



**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:**

\_\_\_\_\_

Arbor Development 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 of a crime? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Is the application currently on probation/parole? Yes \_\_\_\_\_ No \_\_\_\_\_

If applicable, 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**

Name/Title/Organization of Person Completing Form: \_\_\_\_\_

Date: \_\_\_\_\_