

COMMUNITY SERVICES NETWORK (CSN) & SUPPORTIVE HOUSING PROGRAM (SHP) REFERRAL PACKET

This packet is for RESIDENTIAL, SOCIAL, and VOCATIONAL referrals to both the DMHAS funded Community Services Network agencies and the Supportive Housing Program (SHP).

CSN OFFICE USE ONLY
DATE RECEIVED:
DATE COMPLETE:

CLIENT NAME: _____ REFERRAL SOURCE: _____

To what service(s) are you referring? Please check all that apply.

- | | | |
|--------------------------|-----------------------|---|
| <input type="checkbox"/> | Residential | Complete Sections A, B, and additional items below. |
| <input type="checkbox"/> | Social Rehabilitation | Complete Sections A, C, and additional items below. |
| <input type="checkbox"/> | Vocational | Complete Sections A, D, and additional items below. |

Additional Required Items for ALL Referrals (please check when complete):

- Your agency's Clinical Assessment form, or equivalent (see Instructions on pg. 5)
- Your agency's Release of Information form (or equivalent) made out to the Community Services Network
- A copy of most recent **physical exam** completed within the past year, including **PPD test results** (In order to receive services, exam and PPD results are required, however, application can be processed prior to receipt of these documents)

IF YOUR CLIENT IS HOMELESS, please complete the Supportive Housing Program Eligibility Screening Form. He or she may be eligible for SHP services. In order to receive SHP residential services, your client must have a co-occurring substance use disorder, but this is not a requirement for SHP vocational and social rehabilitation services. For more information, please contact Kyle Pedersen, SHP Director, at (203) 764-6331.

The SHP Eligibility Screening Form is located at the end of this referral packet.

Eligibility criteria for DMHAS funded services:

Please check boxes to indicate eligibility

- Client **must** be eighteen years or older and have a diagnosis of a major mental illness.
- Client **must** be a resident of Catchment Area 7 (**New Haven, Woodbridge, Bethany or Hamden**).
- Client **must** be receiving on-going clinical services.
- Client **must not** be DMR eligible. In the event that the client is currently receiving or is eligible for DMR Services, contact the Community Services Network (974-7082) prior to completing this referral.

Please Note: Individuals must receive entitlements (e.g., SAGA, T19, Social Security) to be eligible for certain services. Privately insured individuals may not be eligible for certain services.

Completion Instructions:

- This standardized packet should always be completed in collaboration with your client.
- Clinicians should ***always*** maintain a copy of the submitted referral in their client's files.
- You need to submit only a single copy of this form for referral to one or more services.
- **Send or deliver completed packets to Nancy Figueroa (974-7082) at the Connecticut Mental Health Center, Room 144, 34 Park St., New Haven, CT 06519, or fax to 974-7719.**
- **Please do not submit until packet is complete** (with the exception of physical exams and PPD results)
Incomplete or illegible referrals **cannot** be processed and will be returned to referring provider.

Once a completed referral is received, you will receive a faxed acknowledgement of your request for services for your client. If your client is eligible for services, you will subsequently be invited to present information about your client at the CSN screening meeting, which takes place on Wednesdays from 10am- 12pm at Connecticut Mental Health Center. In the event that you have not been contacted within 2 weeks of making your referral, it is important that you call 974-7082 to check on the status of the paperwork.

Referral Source:

(Please note: The outpatient clinician must be supportive of this referral and will be required to be available for consultation to all rehabilitation providers on an ongoing basis.)

Referred by: _____ Phone #: _____

FAX number: _____

Referring Agency (if applicable): _____

Primary **Outpatient** Clinician if different than above: Name: _____

Phone #: _____

Fax # _____

FOR FURTHER INFORMATION:

CSN Residential:	Shelly Carlson, RN	974-7865
Supportive Housing Program:	Kyle Pedersen, MAR	764-6331
Vocational:	Kyle Pedersen, MAR	764-6331
Social Rehabilitation:	Ann Joy, B.S.	974-7874
Executive Director:	Tom Styron, Ph.D.	974-7174
Associate Director:	Allison Ponce, Ph.D.	974-7075
Senior Administrative Assistant:	Nancy Figueroa	974-7082

SECTION A: REFERRAL & CLINICAL INFORMATION (Required for ALL referrals, all programs)

Demographic Information

Client Name: _____ Address: _____

Telephone: _____ Social Security # _____ Male Female

Age: _____ Date of Birth: _____ Marital Status: _____ # of Children: _____

Ethnicity: _____ Speak English? Yes No Primary Language: _____

Emergency Contact: _____
(Name) (Phone) (Relationship)

Is the client a veteran? Yes No

Diagnosis:

Axis I: _____ DSM IV Codes (Required): _____

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Axis I: _____ DSM IV Codes (Required): _____

Axis II: _____ DSM IV Codes (Required): _____

Axis II: _____ DSM IV Codes (Required): _____

Axis III: _____

Axis IV: _____

Axis V (GAF): _____

If substance use is identified above, has client used within past 6 months? Yes No

When under stress, this client may _____

The best way to respond is _____

Current risk behaviors in last 6 months (e.g., suicidality, homicidality, assaultive behavior, non-compliance)

Current Financial Situation

Income Sources: SAGA cash T-19 Salary SSI SSDI Other _____

Amount/month _____ T-19 number (if applicable) _____

Does client have a **Payee?** Yes No
Conservator? Yes No
Guardian? Yes No

If Yes, Name: _____ Phone: _____

Current Living Arrangement

- | | |
|---|---|
| <input type="checkbox"/> Private residence | <input type="checkbox"/> Correctional facility/jail |
| <input type="checkbox"/> Board and Care | <input type="checkbox"/> Institution/hospital |
| <input type="checkbox"/> Residential program (group home or apt) | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Homeless/shelter
(please complete SHP eligibility form) | <input type="checkbox"/> Other _____ |

Facility name (if applicable) and address of above: _____

Is client currently at risk of homelessness? Yes No (if yes, please fill out SHP eligibility form)

Does client have disability that requires accommodation (e.g., hearing impairment, use of wheelchair, etc.)
If yes, please describe: _____

Client's mode of transportation: Access to car Taxi Bus
 Bicycle Walk Other _____

Legal History: Yes No Unknown
(If yes, check below, and detail in clinical assessment information [see page 5]).

Please note, FULL disclosure is required. Disclosure is essential to provide appropriate services.

- | | | | |
|--------------------------------------|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Weapons | <input type="checkbox"/> Robbery | <input type="checkbox"/> Drug charges | <input type="checkbox"/> Arson |
| <input type="checkbox"/> Sex offense | <input type="checkbox"/> Misdemeanors | <input type="checkbox"/> Assault/homicide | <input type="checkbox"/> Other _____ |

Any current charges pending? Yes No

If yes to any of the above, please clarify (if necessary, please attach additional sheets):

Has client been incarcerated? Yes No

If Yes, when and where?

Current Probation/Parole? Yes No Officer Name _____ Phone _____

Has client experienced domestic violence? No Yes, as perpetrator Yes, as victim

Education:

Able to read/write: Not at all Poorly w/ Assistance Independently

Highest grade achieved: _____

Degrees or certificates awarded: GED high school diploma AA BA/BS other _____

History of special education: Yes No Qualifying condition _____

Has client received services from DMR? Yes No

Required Clinical Assessment Information

Please attach your agency's clinical assessment form or equivalent (e.g., for CMHC, use Clinical Assessment Data Form). Please be sure that the assessment or summary includes items outlined below. Attach additional sheets as necessary.

Use discretion in providing personal and/or family history and, **when appropriate, delete data deemed not relevant to this referral.**

Clinical information **must be current** (i.e., **completed or updated within the last 12 months**) and include:

- Current Medications, Dosage and Frequency.
- Name of Psychiatrist and contact information, if applicable.
- Client's current clinical status (e.g., including relevant information with regard to suicidal and/or homicidal ideation or behavior, symptoms, interpersonal relationships, independent living skills, strengths and weaknesses).
- Client's history of psychiatric illness and treatment (e.g., including relevant information with regard to history of suicidal and/or homicidal ideation or behavior, assaultive behavior, hospitalizations, psychosocial stressors, independent living skills, and strengths and weaknesses).
- Psychosocial History (e.g., including significant developmental issues and the nature of client's relationships with parents, siblings, significant others, children and peers, and the frequency of contact; residential history; vocational/work history; military service; history of victimization)
- Medical History and Information (including name of primary care physician and contact information; date of last physical exam; client's current physical condition and relevant medical problems, such as allergies, physical limitations, seizures, special medical needs, major illnesses, communicable diseases, accidents and operations, and date of most recent PPD or test for tuberculosis.)

- END OF SECTION A -

SECTION B: COMPLETE THIS SECTION FOR REFERRALS TO RESIDENTIAL PROGRAMS

NOTE: Client **must** be a resident of Catchment Area 7 (New Haven, Woodbridge, Bethany or Hamden) or returning to this area to qualify.

(To be completed by referring provider in collaboration with client.)

Client's town of origin: _____

If Yes, describe and note city where application is pending.

- Has client applied for Section 8 Housing? No Yes _____
- Has client applied for Public Housing? No Yes _____
- Has client applied for Shelter Plus Care Subsidy? No Yes _____
- Has client applied for other rental assistance? No Yes _____
- Any other housing or housing support services? No Yes _____

Has client ever been evicted from Section 8 or Public Housing? Yes No

Has client ever been denied access to Section 8 or Public Housing? Yes No

Is client currently in debt (rental, utility, credit card)? Yes No

Has client ever lived in a residential program? Yes No If Yes:

Placement(s)	Date(s)	Reason(s) for leaving
	from / / to / /	
	from / / to / /	
	from / / to / /	
	from / / to / /	

Briefly describe client's history of living arrangements, separate from programs above.

Known skill deficits/client needs (check all that apply):

- personal hygiene
- grocery shopping
- meal preparation
- household cleaning
- budgeting
- using public transportation
- accessing daily support
- safety awareness
- developing daily structure
- making social connections
- coping skills
- coordination of appointments

In what activities / supports is the client currently participating? (check all that apply)

<i>Type</i>	<i>Frequency</i>	<i>Type</i>	<i>Frequency</i>
<input type="checkbox"/> Mental Health Treatment	_____	<input type="checkbox"/> Addiction Treatment / 12 Step	_____
<input type="checkbox"/> Fellowship / Social Programs	_____	<input type="checkbox"/> Religion/Spiritual Practice	_____
<input type="checkbox"/> Employment	_____	<input type="checkbox"/> Vocational Program	_____
<input type="checkbox"/> Education	_____	<input type="checkbox"/> Family Supports / DCF	_____
<input type="checkbox"/> Peer and Family Contact	_____	<input type="checkbox"/> Legal / Probation	_____
<input type="checkbox"/> Nursing / Medical Supports	_____	<input type="checkbox"/> Other	_____

In what additional activities does the client plan to participate and according to what timetable?

In what ways, if any, is the client's current clinical treatment expected to change if accepted into a residential program?

Please identify any barriers that may prevent the client from following through with the referral process:

(To be completed by client using his/her own words.)

I am interested in a residential referral because...

(If Applicable) My experience in other residential programs has been...

Some of the problems I have had with housing or residential programs in the past are...

My ideal housing and living situation would be...

- END OF SECTION B -

**SECTION C: COMPLETE THIS SECTION FOR REFERRALS TO
SOCIAL REHABILITATION PROGRAMS**

(To be completed by referring provider in collaboration with client.)

Fellowship Place has a variety of programs and services. Services are chosen by the member. Many programs, classes, and groups are on site. Fellowship can also help you reach recovery goals using resources in the community, such as college, work, or spiritual interests. You will be working with a Fellowship Recovery Advisor to help you set up your Recovery Plan.

Please check off all in which you may be interested:

A. Structured Day

Career (work, school, training)

- Adult Education, Tutoring, GED, College
(please circle one of the above)
- Community Volunteering
- Computer Classes
- Work Training, Job Search Training
- Food Service Training
- Other _____

Expressive Arts

- Creative Writing
- Art
- Music
- Other _____

Health and Fitness

- Softball
- Fitness Center
- Yoga
- Vegetarian Cooking
- Pampering & Beauty
- Life Skills
- Health Education
- Help with Community
Resources (church, clubs, volunteering)
- Spirituality
- Other _____

Member Services

- Leadership/Member Government
- Member Services (food bags, member bank)
- Advocacy
- Peer Run Support Groups
- WRAP (Wellness Action Recovery Plan)
- Friends and Recovery
- Hispanic Peer Support (Spanish speaking members)
- Other _____

B. Daytime: Club House – Drop In Center

C. Evening: Social Program (dinner, recreation, special events)

D. Weekend: Social Program (lunch, recreation, groups)

E. Fellowship Inn: Social Program (for individuals who are homeless)

Fellowship Place invites members to volunteer their time. Training is provided. Listed below are some of the ways you can help. Please check off any in which you are interested.

Building Maintenance

Trips Assistant

Ground Maintenance

Special Events Help

Gardening

Food Bank

Member Reception Desk

Food Preparation

Member Newsletter

Dining Hall/meal
clean up

Member Services (bank, lost and found, food bags)

Mailings

Member Government

New Haven
Community Volunteer

Not interested at this time. Please check back with me.

Do you have any special skills or training that you would be willing to share with Fellowship Place?

Can we help you with any of the following (please check all that apply):

Feeling comfortable in a group

Managing emotions

Meeting people

Taking care of yourself

Following rules

Independent living

Interpersonal skills & relationships

Increasing motivation

Communication skills

Other _____

Improving concentration and focus

- END OF SECTION C -

SECTION D: COMPLETE THIS SECTION FOR REFERRALS TO VOCATIONAL PROGRAMS

(To be completed by client's primary clinical provider in collaboration with client.)

Potential Service Resources:

- ✓ Is the client a Veteran? Yes No If yes, client is not eligible for CSN vocational programs (but may be eligible for other CSN services; please call CSN office at 974-7082). S/he may be eligible to receive vocational services from the Veterans Affairs Medical Center.

- ✓ Is the client currently receiving, or has s/he received in the past, vocational supports from the Bureau of Rehabilitation Services (BRS). Yes No If yes, current past

Relevant Employment Information:

Please elaborate on the client's specific strengths and interests as they relate to employment:

Indicate how the client's illness has interfered with his/her ability to work (check all that apply):

- Difficulty in relationships w/ co-workers
- Neglects personal hygiene/personal appearance not appropriate
- Difficulty accepting authority or critical feedback
- Unable to organize time or manage multiple tasks
- Limited insight re: strengths/weaknesses and how these impact job match
- Fatigue due to medications limits hours client can work
- Lacks confidence in ability to work due to illness
- Difficulty initiating job search, e.g., preparing resume, attending interviews, etc.
- Other (describe): _____

Please provide details regarding work history:

Place of Employment	Approximate Dates
1)	
2)	
3)	
4)	

Please indicate other general barriers to employment (check all that apply):

- Difficulty with transportation Job preference not available Lack of childcare
- Limited education and/or marketable skills Fears re: loss of benefits Legal history
- Other (describe): _____

Client has expressed a particular interest in being employed at:

In regard to money management, would you recommend that the client receive paychecks directly?

(To be completed by the client using his/her own words.)

I am interested in work/vocational services because...

I have concerns about work/vocational services because...

A job-coach or consultant might be able to help me by...

(If Applicable) The most difficult part about my former jobs/vocational services was...

(If Applicable) The thing I liked best about my former jobs/vocational services was...

I think I am good at...

My ideal job would be...

...and this job is interesting to me because...

Does client have a Social Security card? Yes No

Does client have a photo ID? Yes No

I prefer to receive my vocational services from...

- Easter Seals Goodwill Industries
- Fellowship Place Career Development
- Workers Achieving Gainful Employment (WAGE)
- Marrakech Work Services
- APT Foundation (SHP only)

I do not want to receive vocational services from...

- Easter Seals Goodwill Industries
- Fellowship Place Career Development
- Workers Achieving Gainful Employment (WAGE)
- Marrakech Work Services
- APT Foundation (SHP only)

I have no preference in a vocational provider.

- END OF SECTION D -

SECTION E: SUPPORTIVE HOUSING PROGRAM ELIGIBILITY SCREENING FORM

STEP 1.

Please complete the Supportive Housing Program (SHP) Eligibility Checklists below.

CLIENT NAME: _____

1. TARGET POPULATION:

A. To be eligible for the Supportive Housing Program services, the client must be age 18 or older, reside in Catchment Area 7 (New Haven, Hamden, Bethany and Woodbridge).

18 or Older Yes No
Resides in Catchment Area 7 Yes No

B. To be eligible for the Supportive Housing Program services, the client must have a diagnosed

Serious Mental Illness Yes No (Soc., Voc.)
Substance Abuse Yes No (Soc., Voc.)
Co-occurring serious mental illness and substance abuse Yes No (Soc., Voc., Res.)

2. HOMELESSNESS CRITERIA:

All referrals must also meet the criteria of being currently homeless. Please check all that apply.

- Persons sleeping in places not meant for human habitation, such as cars, parks, sidewalks, and abandoned buildings.
- Persons sleeping in emergency shelters.
- Persons from **homeless transitional or supportive housing programs** who originally came from streets or emergency shelters.
- Persons who ordinarily sleep in one of the above places but are spending a short time (30 consecutive days or less) in a hospital or institution. Does not include any individual imprisoned or otherwise detained under an Act of the Congress or a State law.

STEP 2.

All clients referred to the Supportive Housing Program will need to be receiving clinical services.

For clients who are **not currently receiving clinical care**, a referral should be made to the Connecticut Mental Health Center (CMHC). Call 974-7300 to arrange for an assessment. The Outreach & Engagement worker or Acute Services of CMHC will conduct an assessment.

STEP 3.

Please complete the information requested below.

Please indicate the Supportive Housing component(s) requested (check all that apply):

- 1 Housing
- 2 Social Rehabilitation: Fellowship Inn (Morning Engagement)

After a 10-day orientation to the Inn, would client be interested in participating in Fellowship Place (Main Building)? Yes No

- 3 Vocational Rehabilitation

Race:

(check one box)

- 1 Asian/Pacific Islander
- 2 Black
- 3 Native American/Alaskan Native
- 4 White

Is the client Hispanic: Yes No

Gross Monthly Income:

(check most appropriate box)

- No Income
- \$1-\$250
- \$251-\$500
- \$501-\$1000
- \$1001-\$1500
- \$1501-\$2000
- \$2001+

Assistance Sources (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> 1 Supplemental Security Income | <input type="checkbox"/> 8 Employment Income |
| <input type="checkbox"/> 2 Social Security Disability Insurance (SSDI) | <input type="checkbox"/> 9 Unemployment Benefits |
| <input type="checkbox"/> 3 Social Security | <input type="checkbox"/> 10 No Financial Resources |
| <input type="checkbox"/> 4 SAGA | <input type="checkbox"/> 11 Medicare |
| <input type="checkbox"/> CASH <input type="checkbox"/> MEDICAL | <input type="checkbox"/> 12 Medicaid |
| <input type="checkbox"/> 5 Temp. Assistance for Needy Families (TANF) | <input type="checkbox"/> 13 Food Stamps |
| <input type="checkbox"/> 6 Child Support | <input type="checkbox"/> 14 Other (please specify) _____ |
| <input type="checkbox"/> 7 Veterans Benefits | |

Referral Source:

- | | |
|--|---|
| <input type="checkbox"/> 1 Self | <input type="checkbox"/> 8 Other Social Service Staff |
| <input type="checkbox"/> 2 Street Outreach Workers | <input type="checkbox"/> 9 Police |
| <input type="checkbox"/> 3 Emergency or Transitional Shelter Staff | <input type="checkbox"/> 10 Public Housing Waiting List |
| <input type="checkbox"/> 4 Psychiatric Hospital Staff | <input type="checkbox"/> 11 Church Staff |
| <input type="checkbox"/> 5 Other Hospital or Medical Clinic Staff | <input type="checkbox"/> 12 Other (specify) _____ |
| <input type="checkbox"/> 6 Mental Health Outpatient Clinic | <input type="checkbox"/> 13 Unknown |
| <input type="checkbox"/> 7 Alcohol or Other Drug Program | |

Date person became homeless (this episode):

_____/_____
Month Year

Date person first became homeless:

_____/_____
Month Year

Describe person's history of homelessness and housing instability:

Current Living Situation (check the one category that best describes the client's living situation):

- | | |
|---|--|
| <input type="checkbox"/> 1 Streets | <input type="checkbox"/> 7 Jail/Prison |
| <input type="checkbox"/> 2 Emergency Shelter | <input type="checkbox"/> 8 Domestic Violence Situation |
| <input type="checkbox"/> 3 Transitional Housing | <input type="checkbox"/> 9 Living with Relatives/Friends |
| <input type="checkbox"/> 4 Psychiatric Facility | <input type="checkbox"/> 10 Rental Housing |
| <input type="checkbox"/> 5 Substance Abuse Treatment Facility | <input type="checkbox"/> 11 Other (please specify) |
| <input type="checkbox"/> 6 Hospital | _____ |

If client resides at a shelter, please check which shelter below:

- | | |
|---|---|
| <input type="checkbox"/> 1 Christian Community Action | <input type="checkbox"/> 5 Life Haven |
| <input type="checkbox"/> 2 Columbus House | <input type="checkbox"/> 6 New Haven Home Recovery |
| <input type="checkbox"/> 3 Grant Street Partnership | <input type="checkbox"/> 7 Women in Crisis |
| <input type="checkbox"/> 4 Immanuel Baptist | <input type="checkbox"/> 8 Other shelter (please specify) |
| | _____ |

If client resides in transitional housing for the homeless, please identify below:

- | |
|---|
| <input type="checkbox"/> 1 Christian Community Action |
| <input type="checkbox"/> 2 Davenport House |
| <input type="checkbox"/> 3 Other (specify) |
| _____ |