



COMMUNITY SERVICES NETWORK REFERRAL PACKET Residential, Social, and Supported Employment Services

*** CSN Residential referrals are for individuals seeking transitional housing services only ***

For information on permanent housing options:

- **Greater New Haven Supportive Housing Services**
<http://nhregionalsupportivehousing.blogspot.com/>
- **Greater New Haven Housing Resource Guide:**
also includes information on emergency shelters, recovery houses, and subsidized housing
https://docs.google.com/file/d/0B7mVvcTz_jvDeXhuTEt3em9YS28/edit?pli=1

Completion Instructions: **Do not leave any sections blank** Please complete the entire packet as it is related to services requested. **Incomplete** and **illegible** forms are not accepted. Therefore, we recommend completing this writable pdf that can be printed to fax, mail, or drop off.

- ✓ Release of Information
- ✓ Name of clinician and contact information
- ✓ Clinical assessment
 - **Residential** referrals must include: recent clinical assessment with treatment plan, current medication list, psychosocial history, and current clinical status.
 - **All referrals** require current clinical information to receive services (i.e., completed or updated within last 12 months)
 - Attach additional sheets as necessary
- ✓ This 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
- ✓ Please submit a single copy of this form for referral to one or more services
- ✓ Use discretion in providing personal and/or family history when appropriate, delete data deemed not relevant to this referral

All CSN referrals expire one year from the date of submission.

Mail, fax, or drop off packets to:

Connecticut Mental Health Center
Attention: Jennifer Gambaccini
34 Park Street - Room 144
New Haven, CT 06519
Fax 203-974-7719

****Use the secure drop box when dropping off a packet ****

For questions, please contact:

Ann Joy – Coordinator Supported Employment, Socialization & Education 203-974-7874

Lauren Rusconi – CSN Housing Coordinator 203-974-7311

Jennifer Gambaccini – Data Coordinator/Senior Administrative Assistant 203-974-7082

Additional information can be found at <http://csnct.org>

CLIENT NAME _____ DATE _____

Service(s) check all that apply:

Residential Social Vocational Educational

Referral Source:

Referring Case Manager/Clinician: _____

Mailing Address: _____ Zip Code: _____

Primary Phone (required): _____ Fax (required): _____

Email: _____

Referring Agency: _____ If CMHC – Team: _____

Primary **Outpatient** clinician (if different than above):

Referring Case Manager/Clinician: _____

Mailing Address: _____

Primary Phone (required): _____ Fax (required): _____

Email: _____

Client Information:

First Name: _____ MI: _____ Last: _____

Date of Birth: _____ (mm/dd/yy) Age _____ Social Security # _____

Client identifies gender as: Female Male Trans* Other _____

Is Client a Veteran: Yes No

Primary Language _____

Education: GED HS Diploma College Other level of education _____

Client Contact Information:

Address: _____ Zip Code: _____

Primary Phone: _____ Email: _____

Race:

African American/Black Hawaiian/Pacific Islander
 Asian White
 Native Alaskan Other
 Native American/American Indian

Ethnicity/Hispanic:

Central American South American
 Mexican Non-Hispanic
 Puerto Rican
 Other _____

Please Indicate Housing Type at Time of Referral:

* Hospital (non-psychiatric)				
* Jail/prison or juvenile detention facility				
* Psychiatric hospital or other psychiatric facility				
* Substance abuse treatment facility or detox center				
Emergency shelter				
Permanent housing for formerly homeless persons				
Transitional housing for homeless persons				
Rental by client with no subsidy				
Owned by client with no subsidy				
Place not meant for habitation/streets/cars/parks/sidewalks				
Group Home				
Sober House				
Hotel/Motel				
Staying or living in a family member's room apartment or house		Permanent		Temporary
Staying or living in a friend's room apartment or house		Permanent		Temporary
Other (Please specify)				

Date address/housing became effective: _____ (mm/dd/yy)

*** If in hospital or other facility, please provide admission date**

Legal History

In order to best serve your client, it is important that we understand the details of his/her legal history. Please provide the information below.

Does client have a legal history: Yes No Any charges pending: Yes No

Was client ever incarcerated? Yes No

Legal Issues (all that apply):

Arson Assault Drug charges Homicide Misdemeanor

Robbery Sex Offense Weapons Other _____

Currently on Probation or Parole? (if yes, circle which) Yes No

Income/Financial

MONTHLY Cash Income Sources:

Earned Income	\$
Unemployment Income	\$
Supplemental Social Security (SSI)	\$
Social Security Disability Income (SSDI)	\$
Retirement Income from Social Security	\$
Private Disability Insurance	\$
Veteran's Pension	\$
Veteran's Disability Payment	\$
Temporary Assistance for Needy Families (TANF)	\$
SAGA Cash	\$
Worker's Compensation	\$
Pension from a former job	\$
Child Support	\$
Alimony or other Spousal Support	\$
State Supplement	\$
Other Client Income (do not include food stamps)	\$
No income	

Please specify any income benefit applications that are in process or denied, including dates applied:

Does client utilize money management assistance? Yes No

If yes, which: Payee Conservator Guardian CMHC Money Management

Health Insurance

Medicare Medicaid - please specify Husky A Husky C (Title 19) Husky D

Private Insurance VA/Champus No health coverage

Disability

Physical disability? Yes No

Accommodations needed: _____

Is the client deaf or hard of hearing? Yes No

Does the client require an ASL or deaf interpreter? (specify) _____

Clinical/Diagnoses

Please indicate, in detail, diagnoses and DSM-5 codes: (all fields below are required)

GAF Score: _____ Medical: _____

Psychosocial/enviromental: _____

Has client used substances in the past six months: Yes No

If yes, which substances: _____ Date of last use: _____

Current risk behaviors in the last six months (e.g. suicidality, homicidality, assaultive behavior)

Please do not leave blank - enter n/a if no risk behaviors

SECTION A: Residential Services

Is client currently homeless? Yes No If yes, date became homeless: (mm/dd/yy)

Client's town of origin:

Please describe, in detail, client's housing history and what **supports** the client needs from DMHAS funded services:

SECTION B: Social Rehabilitation Services

Fellowship Place provides you with an opportunity to meet people, to learn, and to have fun. We have a variety of programs and services designed with you in mind. You choose the programs you want to try. Please complete the following, so that we can assign to you a Recovery Advisor, who will assist you in choosing the activities you are interested in and in setting recovery goals.

Please check all programs of interest:

Advocacy: Opportunities for involvement in local and statewide initiatives.

Career Development: Activities include on-site volunteering, tutoring, GED preparation, computer classes, community volunteering and resume and other pre-vocational classes.

Expressive Arts: Activities include visual art groups, creative writing, music, dance and the ArtShip Collaborative.

Fellowship Inn: Services are available for individuals who are homeless**. Activities include help with basic needs, recovery groups, life skills and case management services.

**** Homelessness & Disability Verification forms are required to enroll at Fellowship Inn**

<http://csnct.org>

Health and Wellness: Activities include life skills trainings, cooking class, softball, health groups, smoking reduction/cessation, relaxation/stress management, recovery groups, spirituality groups, and substance abuse recovery groups.

Spanish Language programming: A variety of groups facilitated by bilingual staff are available. Please see the most current Program Calendar.

Social/Recreational: Activities include field trips, cultural events, community outings, Monday night socials, computer open lab, morning coffee and conversation, weekend drop-in, and meals.

Young Adult Services: Specialized programming and activities for individuals ages 18-25.

SECTION C: Vocational Services

What are the client's agency preferences?

APT Foundation

Marrakech Work Services

Easter Seals Goodwill Industries

No preference in a vocational provider

Fellowship Place Career Development

Career Resources / SAMHSA Grant

(eligibility requirements: serious mental illness and criminal justice background)

Relevant Employment Information:

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