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 REFERALLS EXPIRE ONE YEAR FROM DATE OF SUBMISSION.**

For information on permanent housing options:

- **Greater New Haven Supportive Housing Services**
  
  [http://nhregionalsupportivehousing.blogspot.com/](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](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 be specific __________________________

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: ____________________________________________

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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 (specify) ____________________  

Please Indicate Housing Type at Time of Referral: (All referrals should include this)  
☐ * 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:  ☐ Probation  ☐ Parole  ☐
### Income/Financial

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

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned Income</td>
<td>$</td>
</tr>
<tr>
<td>Unemployment Income</td>
<td>$</td>
</tr>
<tr>
<td>Supplemental Social Security (SSI)</td>
<td>$</td>
</tr>
<tr>
<td>Social Security Disability Income (SSDI)</td>
<td>$</td>
</tr>
<tr>
<td>Retirement Income from Social Security</td>
<td>$</td>
</tr>
<tr>
<td>Private Disability Insurance</td>
<td>$</td>
</tr>
<tr>
<td>Veteran's Pension</td>
<td>$</td>
</tr>
<tr>
<td>Veteran's Disability Payment</td>
<td>$</td>
</tr>
<tr>
<td>Temporary Assistance for Needy Families (TANF)</td>
<td>$</td>
</tr>
<tr>
<td>SAGA Cash</td>
<td>$</td>
</tr>
<tr>
<td>Worker’s Compensation</td>
<td>$</td>
</tr>
<tr>
<td>Pension from a former job</td>
<td>$</td>
</tr>
<tr>
<td>Child Support</td>
<td>$</td>
</tr>
<tr>
<td>Alimony or other Spousal Support</td>
<td>$</td>
</tr>
<tr>
<td>State Supplement</td>
<td>$</td>
</tr>
<tr>
<td>Other Client Income</td>
<td>$</td>
</tr>
<tr>
<td>No income</td>
<td>$</td>
</tr>
</tbody>
</table>

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

[Blank space for specification]

**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) ____________________________

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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, assaulting 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:

__________________________________________________________  Case management 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?

- **APT Foundation**
- **Goodwill of Southern New England**
- **Fellowship Place Career Development**
- **Marrakech Work Services**
- **No preference in a vocational provider**

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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: