Arbor
HOUSING AND DEVELOPMENT

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www.ArborDevelopment.org

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:
_____
_____

Does the applicant meet the criteria for a Severe and Persistent Mental Illness? Yes_____ No _____
If YES, signed form must be attached.
If NO, STOP, individual does not qualify for our programs.

Arbor Housing and 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: **After 10-1-15 only ICD 10 Diagnostic Information will be accepted.**
Primary Mental Health Diagnosis:_____
Additional Diagnosis: _____
Additional Diagnosis: _____
Additional Diagnosis_____
Additional Diagnosis: _____
Number of psychiatric hospitalizations _____ Date of last admit/discharge _____
Current Mental Health Services: _____
Therapist _____
Case Manager _____
ICM _____
Current Care Manager _____
Continuing Day Treatment Program _____
Current Substance Abuse Services: _____
Counselor/Phone number _____
Current Prescribed Medications: _____
Physical/MedicalLimitations:_____
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: _____
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 _____
Has the applicant ever been arrested/convicted for the sale of Methamphetamine? _____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 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:**_____