

REFERRAL FORM

Has applicant been referred to the Steuben County SPOE? Yes No

Is applicant currently enrolled in Steuben County SPOE? Yes No

Name _____ Date _____

Address _____ County of Origin _____

Phone _____ Gender ___ Male ___ Female

Date of Birth _____ Ethnicity _____

Social Security #: _____ Veteran ___ YES ___ NO

Marital Status S Sep M D W Number of Dependents _____

Emergency Contact _____ Address/Phone _____

Referral Source Contact/ phone: _____

Is this person homeless: _____ Please list all incidents of homelessness in the last 4 years:

SCAP offers a continuum of residential services for individuals recovering from severe and persistent mental illness. We offer several levels of care, with varying levels of staff supervision.

Please check the level of care most appropriate for the applicant:

_____ The Community Residence program: a 24-hour supervised residential setting.

_____ The RITE program: an apartment setting with daily or weekly staff contact.

_____ Supported Living: an Independent apartment setting with limited financial assistance and staff support.

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Number of psychiatric hospitalizations _____ Date of last admit/discharge _____

Current Mental Health Services: _____

Therapist _____

Case Manager _____

ICM _____

Continuing Day Treatment Program _____

Current Substance Abuse Services: _____

Counselor/Phone number _____

Current Prescribed Medications:

Physical/Medical Limitations:

Allergies:

Behavioral History:

	Yes	No
Suicide Attempt(s)	_____	_____
Self abuse/injury	_____	_____
Physically assaultive	_____	_____
Sexually assaultive	_____	_____
Attempted homicide	_____	_____
Pyromania	_____	_____
Destruction of property	_____	_____
Criminal arrests	_____	_____
Substance abuse	_____	_____

If yes, please explain: _____

Financial Information:

SSI: _____ Yes _____ No Amount: _____
 SSD: _____ Yes _____ No Amount: _____
 DSS: _____ Yes _____ No Amount: COUNTY: _____
 Medicaid Number: _____ Is Medicaid Managed Care? _____
 If yes, name/address/phone# of primary physician: _____

Medicare Number: _____
 Representative Payee (If other than self) _____
 Address : _____ Phone #: _____

Legal History:

Has the applicant ever been arrested/convicted _____ yes _____ no
 If yes, please explain _____
 Is the application currently on probation/parole _____ yes _____ no
 Name of probation/parole officer: _____
 Is the applicant involved with a drug court? _____ yes _____ no
 If yes, name/address/phone _____
 Is the applicant mandated to treatment? _____ yes _____ no
 Are there any current charges pending? _____ yes _____ no
 Has the applicant ever been charged or
 Convicted of a sexual offense? _____ yes _____ no
 Is the applicant subject to a current order of protection? _____ yes _____ no

Please attach a copy of the applicant's current legal status if applicable.

Does the applicant meet the criteria for a Severe and Persistent Mental Illness? Yes _____ No _____

IN ORDER TO PROCESS THIS APPLICATION, A COPY OF THE APPLICANT'S BIOPSYCHOSOCIAL AND PHYSICAL HISTORY FROM WITHIN THE LAST 6 MONTHS MUST BE ATTACHED

Completed by: _____ Date: _____