Arbor
HOUSING AND DEVELOPMENT

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www.ArborDevelopment.org

REFERRAL FORM

Date: _____ County of Origin _____

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

If yes, which county: _____

Referral Source Contact _____ Phone: _____

Name _____ Gender ☐ Male ☐ Female

Address _____ Phone _____

Date of Birth _____ Social Security # _____

Ethnicity _____

Physical/Medical Limitations _____

Allergies _____

Has this person served in any Branch of the Military? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed # of Dependents _____

Emergency Contact _____ Relationship _____

Address _____ 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 Housing and Development offers a continuum of residential services for individuals recovering from a 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

☐ Supportive Living: an independent apartment setting with limited financial assistance and staff support

Primary Mental Health Diagnosis _____

Additional Diagnosis _____

# of psychiatric hospitalizations w/in the past year _____ Last admit/discharge _____

Mental Health Services _____

Therapist _____ Phone _____

Care Manager _____ Phone _____

Substance Abuse Services _____

Counselor Name _____ Phone _____

Behavioral History: If yes, please explain:

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

Financial Information:

SSI ☐ Yes ☐ No Amount _____

SSD ☐ Yes ☐ No Amount _____

Food Stamps ☐ Yes ☐ No Amount _____ Food Stamps County _____

DSS ☐ Yes ☐ No Amount _____ DSS County _____

Name of worker _____

Address of worker: _____ Phone _____

Medicaid Number _____ 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 _____

Has the applicant ever been arrested/convicted for the manufacturing of Methamphetamine? ☐ Yes ☐ No

If yes, please explain _____

Is the applicant currently on probation? ☐ Yes ☐ No

Name of probation officer _____ Phone _____

Is the applicant currently on parole? ☐ Yes ☐ No

Name of parole officer _____ Phone _____

Is the applicant involved with a drug court? ☐ Yes ☐ No

Name/location _____ Phone _____

Is the applicant mandated to treatment? ☐ Yes ☐ No

Are there any current charges pending? ☐ Yes ☐ No

If yes, please explain _____

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 history if applicable**.

Does the Client Meet the Criteria for 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: _____

CRITERIA FOR SEVERE AND PERSISTENT MENTAL ILLNESS AMONG ADULTS 595.4

Client Name:_____ SS#:_____

To be considered an adult diagnosed with severe and persistent mental illness A must be met. In addition, B or C or D must be met. Please check all criteria which pertain to your client.

_____A. DESIGNATED MENTAL ILLNESS DIAGNOSIS

The individual is 18 years of age or older and currently meets the criteria for an **ICD 10**- psychiatric diagnosis **other than alcohol or drug disorder. (291.xx, 292.xx, 303.xx, 305.xx), organix brain syndromes (290.xx, 293.xx, 294.xx), developmental disabilities (299.xx, 315.xx, 319.xx) or social conditions (Vxx.xx).**

_____B. SSI or SSDI ENROLLMENT/ELIGIBILITY DUE TO MENTAL ILLNESS

The individual is currently enrolled, or has applied, in SSI or SSDI due to a designated mental illness.

_____C. EXTENDED IMPAIRMENT IN FUNCTIONING DUE TO MENTAL ILLNESS

The individual must meet 1 or 2 below:

_____**1.** The individual has experiences two (2) of the following four functional limitations due to a designated mental illness over the past 12 months on a continuous or intermittent basis.

_____**A.** Marked difficulty in self-care (personal hygiene, diet, and clothing, avoiding injuries, securing health care or complying with medical advice).

_____**B.** Marked restriction of activities of daily living (maintaining a residence, using transportation, day-to-day money management, accessing community services).

_____**C.** Marked difficulties in maintaining social functioning (establishing and maintaining social relationships, interpersonal interactions with primary partner, children, other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).

_____**D.** Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings; individuals may exhibit limitation in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in completion of tasks).

_____**2.** The individual has met criteria for ratings of 50 or less on the Global Assessment of Functioning Scale (Axis V of the ICD-10) due to designated mental illness over the past twelve month on a continuous or intermittent basis.

_____D. RELIANCE ON PSYCHIATRIC TREATMENT, REHABILITATION, AND SUPPORTS

A documented history shows that the individual, at some prior time, met the threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder, e.g., hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings which may greatly reduce the demands placed on the individual and, thereby, minimize overt symptoms and signs of the underlying mental disorder.

COMPLETED BY:_____ **DATE:**_____