Community Living Services Referral Form

Referral For (Please check appropriate boxes)		
☐ **ESSEX** 515 Valley Street, Suite 180 Maplewood, NJ 07040 973-313-0976, 973-313-2479 (FAX) ☐ **Residential** ☐ **Supportive Housing** ☐ **HUD**	☐ **HUNTERDON** 908-788-7580, 908-788-6760 (FAX) ☐ **Residential*** ☐ **Supportive Housing*** ☐ **ICMS**** **Res & SH refer to Essex contact info* ***ICMS refer to Warren contact info*	☐ **MIDDLESEX** Please refer to Monmouth contact information ☐ **Residential**
☐ **MONMOUTH** 1215-1217 Main Street Asbury Park, NJ 07712 732-380-0390, 732-380-0391 (FAX) ☐ **Residential** ☐ **Supportive Housing** ☐ **Behavioral Health Homes**	☐ **SOMERSET** 908-722-4300, 908-722-1134 (FAX) ☐ **Residential*** ☐ **Supportive Housing*** ☐ **ICMS**** **Res & SH refer to Essex contact info* ***ICMS refer to Warren contact info*	☐ **WARREN** 2083 Route 57 Washington, NJ 07882 908-689-6600, 908-689-8241 (FAX) ☐ **Residential** ☐ **HUD** ☐ **Supportive Housing** ☐ **ICMS**

Date: _____ **Agency:** _____
Submitted by: _____ **Phone Number:** _____
Name of Person Being Referred: _____
Phone Number: _____ **Current Address – IF DIFFERENT FROM HOME ADDRESS: (for hospital referrals, include unit and Social Worker)**
Home Address: _____
_____ _____
_____ _____
Birth date: _____ **Primary Language:** _____
Social Security #: _____ **Marital Status:** _____
Race/Ethnicity: _____ **Emergency Contact:** _____
Gender: _____ **Phone Number:** _____

1. **DSM-V Diagnosis – Code & Description**

2. **Psychiatric Institutionalization (list 3 most recent, including current)**

Name of Institution	Admission Date	Discharge Date

3. **Current Medications:**

Medication	Dose; Route; Frequency

-**DISCLAIMER**-**The submission of this packet does not guarantee an interview.**

4. **History of drug and/or alcohol abuse (Please give details including 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)? ☐ NO**
   ☐ YES If Yes, Please explain: _____

8. **Pending legal charges:**

9. **Medical (if applicable):**
   Diagnosis: _____
   Treating Physician: _____
   (Name) (Address) (Phone)
   Allergies: _____
   Smoker: ☐ N ☐ Y If Yes, # of years _____

10. **Reason for Referral:**

11. **Resources (Please list amounts if known):**

☐ SSI _____	**☐ AFDC** _____	**☐ VA** _____
☐ SSD _____	**☐ Rent Asst** _____	**☐ Payee** _____
☐ SSA _____	**☐ Gen Asst** _____	**☐ Other** _____
☐ MLTSS _____	**☐ MCO** _____	

Medicare/Medicaid #: _____ **Private Insurance:**_____

12. **Will special accommodations be needed to complete the assessment process? ☐ No**
    ☐ Yes If yes, please explain: _____

FOR OFFICE USE ONLY

Date Received: _____ Staff Name: _____
Date of 1st contact w/referring party: _____ Name of 1st contact: _____
Disposition: _____
_____
_____

13. **Check One:**

☐ Accepted ☐ Denied ☐ Pending

Staff Signature: _____ Date: _____