



Organization Name:	Program Name:	
Individual's Name (First / MI / Last):	Record #:	DOB:

By signing this form, I am expressing my desire to be admitted to PROS. I have talked with PROS staff about available services and how PROS may be able to help me achieve my goals.

I am aware that I may change my mind at any time about which goals I wish to work on and which components and services I would like to attend.

I understand that enrollment in another program may impact my eligibility in PROS. I understand that the New York State Office of Mental Health may share my basic registration information with other providers in order to avoid co-enrollment.

[Admission to the PROS program does not affect Intensive Case Management (ICM); Supportive Case Management (SCM); Blended Case Management (BCM); or residential services.]

Component Abbreviations:

- CRS: Community Rehabilitation and Support
- IR: Intensive Rehabilitation
- ORS: Ongoing Rehabilitation and Support

Program Abbreviations:

- CDT: Continuing Day Treatment
- IPRT: Intensive Psychiatric Rehabilitation Treatment Program
- PMHP: Prepaid Mental Health Plan

At this time, I would like to participate in the following components:

Select one option	Component	Co-Enrollment Notes
<input type="checkbox"/>	CRS, IR/ ORS and Clinical Treatment	I will not receive CRS, IR/ ORS or Clinical Treatment from another PROS in the same time period. I will not receive services at a CDT, IPRT, PMHP or clinic.
<input type="checkbox"/>	CRS and IR/ ORS	I will not receive CRS and IR/ ORS from another PROS in the same time period. I will not receive services at a CDT or IPRT.
<input type="checkbox"/>	CRS and Clinical Treatment	I will not receive CRS or Clinical Treatment from another PROS in the same time period. I will not receive services at a CDT, IPRT, PMHP or clinic. I can receive IR/ ORS from another PROS.
<input type="checkbox"/>	CRS only	I will not receive CRS from another PROS in the same time period. I will not receive services at a CDT or IPRT. I can receive IR/ ORS from another PROS.
<input type="checkbox"/>	IR/ ORS only	I can receive CRS and Clinical Treatment from another PROS. I can attend a CDT or a clinic.

Individual Served:	Individual Served Signature:	Date:
Completed By - Print Staff Name/Credentials (Any Clinical Staff):	Staff Signature:	Date: