Overview of Easterseals Community Living Service (CLS) Programs

- **Behavioral Health Home** (BHH): Care coordination program linking Monmouth County residents with active Medicaid, and diagnosed with a mental illness, to appropriate medical and Psychiatric providers.

- **Integrated Case Management Services** (ICMS): Case Management services providing linkages for individuals diagnosed with mental illness to community resources and entitlements in their respective communities.

- **Residential** (RES): Supervised, shared, residential homes for individuals with a chronic mental illness. Designed to maximize an individual's potential by providing a structured, supportive environment where participants can take control of their own personal wellbeing, learning the skills to live independently. Services include daily staff supervision with medication monitoring:

  - Level A+: 24 hours, 7 days a week, supervised residences. Allocated to State Hospital Assignments.
  - Level A: 12 hour supervised residences open to community referrals.
  - Level B: 4 hour supervised residences open to community referrals.

- **Supportive Housing** (SH): Case Management services, delivered in the community, to individuals diagnosed with mental illness. Service goals are focused on mental health stability, employment, education, housing, and community involvement. Services are provided to individuals, with and without housing subsidies, to help avoid hospitalization, or higher level of care, through enhancing and improving budgeting skills, coping mechanisms, employment training, educational resources and socialization opportunities.

  - Housing voucher subsidies, for unsupervised apartments, may or may not be provided.

Easterseals New Jersey
Community Living Services Referral Form
TO BE COMPLETED FOR ALL PROGRAMS

FAX ALL REFERRALS TO 908-852-2255
OR EMAIL dsmith@nj.easterseals.com

Date: ____________________ **Agency:** ____

Submitted by: ____ **Phone Number:** ______________________

Referral Agency Email Address: ____

Name of Person Being Referred: ____

Home Address: ____

Current Address – IF DIFFERENT FROM HOME ADDRESS: (For hospital referrals, include unit and Social Worker)

Phone Number: ________________________ **Birth Date:** ________________________ **Marital Status:** ________________

Email Address: ____ **Primary Language:** ___________________

Race/Ethnicity: _________________________________ **Gender:** ____________________

Emergency Contact: ____ **Phone:** ___________________________

1. **Please check services below:**

County	Program
Essex	☐ Residential ☐ Supportive Housing
Hunterdon	☐ Residential ☐ ICMS ☐ Supportive Housing
Middlesex	☐ Residential
Monmouth	☐ BHH ☐ Residential ☐ Supportive Housing
Somerset	☐ Residential ☐ ICMS ☐ Supportive Housing
Warren	☐ Residential ☐ ICMS ☐ Supportive Housing

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2. CHRONIC PERSISTENT MENTAL HEALTH PSYCHIATRIC DIAGNOSES

DSM/ICD 10 CODE: _______________ **DIAGNOSIS:** _______________________________________

DSM/ICD 10 CODE: _______________ **DIAGNOSIS:** _______________________________________

DSM/ICD 10 CODE: _______________ **DIAGNOSIS:** _______________________________________

Treatment Provider: ____

3. PSYCHIATRIC HOSPITALIZATIONS (list all known, including current. Attach additional sheets if needed)

NAME OF INSTITUTION	ADMISSION DATE	DISCHARGE DATE

4. CURRENT MEDICATIONS

MEDICATIONS	DOSE; ROUTE; FREQUENCY	MEDICATIONS	DOSE; ROUTE; FREQUENCY

5. HISTORY OF DRUG AND/OR ALCOHOL ABUSE (please give details):

____

____

____

____

____

DATE OF LAST USE: ____________________________

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6. HISTORY OF SUICIDAL IDEATION/PLANS/ATTEMPTS (please include dates and details):

____

____

____

____

____

____

7. HISTORY OF AGGRESSIVE AND/OR VIOLENT BEHAVIOR (please give details):

____

____

____

____

8. IS CONSUMER CURRENTLY ON KROL STATUS (found not guilty of criminal charges due to a mental illness)?

☐ NO
☐ YES; If Yes, Please Explain: ____

9. PAST, CURRENT, AND / OR PENDING LEGAL CHARGES (INCLUDING MEGAN'S LAW ANDPROBATION)

____

____

____

____

10. MEDICAL (if applicable):

Diagnosis: ____

Treating Physician: ____

11. ALLERGIES: ____

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12. REASON FOR REFERRAL: (CHECK ALL THAT APPLY AND EXPLAIN IN DETAIL BELOW)

- ☐ Daily Living Skills Assistance
- ☐ Housing Needs (Specify below)
- ☐ Budgeting Management
- ☐ Mental Health Counseling
- ☐ Linkages to Community Resources
- ☐ Linkages to Medical/Psychiatric Services
- ☐ Employment/Vocational Assistance
- ☐ Other

____
____
____
____

13. RESOURCES (Please list amounts if known):

- ☐ SSI: ____________
- ☐ AFDC: ____________
- ☐ VA: ____________
- ☐ SSD: ____________
- ☐ Rent Asst: ____________
- ☐ Other: ____________
- ☐ SSA: ____________
- ☐ Gen. Asst: ____________

Medicaid #: ____________ Private Ins/Medicare #: ____________ MCO/HMO: : ____________

14. REPRESENTATIVE PAYEE?

- ☐ NO
- ☐ YES Name or organization: ________________________

15. WILL SPECIAL ACCOMODATIONS BE NEEDED TO COMPLETE THE ASSESSMENT PROCESS?

- ☐ NO
- ☐ YES; If Yes, Please Explain: ________________________

I ATTEST THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE

Name: ________________________

Title: ________________________

Date: ____________

Signature: ________________________

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Easterseals New Jersey
Community Living Services Referral Form

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH & ADDICTION SERVICES

CSS Eligibility Criteria Checklist *
(Supportive Housing and ICMS Referrals ONLY)

Community Support Services (CSS) Eligibility Criteria Checklist (**Must be completed by a Licensed Provider**). Consumers must meet the medical necessity standard to be eligible to receive CSS. The medical necessity standard requires the presence of a "severe mental health need." N.J.A.C. 10:37B-1.2 (definition of eligible consumer). In order to ensure that a consumer seeking CSS meets the medical necessity standard, the following checklist outlining the criteria for establishing a severe mental health need, as that term is defined at N.J.A.C. 10:37B-1.2, must be completed.

I. Background Information

A. Consumer Information:

Last Name: ______________________

Middle Initial: ______________________

First Name: ______________________

DOB: ______________________

B. Person completing the checklist:

Last Name: ______________________

First Name: ______________________

Title: ______________________

Employer: ______________________

C. Date Checklist Completed: ______________

II. Severe Mental Health Needs: The consumer must meet the criteria set forth in Sections A, B and C below.

A. The consumer has a serious mental illness as evidenced by a diagnosis of and a documented history of treatment of or evaluation for the following (please check all applicable diagnoses, if any):

- ☐ Schizophrenia
- ☐ Schizophreniform Disorder
- ☐ Schizoaffective Disorder
- ☐ Delusional Disorder
- ☐ Psychotic Disorder NOS
- ☐ Major Depressive Disorder Recurrent
- ☐ Bipolar I Disorder
- ☐ Bipolar II Disorder
- ☐ Bipolar Disorder NOS
- ☐ Schizotypal Personality Disorder; or
- ☐ Borderline Personality Disorder
- ☐ Other SMI diagnosis: (Specify below)

____

B. The consumer requires active rehabilitation and support services to achieve the restoration of functioning to promote the achievement of community integration and valued life roles in the social, employment, educational and/or housing domains. ☐ Yes ☐ No

C. The consumer meets at least one of the following three criteria (please check all that apply):

☐ i. Currently functions at a level, as assessed by an instrument approved by the Division, that puts the consumer at risk of hospitalization or other intensive treatment setting, such as 24 hour supervised congregate group or nursing home as assessed using an instrument approved by DMHAS instrument.

☐ ii. Exhibits deterioration in functioning that will require hospitalization or treatment in another intensive treatment setting in the absence of community-based services and supports.

☐ iii. Does not have adequate resources and supports to live safely in the community.

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Easterseals New Jersey
Community Living Services Referral Form

BHH ONLY

TYPES OF SERVICES SOUGHT BY CONSUMER: (check all that apply)

☐ Crisis Stabilization / Emergency Services	☐ Community Residential Program (with MH services)	☐ Coping Skills / Stress Management
☐ Primary Care Physician	☐ Crisis Housing	☐ Wellness Recovery Action Plan
☐ Social Supports	☐ Outreach / In-Home Services	☐ Behavioral Supports
☐ Client Advocacy/legal	☐ Residential Support Services	☐ Career Planning
☐ Daily Living Skills	☐ Medication Education	☐ Assistance with Advanced Directive
☐ Psychiatric Prescriber	☐ Pre-Vocational Services	☐ Dental Care
☐ Partial Care	☐ Employment	☐ Eye Exam
☐ Addiction Services	☐ Nutritional Education	☐ Vaccinations / Prevention Medicine
☐ Psychotherapy Counseling	☐ Exercise Plan	☐ Self-Monitoring devices (glucometer, BP, Pulse ox)
☐ Self-Help Services	☐ Diagnosis Education	☐ Transportation
☐ Service Coordination / Linkage	☐ Information and Referral	☐ Other ______________ ______________

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Easterseals New Jersey
Community Living Services Referral Form

EASTERSEALS NEW JERSEY
AUTHORIZATION FOR RELEASE OF INFORMATION FORM
TO BE COMPLETED FOR ALL PROGRAMS

I hereby authorize Easterseals New Jersey to (check one or both as it applies): ☐ disclose to: ☐ request from:

____

(Specify individual, agency, organization, and address)
The following information regarding (name of individual receiving services):_______________________

_______________________________ ____________ ____________
(Address) (DOB) (SSN)

For the purpose of: ____

Dates of services: ____

Information to be disclosed or requested: CHECK AND INITIAL **ONLY THOSE WHICH APPLY**

☐ ______Assessment	☐ ______Interagency communication	☐ ______Social security information
☐ ______Behavior contract or plan	☐ ______Psychiatric assessment	☐ ______Work adjustment training report
☐ ______Criminal history	☐ ______Psychological assessment/testing	☐ ______Physical health assessment
☐ ______Discharge summary	☐ ______Service agreement	☐ ______Prevocational evaluation report
☐ ______Financial information/earnings	☐ ______Service plan	☐ ______Legal information
☐ ______Intake assessment	☐ ______Social assessment	☐ ______Placement report

I understand that this may include (as applicable) information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care, and/or treatment for alcohol or drug abuse.

The information will be released in this format (Check all that may apply): ☐ written ☐ verbal ☐ fax ☐ electronic ☐ other (specify)______________________

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire within one year from the date of the signature, or on the following date, event, or condition, whichever is sooner:

____

I hereby release Easterseals New Jersey, its employees and officers from any legal responsibility or liability for disclosure of or receipt of the above information to the extent indicated and authorized.
I understand that Easterseals New Jersey may not condition services or payment on whether I sign this authorization.

I understand that there is a potential for information disclosed under the authorization to be subject to redisclosure by the recipient and no longer protected.

Signature:

____
(Individual Receiving Services) (Date)

____
(Or legal representative) (Relationship to individual served) (Date)

____
(Signature of witness for Easterseals) (Date)

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Revised 4/7/2023

Community Living Services Residential Application:

Please Note that all residential placements have shared bedrooms

The following documents are required upon application submission to be considered for services:

- ☐ Completed referral form with signed release of information form
- ☐ Licensed independent practitioner form indicating free of communicable disease/ medical clearance
- ☐ Verification of current medication prescriptions (copies of active prescriptions, or detailed list from current Pharmacy are acceptable)
- ☐ Medicaid eligibility-EMEVS
- ☐ Documented income verification
- ☐ Documentation confirming primary Psychiatric diagnosis. The following documents are acceptable:
  - ☐ Most recent psychiatric evaluation
  - ☐ Records indicating psychiatric diagnosis.
  - ☐ Previous history and physical exam
  - ☐ Current and / or previous hospitalization records
    - ☐ If currently hospitalized, please provide most recent progress notes.
  - ☐ Documentation from partial care program completed by a Licensed Clinician

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Easterseals New Jersey
Community Living Services Referral Form

DUE UPON SUBMISSIONOF REFERRAL / ASSIGNMENT

Easterseals New Jersey
BEHAVIORAL HEALTH SERVICES
PREADMISSION PHYSICAL EXAMINATION FOR RESIDENTIAL CONSUMERS

Licensed Independent Practitioner's Certification

I examined ___________________________________on ____________found him/her to be: **(please check "yes" or "no")**

Free of communicable illness: ☐ YES ☐ NO	**In need of skilled nursing care:** ☐ YES ☐ NO
Mantoux Test: ☐Date administered: ___________ ☐Date Read: ___________ ☐Result ___________	**Continent of bowels and bladder or able to manage incontinence independently:** ☐ YES ☐ NO
Covid-19	
Covid-19 vaccination: ☐ YES ☐ 1st Dose Date________________ ☐ 2nd Dose Date _______________ ☐ Booster Doses _______________ ___________________________ ☐ NO	**Covid-19 symptoms:** 1. Does the person have a cough? ☐YES ☐NO 2. Does the person have a fever of 99.5° or more?☐YES ☐NO If yes, sustained how long_______________ 3. Does the person have shortness of breath?☐YES ☐NO 4. Has the person or someone living with the person traveled to a high-risk country in the past 14 days?☐YES ☐NO 5. Has the individual been in contact with anyone exhibiting symptoms or diagnosed with Covid-19 while in the hospital?☐YES ☐NO

CLS

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Community Living Services Referral Form

- **MEDICAL INFORMATION**

☐ Medical Diagnosis (if any):

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☐ Prognosis / Treatment:

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☐ Medication (other than psychotropic medications):

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☐ Health / Nutritional Needs:

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____

Name of Licensed Practitioner: ______________________________

Address: ______________________________

Phone Number: ______________________________

Signature: ______________________________

Date: ______________________________

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EMAIL dsmith@nj.easterseals.com

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