Easterseals New Jersey
Community Living Services
REFERRAL FORM

Referral For (Please Check One)

Essex 515 Valley Street, Suite 180 Maplewood, NJ 07040 973-313-0976 973-313-2479 (FAX) Residential Supportive Housing HUD	**Hunterdon** ENJ-Admin Support 25 Kennedy Blvd., Suite 600 East Brunswick, NJ 08816 908-788-7580 908-788-6760 (FAX) Residential* Supportive Housing* ICMS**	**Middlesex** Please refer to Monmouth contact information Residential *Res & SH refer to Essex County Contact* ***ICMS refer to Warren County Contact*
Monmouth 1215-1217 Main St. Asbury Park, NJ 07712 732-380-0390 732-380-0391 (FAX) Residential Supportive Housing Behavioral Health Home	**Somerset** ENJ-Admin Support 25 Kennedy Blvd., Suite 600 East Brunswick, NJ 08816 908-722-4300 908-722-1134 (FAX) Residential* Supportive Housing* ICMS**	**Warren** 2083 Route 57 Washington, NJ 07882 908-689-6600 908-689-8241 (FAX) 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 #: ___________________________

Race / Ethnicity: __________________________

Gender: ________________________________

Primary Language: __________________________

Marital Status: ____________________________

Emergency Contact: __________________________

Phone Number: ______________________________

1. Psychiatric / Medical Information

Psychiatric Diagnoses: ____

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

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:

____

____

____

11. RESOURCES (Please list amounts if known):

☐ SSI ___________	☐ AFDC _______________	☐ VA _______________
☐ SSD ___________	☐ Rent Asst: ____________	☐ Payee: ____________
☐ SSA ___________	☐ Gen. Asst: ____________	☐ Other: _____________

Medicare/Medicaid #: ______________________________ Private Insurance: ______________________________

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

If Yes, Explain: ____

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.

(Individual receiving services) (Date)

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

Signature: ____

____
(Signature of witness for Easterseals) (Date)

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:____

DMHAS Authorized Signature: ____

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 (refer to scale on next page): _____

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.