



**Easterseals New Jersey  
Community Living Services  
REFERRAL FORM**

Referral For (Please Check One)		
<b>Essex</b> ESNJ-Admin Support 25 Kennedy Blvd., Suite 600 East Brunswick, NJ 08816 973-313-0976    973-313-2479 (FAX) <input type="checkbox"/> Residential <input type="checkbox"/> Supportive Housing <input type="checkbox"/> HUD	<b>Hunterdon</b> ESNJ-Admin Support 25 Kennedy Blvd., Suite 600 East Brunswick, NJ 08816 908-788-7580    908-788-6760 (FAX) <input type="checkbox"/> Residential <input type="checkbox"/> Supportive Housing <input type="checkbox"/> ICMS <i>*Res &amp; SH refer to Essex County Contact</i> <i>*ICMS refer to Warren County Contact</i>	<b>Middlesex</b> Please refer to Monmouth contact information <input type="checkbox"/> Residential
<b>Monmouth</b> 1215-1217 Main St. Asbury Park, NJ 07712 732-380-0390    732-380-0391 (FAX) <input type="checkbox"/> Residential <input type="checkbox"/> Supportive Housing <input type="checkbox"/> Behavioral Health Home	<b>Somerset</b> ESNJ-Admin Support 25 Kennedy Blvd., Suite 600 East Brunswick, NJ 08816 908-722-4300    908-722-1134 (FAX) <input type="checkbox"/> Residential <input type="checkbox"/> Supportive Housing <input type="checkbox"/> ICMS <i>*Res &amp; SH refer to Essex County Contact</i> <i>*ICMS refer to Warren County Contact</i>	<b>Warren</b> Camp Merry Heart - CLS 21 O Brien Road, Hackettstown, NJ 07840 908-689-6600    908-689-8241 (FAX) <input type="checkbox"/> Residential <input type="checkbox"/> Supportive Housing <input type="checkbox"/> ICMS <input type="checkbox"/> HUD

Date: \_\_\_\_\_ Agency: \_\_\_\_\_

Submitted by: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Person Being Referred: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Current Address – IF DIFFERENT FROM HOME ADDRESS:  
Home Address: \_\_\_\_\_ (for hospital referrals, include unit and Social Worker )

Birth date: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Race / Ethnicity: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_  
Gender: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**1. Psychiatric / Medical Information**

Psychiatric Diagnoses:

- |   |   |
|---|---|
| _____ Schizophrenia                             | _____ Schizophreniform Disorder           |
| _____ Schizoaffective Disorder                  | _____ Delusional Disorder                 |
| _____ Psychotic Disorder NOS ( <b>SH Only</b> ) | _____ Major Depressive Disorder Recurrent |
| _____ Bipolar I disorder                        | _____ Bipolar II Disorder                 |
| _____ Bipolar Disorder NOS                      | _____ Schizotypal Personality Disorder    |
| _____ Borderline Personality Disorder           | _____ Other ( <b>Must be approved</b> )   |

Treatment Provider: \_\_\_\_\_

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

Name of Institution	Admission Date	Discharge Date



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3. CURRENT MEDICATIONS:

Table with 2 columns: Medication / Dose; Route; Frequency. Multiple empty rows for data entry.

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, SSD, SSA, AFDC, Rent Asst, Gen. Asst, VA, Payee, Other

Medicaid #: Private Insurance / Medicare #:

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

If Yes, Explain: \_\_\_\_\_



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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

Table with 2 columns of checkboxes for various information types: Assessment, Behavior contract or plan, Criminal history, Discharge summary, Financial information/earnings, Intake assessment, Interagency communication, Psychiatric assessment, Psychological assessment/testing, Service agreement, Service plan, Social assessment, Social security information, Work adjustment training report, Physical health assessment, Pre-vocational evaluation report, Legal information, 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)



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)

\_\_\_\_\_



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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 self-care 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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**FOR OFFICE USE ONLY**

Date Received: \_\_\_\_\_ Staff Name: \_\_\_\_\_

Date of 1<sup>st</sup> Contact w/Referring Party \_\_\_\_\_ Name of First Contact: \_\_\_\_\_

Disposition: \_\_\_\_\_

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**Check One:**

Accepted

Denied

Pending

Staff Signature:

Date:

\_\_\_\_\_

\_\_\_\_\_