Community Living Services Residential Application:

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
- ☐ Documentation confirming primary Psychiatric diagnosis. The following documents are acceptable:
    - Previous medical record indicating Psychiatric diagnosis
    - Letter from Psychiatrist indicating diagnosis
    - Previous History and Physical exam
    - Previous Hospitalization records
    - Documentation from partial care program completed by a Licensed Clinician

Easterseals New Jersey
Community Living Services
REFERRAL FORM

Referral For (Please Check One)
FAX ALL REFERRALS TO 908-852-2255

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 Essex 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
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:* _____

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 (circle 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

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")** And

- Free of communicable illness **YES☐** **NO☐**
- **Mantoux Test, date administered _____** **Result _____** **Date _____**
  (MUST BE FILLED IN)
- Not in need of skilled nursing care **YES☐** **NO☐**
- Continent of bowels and bladder or able to manage incontinence independently
  YES☐ **NO☐**

Covid-19 Symptoms

M.D. initial _____Does the person have a cough ☐ yes ☐ no
M.D. initial _____Does the person have a fever of 99.5 or more? ____ yes _____ No Sustained how long _____
M.D. initial _____Does the person have shortness of breath? _____ yes _____No
M.D. initial _____Has the person or someone living with the person traveled to a high-risk country in the past 14 days?_____ yes _____ No
M.D. initial _____Has the individual been in contact with anyone exhibiting symptoms or diagnosed with Covid-19 while in the hospital?
_____ yes _____ No

Medical Diagnosis (if any):

Prognosis/Treatment:

Medication (other than psychotropic medication):

Health/Nutritional Needs:

_____ **Name of Licensed Independent Practitioner**

_____ **Signature**

_____ **Address / Phone Number**

_____ **Date**

Please file in the Pre-Admission section in the residential charts