*C*enter *for* *R*ehabilitation, *E*ducation, *A*dvocacy, *T*reatment *and* *E*mployment

*A University of **P**ersonalized **R**ecovery **O**riented **S**ervices*

1 Amy Kay Parkway
Kingston, New York 12401
(845) 331-1261 x 316 or 289

APPLICATION

To be eligible for admission to a PROS program, a person must be 18 years of age or older, have a designated mental health diagnosis and have a functional disability due to the severity and duration of mental illness.

Date ______________

Applicant Information:

Name:____

Address:____

Telephone Number:______________________________________

Date of Birth:____

Insurance Type: Medicaid______ Medicaid ID #________________
Non Medicaid____________

Please include the following required documents with this application:

_____Psychiatric Assessment
_____Psychosocial Assessment
_____Permission to Release/Obtain Information

Please include the following documents with this application, if possible
_____Health Assessment
_____Substance Abuse Assessment

ICD 10 CODES: Diagnoses (Please list Primary Mental Health Diagnosis first):

____

____

____

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Please describe the reason for referral to PROS / C.R.E.A.T.E.

____

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Revised 07/19

Please check the services for which the applicant is being referred:

*Psychiatric Rehabilitation ______
(Groups)

*Psychotherapy/Medication Management______

*On-Going Employment Supports _____
(For those already employed 10+hours weekly)

Please check areas of functional impairment due to the applicant's mental health condition.
____________Self Care (i.e. personal hygiene, diet, clothing, avoiding injuries, securing health care, complying with medical advice)

___________ Activities of Daily Living (i.e. maintaining a residence, using transportation, day to day self management, accessing community services, participating in community activities)

__________ Social Functioning (i.e. establishing and maintaining social relationships; interpersonal interactions with primary partner, children or other family members, friends, neighbors; social skills; compliance with social norms; appropriate use of leisure time)

__________ Task Performance (i.e. initiating, persisting in and/or completing tasks commonly found in work, home or educational settings)

__________ Cognitive Functioning (i.e. concentration, attention, information processing, decision making, planning, problem solving, organizing, critical thinking)

Other (please describe)____

PLEASE NOTE: A referral to PROS / C.R.E.A.T.E. must be signed by a Licensed Mental Health Practitioner, in accordance with Section 512.7 (c)(iv)(a) of 14 NYCRR Part 512.
I, the undersigned, am referring the above named individual to C.R.E.A.T.E.

____
Signature Date

____
Name Title

License Number____

Agency Affiliation____

Address____

Telephone_________________________FAX__________________________

Please mail applications to:
Attn: **PROS** Admissions Damian Cleary
Or Michael Balles, LMSW, Program Director
Gateway Community Industries
1 Amy Kay Parkway
Kingston, New York 12401
or FAX 845 331-2112

Revised 07/19