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)

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 # ______________________

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: ___________________________________________

Date Received (CSN use only): ____________________________
**Race:**
- African American/Black
- Hawaiian/Pacific Islander
- Asian
- Native Alaskan
- 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)

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

**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  

Version 9.19
**Income/Financial**

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

<table>
<thead>
<tr>
<th>Income 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]

**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, homicidally, 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:

□ Case management services

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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 Art Ship 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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Relevant Employment Information:

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