Community Living Services
REFERRAL FORM

Referral For (Please Check One)		
◻ **Essex** 515 Valley Street Maplewood, NJ 07040 973-313-0976, 973-313-2479 (FAX)	◻ **Hunterdon** 200 Route 31 North, Suite 115 Flemington, New Jersey 08822 908-788-7580, 908-788-6760 (FAX)	◻ **Middlesex** Please refer to Monmouth contact information
◻ **Monmouth** 1215-1217 Main Street Asbury Park, NJ 07712 732-380-0390, 732-380-0391 (FAX)	◻ **Somerset** ESNJ-Admin Support 25 Kennedy Blvd., Suite 600 East Brunswick, NJ 08816 908-722-4300, 908-722-1134 (FAX)	◻ **Warren** 2083 Route 57 Washington, NJ 07882 908-689-6600,908-689-8241 (FAX)

Date: ______________________________ **Agency:** ____

Submitted by: ________________________ **Phone Number:** _________________________________

Referral For (Please Check One)			
◻ Residential	◻ PATH	◻ HUD	◻ Monmouth Supportive Services
◻ Intensive Case Management Services (ICMS)	◻ Family Care	◻ Supported Housing	◻ Other (Please specify: ____________________

Name of Person Being Referred: ____

Phone Number: _____________________________

Home Address:

____

____

Current Address – IF DIFFERENT FROM HOME ADDRESS:
(for hospital referrals, include unit and Social Worker)

____

____

Birth date: ____________________________

Social Security #: __________________________

Primary Language: _________________________

Marital Status: ____________________________

Race / Ethnicity: ________________________

Emergency Contact: _________________________

Phone Number: _____________________________

1. DSM IV DIAGNOSIS - CODE & DESCRIPTION

AXIS I: ____
AXIS II: ____
AXIS III: ____
AXIS IV: ____
AXIS V: GAF (Current) ____________

2. PSYCHIATRIC INSTITUTIONALIZATION (list 3 most recent, including current)

Name of Institution	Admission Date	Discharge Date

3. CURRENT MEDICATIONS:

Medication	Dose; Route; Frequency

4. HISTORY OF DRUG AND/OR ALCOHOL ABUSE (please give details):

LAST USE ____________________________________

5. HISTORY OF SUICIDAL IDEATION/PLANS/ATTEMPTS (please include dates and details):

6. HISTORY OF AGGRESSIVE AND/OR VIOLENT BEHAVIOR (please give details):

7. IS CONSUMER CURRENTLY ON KROL STATUS (found not guilty of criminal charges due to a mental illness)?

- ☐ **YES** If Yes, Please Explain: ____
- ☐ **NO**

8. PENDING LEGAL CHARGES

____

____

9. MEDICAL (if applicable):

Diagnosis: ____

Treating Physician: ____

(Name) (Address) (Phone)

Allergies: ____

10. REASON FOR REFERRAL:

____

____

____

11. RESOURCES (Please list amounts if known):

☐ SSI ___________	☐ AFDC _______________	☐ VA _______________
☐ SSD ___________	☐ Rent Asst: _____________	☐ Payee: _____________
☐ SSA ___________	☐ Gen. Asst: _____________	☐ Other: ______________

Medicare/Medicaid #: ______________________________ Private Insurance: _________________________________

12. WILL SPECIAL ACCOMODATIONS BE NEEDED TO COMPLETE THE ASSESSMENT PROCESS? No

If Yes, Explain: ____

FOR OFFICE USE ONLY

*Date Received:*___________________________________ *Staff Name:* _____________________________________

Date of 1st Contact w/Referring Party ________________ *Name of First Contact:* ___________________________

*Disposition:*____

____

____

***Check One**:*

- ☐ *Accepted*
- ☐ *Denied*
- ☐ *Pending*

Staff Signature: ____ *Date:* _______________________

EASTERSEALS NEW JERSEY
AUTHORIZATION FOR RELEASE OF INFORMATION FORM

I hereby authorize Easterseals New Jersey to (check one or both as it applies)
❑ disclose to
❑ request from

____
(Specify individual, agency, organization, and address)
The following information regarding (name of individual receiving services): ____

____
(Address)

____
(Date of birth) (Social Security Number)

for the purpose of ____

Dates of services ____

Information to be disclosed or requested: CHECK <u>AND INITIAL</u> **ONLY THOSE WHICH APPLY**

❑ ______Assessment	❑ ______Service agreement
❑ ______Behavior contract or plan	❑ ______Service plan
❑ ______Criminal history	❑ ______Social assessment
❑ ______Discharge summary	❑ ______Social security information
❑ ______Financial information/earnings	❑ ______Work adjustment training report
❑ ______Intake assessment	❑ ______Physical health assessment
❑ ______Interagency communication	❑ ______Prevocational evaluation report
❑ ______Psychiatric assessment	❑ ______Legal information
❑ ______Psychological assessment/testing	❑ ______Placement report

I understand that this may include (as applicable) information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus
(HIV) infection, behavioral health service/psychiatric care, and/or treatment for alcohol or drug abuse.

The information will be released in this format (**check** all that may apply): written verbal fax electronic other (specify)____________________________

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire within one year from the date of the signature, or on the following date, event, or condition, whichever is sooner:

____

I hereby release Easterseals New Jersey, its employees and officers from any legal responsibility or liability for disclosure of or receipt of the above information to the extent indicated and authorized.

I understand that Easterseals New Jersey may not condition services or payment on whether I sign this authorization.

I understand that there is a potential for information disclosed under the authorization to be subject to redisclosure by the recipient and no longer protected.

Signature: ____
(Individual receiving services) (Date)

____
(Or legal representative) (Relationship to individual served) (Date)

____
(Signature of witness for Easterseals) (Date)