

**NYS Office of Addiction Services and Supports
Waiting List Applicant Data Report***

Provider Number _____

Program Number _____ (Page 1) [Placement]

Fill out for Placement							Placement Reason
Client ID (Do not use name or SS)	Sex	Birth Date (_ / _ / _ _ _ _)	Last 4 SSN	Last Name First 2 Letters	Required Information for Waiting List Placement	Transaction Date	
	<input type="checkbox"/> Male <input type="checkbox"/> Female X				Pregnant: <input type="checkbox"/> Y <input type="checkbox"/> N Injector: <input type="checkbox"/> Y <input type="checkbox"/> N MICA: <input type="checkbox"/> Y <input type="checkbox"/> N Zip Code of Residence: _____ County of Residence: _____	Placement: ____/____/____	<input type="checkbox"/> Insufficient certified capacity. Contacted OASAS RO and unable to refer to another program <input type="checkbox"/> Insufficient staffing (below regulatory requirement). Contacted OASAS RO and unable to refer to another program <input type="checkbox"/> Insufficient capacity. Temporary physical plant issue. Contacted OASAS RO and unable to refer to another program <input type="checkbox"/> Client currently in treatment at this level of care, but seeking more convenient treatment site <input type="checkbox"/> Client discharge pending (from another level of SUD care) <input type="checkbox"/> Client release pending (from a correctional facility) <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female X				Pregnant: <input type="checkbox"/> Y <input type="checkbox"/> N Injector: <input type="checkbox"/> Y <input type="checkbox"/> N MICA: <input type="checkbox"/> Y <input type="checkbox"/> N Zip Code of Residence: _____ County of Residence: _____	Placement: ____/____/____	<input type="checkbox"/> Insufficient certified capacity. Contacted OASAS RO and unable to refer to another program <input type="checkbox"/> Insufficient staffing (below regulatory requirement). Contacted OASAS RO and unable to refer to another program <input type="checkbox"/> Insufficient capacity. Temporary physical plant issue. Contacted OASAS RO and unable to refer to another program <input type="checkbox"/> Client currently in treatment at this level of care, but seeking more convenient treatment site <input type="checkbox"/> Client discharge pending (from another level of SUD care) <input type="checkbox"/> Client release pending (from a correctional facility) <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female X				Pregnant: <input type="checkbox"/> Y <input type="checkbox"/> N Injector: <input type="checkbox"/> Y <input type="checkbox"/> N MICA: <input type="checkbox"/> Y <input type="checkbox"/> N Zip Code of Residence: _____ County of Residence: _____	Placement: ____/____/____	<input type="checkbox"/> Insufficient certified capacity. Contacted OASAS RO and unable to refer to another program <input type="checkbox"/> Insufficient staffing (below regulatory requirement). Contacted OASAS RO and unable to refer to another program <input type="checkbox"/> Insufficient capacity. Temporary physical plant issue. Contacted OASAS RO and unable to refer to another program <input type="checkbox"/> Client currently in treatment at this level of care, but seeking more convenient treatment site <input type="checkbox"/> Client discharge pending (from another level of SUD care) <input type="checkbox"/> Client release pending (from a correctional facility) <input type="checkbox"/> Other: _____

*Please Note: Both placement and removal transactions for an applicant may be entered online at the same time.

**NYS Office of Addiction Services and Supports Waiting
List Applicant Data Report***

Provider Number _____

Program Number _____ (Page 2) [REMOVAL]

Fill out for Removal						Removal Reason
Client ID (Do not use name or SS)	Sex	Birth Date (_/_/____)	Last 4 SSN	Last Name First 2 Letters	Transaction Date	
	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female X				Removal ____/____/____	<input type="checkbox"/> Admitted to another program within provider <input type="checkbox"/> Admitted to another SUD* treatment program (in another provider) <input type="checkbox"/> Admitted to another type of program (a non-SUD program) Referred <input type="checkbox"/> to another SUD Program <input type="checkbox"/> Refused treatment <input type="checkbox"/> Relocated out of area <input type="checkbox"/> Incarcerated <input type="checkbox"/> Lost to contact <input type="checkbox"/> Death <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female X				Removal ____/____/____	<input type="checkbox"/> Admitted to another program within provider <input type="checkbox"/> Admitted to another SUD program (in another provider) <input type="checkbox"/> Admitted to another type of program (a non-SUD program) <input type="checkbox"/> Referred to another SUD Program <input type="checkbox"/> Refused treatment <input type="checkbox"/> Relocated out of area <input type="checkbox"/> Incarcerated <input type="checkbox"/> Lost to contact <input type="checkbox"/> Death <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female X				Removal ____/____/____	<input type="checkbox"/> Admitted to another program within provider <input type="checkbox"/> Admitted to another SUD program (in another provider) <input type="checkbox"/> Admitted to another type of program (a non-SUD program) <input type="checkbox"/> Referred to another SUD Program <input type="checkbox"/> Refused treatment <input type="checkbox"/> Relocated out of area <input type="checkbox"/> Incarcerated <input type="checkbox"/> Lost to contact <input type="checkbox"/> Death <input type="checkbox"/> Other: _____

*SUD=Substance use disorder

**Please Note: Both placement and removal transactions for an applicant may be entered online at the same time.