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 idragon@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: ____________________________

______________________________________________________________________________________________________________________________

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

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: