ____________

Principal Income (select all that apply):

( ) Disability Insurance/Workman's Comp	( ) Public Assistance	( ) Wages/Salary Income
( ) Family/Relative	( ) Social Security	( ) Other
( ) Pension	( ) Unemployment Benefits	( ) Unknown

Section 3: Referral Source Information

Is referral source a family member or friend: YES NO **If yes** (circle): FAMILY FRIEND

If No: Name of Referral Source/Agency: __________________________________ Name of Person Making Referral: ____________________________

Street Address of Referral Source: ____ City, State, Zip: __________________________________

Phone #: _____________________________ Fax #: ___________________________ Discharge Date (if applicable) ______________________

Section 4: Initial Contact Form

Have you previously received treatment at Legacy Treatment Services? (circle): YES NO **If Yes**, When/For What: ________________________________

Current Housing Problem:	Description of current housing, lack of housing, risk of housing loss and potential timeframe?

Any current thoughts to harm self or others (circle): YES NO **If yes,** provide further information: ____

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Are you currently receiving behavioral health/mental health treatment services anywhere else? (circle): YES NO

If yes, provide details:

Inpatient/Residential (circle): YES NO **If yes**, where: ______________________________

Partial Care/Partial Hospital YES NO **If yes**, where: ______________________________

Outpatient: YES NO **If yes**, where: ______________________________

Other YES NO **If yes**, where: ______________________________

Do you have any Medical Issues? (circle): YES NO **If yes**, describe: ______________________________

Are you currently taking any prescribed medications? (circle): YES NO **If yes,** do you need a refill? (circle): YES NO

If yes, current meds/dosage/prescriber: ______________________________

Do you have any past or current legal issues? YES NO Are you court mandated for treatment? YES NO

Do you have any special needs: (circle): YES NO

If yes, check all that apply: ( ) Assistive Listening Device(s) ( ) TDD/TTY Device ( ) Sign Language Interpreter ( ) Transportation ( ) Language Interpreter ( ) Other ______________________________

Substance Use History

Do you currently use Opiates? (circle): YES NO How long have you been using opiates?: ______________________________

When was the last time you used opiates?: ______________________________ How Frequently do you use opiates?: ______________________________

Are you currently in treatment for opioid use? (circle): YES NO **If yes**, where: ______________________________

If no, have you been in treatment in the past? (circle): YES NO **If yes,** where/when:______________________________

Are you currently receiving Medication Assisted Treatment (MAT) (circle): YES NO

If yes, are you taking:

Methadone (circle): YES NO **If yes**, who prescribes: ______________________________

Suboxone (circle): YES NO **If yes**, who prescribes: ______________________________

Vivitrol (circle) YES NO **If yes,** who prescribes: ______________________________

Section 5: Payer/Insurance Information:

Insurance Name: ______________________________ Can we verify your benefits? (circle): YES NO

Are you the policy subscriber? (circle): YES NO **If no,** policy subscriber & relationship______________________________

ID/Member #: ______________________________ Group Number: ______________________________

Phone Number: ______________________________

Do you have a secondary insurance policy (circle): YES NO **If yes,** Insurance Name: ______________________________

Are you the policy subscriber? (circle): YES NO **If no,** policy subscriber & relationship______________________________

ID/Member #: ______________________________ Group Number: ______________________________

Phone Number: ______________________________

Any Additional Comments: