

REFERRAL FORM

Has applicant been referred to the SPOE Committee for services? Yes No

If yes, which county: _____

Name _____ Date _____

Address _____ County of Origin _____

Phone _____ Gender Male Female

Date of Birth _____ Ethnicity _____

Social Security #: _____

Has this person served in any Branch of the Military? YES NO

Marital Status S Sep M D W Number of Dependents _____

Emergency Contact _____ Address/Phone _____

Referral Source Contact/ phone: _____

Is this person homeless: Yes No Starting date: _____ End Date: _____

If you have checked yes where did they sleep last night? _____

Please List all previous incidents of homelessness in the last four years and verify with dates:

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:

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: _____
Third Party Insurance (include policy 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: _____