Reset Form

[redacted]/KE [redacted] _____ Please complete the entire packet as it is related to services requested. /[redacted] [redacted] [redacted] [redacted] Therefore, we recommen c ple in is i a le p f a can e p in e 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
Clinical assessment - All referrals
- o Z] • v š] o referrals must include assessment with treatment plan, current medication list, psychosocial history, and current clinical status.
- o oŒo (Œ Œ urrent clinical information to receive services (i.e., completed or updated [redacted])
- o Attach additional sheets as necessary

9 This packet should [redacted] be completed in collaboration with your client
9 Clinicians should [redacted] maintain a copy of the submitted referral in their client's files
9 Please submit a single copy of this form for referral to one or more services
9 Use discretion in providing personal and/or family history when appropriate, delete data deemed not relevant to this referral

[redacted]

x '[redacted]

x '[redacted]
also includes information on emergency shelters, recovery houses, and subsidized housing

Mail, fax, or drop off packets to:

Connecticut Mental Health Center
Attention: Jennifer Gambaccini[redacted]
34 Park Street - Room 144
New Haven, CT 06519

**Use the [redacted] when dropping off a packet **

[redacted]

[redacted]

FSTJPO[redacted] /[redacted]

Date Received (CSN use only):_____

CLIENT NAME _____ MPI # _____

(For 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 ☐ 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
- ☐ Asian
- ☐ Native Alaskan
- ☐ Native American/American Indian
- ☐ Hawaiian/Pacific Islander
- ☐ White
- ☐ Other _____

Ethnicity/Hispanic:

- ☐ Central American
- ☐ South American
- ☐ Mexican
- ☐ Non-Hispanic
- ☐ Puerto Rican
- ☐ Other (specify) _____

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: Probation ☐ Parole ☐

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 - check one Husky A ☐ Husky C (Title 19) ☐ Husky D ☐

Private Insurance ☐ VA/CHAMPUS ☐ No health coverage ☐

Disability

Physical disability? Yes ☐ No ☐

Accomodations needed:_____

Is the client deaf or hard of hearing? ☐ Yes ☐ No

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

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.

- ☐ **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

- ☐ **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: