



## COMMUNITY SERVICES NETWORK REFERRAL PACKET

### Residential, Social, and Supported Employment Services

**CSN Residential referrals are for individuals seeking transitional housing services only and should have a minimum income of \$735 per month.**

**Completion Instructions:** **DO NOT LEAVE SECTIONS BLANK** this includes Housing Type. 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. Please do not email referrals.

- ✓ **Release of Information** made out to the Community Services Network (CSN)
- ✓ **Name of clinician and/or Provider** contact information
- ✓ **Occupational Therapy Evaluation**-Requested for all individuals in an inpatient setting. This tool will assist in determining an appropriate level of care in our residential housing programs.
- ✓ **Clinical assessment** - All referrals
  - **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 the 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 DATE OF SUBMISSION.**

**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](https://docs.google.com/file/d/0B7mVvcTz_jvDeXhuTEt3em9YS28/edit?pli=1)

Mail, fax, or drop off packets to:

Connecticut Mental Health Center  
 Attention: Community Services Network  
 34 Park Street - Room 144  
 New Haven, CT 06519  
**Fax 203-974-7719**

For questions, please contact:

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

**Lauren Rusconi – CSN Housing Coordinator 203-974-7311**

**Suzan Henriquez-Whitted-Senior Administrative Assistant – 203-974-7082**

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

CLIENT NAME \_\_\_\_\_ MPI # \_\_\_\_\_  
(For all CMHC client referrals)

**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  Other - Please bespecific \_\_\_\_\_

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
- Asian
- Native Alaskan
- Native American/American Indian
- Hawaiian/Pacific Islander
- White
- Other \_\_\_\_\_

**Ethnicity/Hispanic:**

- Central American
- Mexican
- Puerto Rican
- Other (specify) \_\_\_\_\_
- South American
- Non-Hispanic

**Please Indicate Housing Type at Time of Referral:** (All referrals should include this)

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

**Income/Financial**

**MONTHLY Cash Income Sources: (do not include food stamps)**

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	\$
No income	<input type="checkbox"/>

**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 (check one of the following):     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, all DSM-5 codes and diagnoses:

**(All fields are DMHAS requirements and will not be processed if left blank)**

GAF Score: \_\_\_\_\_ Medical: \_\_\_\_\_

Psychosocial/environmental: \_\_\_\_\_

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: \_\_\_\_\_  Case management services

**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.
- 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.
- 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.
- Spanish Language programming:** A variety of groups facilitated by bilingual staff are available. Please see the most current Program Calendar.
- Young Adult Services:** Specialized programming and activities for individuals ages 18-25.

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- Fellowship Inn:** Services are available for individuals who are **homeless only.**\*\*\* 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.  
Forms can be found at <http://csnct.org>**

## SECTION C: Vocational Services

**What are the client's agency preferences?**

- |  |   |
|--|---|
| <input type="checkbox"/> APT Foundation                      | <input type="checkbox"/> Marrakech Work Services                |
| <input type="checkbox"/> Goodwill of Southern New England    | <input type="checkbox"/> No preference in a vocational provider |
| <input type="checkbox"/> Fellowship Place Career Development |   |

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- SAMHSA Grant  
(eligibility requirements: Criminal justice background and mental illness)**

**Relevant Employment Information:**

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