Easterseals New Jersey
Community Living Services
REFERRAL FORM

FAX ALL REFERRALS TO 908-852-2255

Referral For (Please Check One)		
Essex ESNJ-Admin Support 25 Kennedy Blvd., Suite 600 East Brunswick, NJ 08816 973-313-0976 ☐ Residential ☐ Supportive Housing ☐ HUD	**Hunterdon** ESNJ-Admin Support 25 Kennedy Blvd., Suite 600 East Brunswick, NJ 08816 908-788-7580 ☐ Residential ☐ Supportive Housing ☐ ICMS **Res & SH refer to Essex County Contact* **ICMS refer to Warren County Contact*	**Middlesex** Please refer to Monmouth contact information ☐ Residential
Monmouth 1215-1217 Main St. Asbury Park, NJ 07712 732-380-0390 ☐ Residential ☐ Supportive Housing ☐ Behavioral Health Home	**Somerset** ESNJ-Admin Support 25 Kennedy Blvd., Suite 600 East Brunswick, NJ 08816 908-722-4300 ☐ Residential ☐ Supportive Housing ☐ ICMS **Res & SH refer to Essex County Contact* **ICMS refer to Warren County Contact*	**Warren** Camp Merry Heart - CLS 21 O Brien Road, Hackettstown, NJ 07840 908-689-6600 ☐ Residential ☐ Supportive Housing ☐ ICMS ☐ HUD

Date: _____ **Agency:** _____

Submitted by: _____ **Phone Number:** _____

Name of Person Being Referred: _____

Phone Number: _____
Home Address:
_____
_____

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

Birth date: _____
Social Security #: _____

Primary Language: _____
Marital Status: _____

Race / Ethnicity: _____
Gender: _____

Emergency Contact: _____
Phone Number: _____

1. Psychiatric / Medical Information

Psychiatric Diagnoses:

____Schizophrenia
____Schizoaffective Disorder
____Psychotic Disorder NOS **(SH Only)**
____Bipolar I disorder
____Bipolar Disorder NOS
____Borderline Personality Disorder
____Schizophreniform Disorder
____Delusional Disorder
____Major Depressive Disorder Recurrent
____Bipolar II Disorder
____Schizotypal Personality Disorder
____Other **(Must be approved)**

Treatment Provider: _____

2. PSYCHIATRIC INSTITUTIONALIZATION (list 3 most recent, including current)

Name of Institution	Admission Date	Discharge Date

3. CURRENT MEDICATIONS:

Medication / Dose; Route; Frequency	Medication / Dose; Route; Frequency

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

_____

_____

LAST USE _____

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

_____

_____

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

_____

_____

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

☐ **YES** If Yes, Please Explain: _____

☐ **NO**

8. PENDING LEGAL CHARGES

_____

_____

9. MEDICAL (if applicable):

Diagnosis: _____

Treating Physician: _____

(Name) (Address) (Phone)

Allergies: _____

10. REASON FOR REFERRAL:

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: ___

If checked, please explain and include primary need: _____

_____

11. RESOURCES (Please list amounts if known):

☐ SSI _____ ☐ AFDC _____ ☐ VA _____

☐ SSD _____ ☐ Rent Asst: _____ ☐ Payee: _____

☐ SSA _____ ☐ Gen. Asst: _____ ☐ Other: _____

Medicaid #: _____ Private Insurance / Medicare #: _____

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

If Yes, Explain: _____

EASTERSEALS NEW JERSEY
AUTHORIZATION FOR RELEASE OF INFORMATION FORM

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)

_____
(Date of birth) (Social Security Number)

for the purpose of _____

Dates of services _____

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

☐ _____Assessment	☐ _____Service agreement
☐ _____Behavior contract or plan	☐ _____Service plan
☐ _____Criminal history	☐ _____Social assessment
☐ _____Discharge summary	☐ _____Social security information
☐ _____Financial information/earnings	☐ _____Work adjustment training report
☐ _____Intake assessment	☐ _____Physical health assessment
☐ _____Interagency communication	☐ _____Prevocational evaluation report
☐ _____Psychiatric assessment	☐ _____Legal information
☐ _____Psychological assessment/testing	☐ _____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)

Easterseals New Jersey
Community Living Services
REFERRAL FORM

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH & ADDICTION SERVICES

CSS Eligibility Criteria Checklist

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: _____

First Name: _____ Middle Initial: _____

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.

Consumer's GLOF: _____

GLOBAL LEVEL OF FUNCTIONING SCALE

Level

01: Dysfunctional in all four areas and is totally dependent upon others to provide a supportive protective environment. The person requires constant observation so as not to harm self or others.

02: Dysfunctional in all four areas and is almost totally dependent upon others to provide a supportive protective environment.

03: Not working; ordinary social unit cannot or will not tolerate the person; can perform minimal selfcare functions but cannot assume most responsibilities or tolerate social encounters beyond restrictive settings (e.g., in group, play, or occupational therapy).

04: Not working; probably living in ordinary social unit but not without considerable strain on the person and/or others in the household. Symptoms are such that movement in the community should be restricted or supervised.

05: May be capable of working in a very protective setting; marginally able to live in ordinary social unit and contribute to the daily routine of the household; can assume responsibility only for basic personal self-care matters.

NOTE: LEVELS 6 THROUGH 10 DESCRIBE PERSONS WHO ARE USUALLY FUNCTIONING SATISFACTORILY IN THE COMMUNITY, BUT FOR WHOM PROBLEMS IN ONE OR MORE OF THE CRITERION AREAS FORCE SOME DEGREE OF DEPENDENCY ON SOME FORM OF THERAPEUTIC INTERVENTION.

06: Emotional stability and stress tolerance are sufficiently low that successful functioning in the social and/or vocational/educational realms is marginal. The person is barely able to hold on to either job or social unit or both, without direct therapeutic intervention and a reduction of conflicts in either or both realms.

07: The person's vocational and/or social areas of functioning are stabilized, but only because of direct therapeutic intervention. Symptom presence and severity are probably sufficient to be both noticeable and somewhat disconcerting to the client and/or those around the client in daily contact.

08: The person is functioning and coping well socially and vocationally (educationally); however, symptom recurrences are sufficiently frequent to maintain a reliance on some sort of regular therapeutic intervention.

09: Functioning well in all areas with little evidence of distress present. However, a history of symptom recurrence suggests periodic contact with a mental health center, e.g., a client may receive a medication check from a family physician who then contacts the center monthly, or the client returns for bi-monthly social activities.

10: The person is functioning well in all areas and no contact with the Mental Health services is recommended.

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Community Living Services
REFERRAL FORM

FOR OFFICE USE ONLY

*Date Received:*_____ *Staff Name:* _____

Date of 1st Contact w/Referring Party _____ *Name of First Contact:* _____

*Disposition:*_____

***Check One**:*

☐ *Accepted* ☐ *Denied* ☐ *Pending*

Staff Signature: *Date:*