Sky Light Center

Referral Application **Enrollment –P.1**

Intake

Date of Application: ____/ ____/___ Referral for: ☐Day Program ☐Returning Member ☐ Ace Program

Applicant

First Name:_____ MI:_____ Last Name:_____

DOB:_____ CMHCN:_____ SSN:_____

Referral Agency-Referral Type

☐ Self, Family, Friends
☐ Private Practitioner (Psychiatrist/MD)
☐ Community Mental Health Center/Clinic
☐ County, Local Hospital
☐ Another Clubhouse
☐ State Social Services
☐ County Social Services
☐ State Vocational Rehab
☐ Supervised Community Services
☐ Public Shelter for the Homeless
☐ Homeless Outreach Team
☐ Police, Courts, Forensic Hospital
☐ Other_____

Referral Agency Name:_____

Referral Contact:_____ Phone:(____)_____

Referral Notes:

_____

_____

_____

Address

Applicant's Address

Street_____ Apt._____

City_____ County/Borough _____State_____ Zip Code_____

Phone Numbers

☐ Home_____ ☐Business_____ ☐Friend_____
☐ Parents_____ ☐Fax_____ ☐Other_____
☐ Beeper_____ ☐Weekend_____ ☐ No Phone

Hints on how to locate.

_____

_____

Housing Type

☐ Own Home/Apartment (Non-subsidized)
☐ Home of a Family Member (Shared Responsibility)
☐ Home of Family Member (Dependent on Family)
☐ Rooming/Boarding House, Hotel
☐ SRO, Temporary Housing
☐ Supported Apartment (Subsidized, Non-Supervised)
☐ Supervised Housing (Part-time Supervision)
☐ Group Home (24 hour Supervision)
☐ Foster Care
☐ Psychiatric Hospital
☐ Nursing Home
☐ Prison/Jail
☐ Shelter
☐ Undomiciled/Homeless
☐ Other_____

Housing Status

☐ Alone
☐ With Roommate(s)/Housemates(s)
☐ With Parent(s)
☐ With Other Adult Relative(s)
☐ With Minor Child(ren) Only
☐ With Partner and Child(ren)
☐ Institutional Setting

*Total number of people in household including applicant:*_____

Housing Satisfaction

☐Very Satisfied ☐Somewhat Satisfied
☐Neutral ☐Somewhat Unsatisfied ☐Very Unsatisfied

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Referral Application **Enrollment –P.2**

Background

Gender ☐ Male ☐ Female ☐ Other_____

Ethnicity 1

☐ African – American
☐ American Indian/Native American
☐ Asian e.g. Chinese, Japanese, Korean
☐ Caribbean e.g. Haitian, Jamaican
☐ Caucasian
☐ Latino/Hispanic e.g. Puerto Rican, Cuban, Mexican
☐ Middle Eastern e.g. Indian, Turkish, Iranian
☐Pacific Islander e.g. Samoan, Fijian

Ethnicity 2 (*if applicable)*

☐ African – American
☐ American Indian/Native American
☐ Asian e.g. Chinese, Japanese, Korean
☐ Caribbean e.g. Haitian, Jamaican
☐ Caucasian
☐ Latino/Hispanic e.g. Puerto Rican, Cuban, Mexican
☐ Middle Eastern e.g. Indian, Turkish, Iranian
☐ Pacific Islander e.g. Samoan, Fijian

Language

☐ English Speaking
☐ Primary Other: *(please specify)*_____

Marital Status

☐ Single, Never Married ☐ Widowed ☐ Permanent Partner ☐ Divorced ☐ Separated ☐ Married

Education Level

☐ Less than High School ☐ Some High School ☐ GED ☐ High School Diploma
☐ Trade School ☐ Some College ☐ Junior College ☐ Bachelor's Degree
☐ Some Graduate Work ☐ Master's Degree ☐ Advanced Graduate Degree

Primary Weekday Activity

☐ Independent Employment ☐ School-High School ☐ School-Trade School/College
☐ Parenting/Care Taking at Home ☐ Transitional Employment ☐ Enclave Work Sheltered Workshop
☐ Clubhouse Work ☐ Other Volunteer Work ☐ Day Program outside the Clubhouse
☐ In Hospital/House Bound Psychiatric Reasons ☐ No Structured Daytime Activity

Income Source #1 **Amount Income Source #1: $_____**

☐ Wages – Independent Employment ☐ SSI ☐ Retirement Benefits
☐ Wages – Transitional Employment ☐ General Assistance (State) ☐ Family Support
☐ Wages – Supported Employment ☐ Local Assistance (County/State) ☐ Friend Support
☐ Wages – Shelter Workshop ☐ AFDC ☐ No financial support
☐ SSDI ☐ Veteran's Benefits ☐ Other_____

Income Source #2 **Amount Income Source #2: $_____**

☐ Wages – Independent Employment ☐ SSI ☐ Retirement Benefits
☐ Wages – Transitional Employment ☐ General Assistance (State) ☐ Family Support
☐ Wages – Supported Employment ☐ Local Assistance (County/State) ☐ Friend Support
☐ Wages – Shelter Workshop ☐ AFDC ☐ No financial support
☐ SSDI ☐ Veteran's Benefits ☐ Other_____

Income Source #3 **Amount Income Source #3: $_____**

☐ Wages – Independent Employment ☐ SSI ☐ Retirement Benefits
☐ Wages – Transitional Employment ☐ General Assistance (State) ☐ Family Support
☐ Wages – Supported Employment ☐ Local Assistance (County/State) ☐ Friend Support
☐ Wages – Shelter Workshop ☐ AFDC ☐ No financial support
☐ SSDI ☐ Veteran's Benefits ☐ Other_____

Additional Amount: $_____

TOTAL INCOME: $_____

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Referral Application **Enrollment –P.3**

Emergency Information

Medical Alerts

☐ Chronic Physical Illness ☐ Asthma ☐ Recent Surgery
☐ Deaf/Hearing Impairment ☐ Other Physical Disability ☐ Diabetes
☐ Blind/Vision Impairment ☐ Severe Allergic Reactions ☐ Hypertension
☐ Epilepsy/Seizure ☐ New Psychiatric Medication ☐ Other_____

Alert Memo

_____
_____
_____
_____
_____

Medical and Psychiatric Contacts *(fill in as appropriate and include address and phone number.)*

Psychiatrist:	Address:	Phone:
Therapist:	Address:	Phone:
Primary Care MD:	Address:	Phone:
Clinic:	Address:	Phone:

Emergency Contacts

Primary:	
Relationship to applicant:	Phone:
Secondary:	
Relationship to applicant:	Phone:

Notes:

_____
_____
_____
_____
_____

Employment

Employment

Has applicant ever worked for pay? ☐ Yes ☐ No
Has he/she worked for pay within the last 12 months? ☐ Yes ☐ No

Estimated TOTAL YEARS applicant has worked for pay._____
Estimated TOTAL NUMBER OF JOBS worked for pay. _____

Employment History Notes

_____
_____
_____

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Referral Application **Enrollment –P.4**

Job held the LONGEST

Job Title:_____

Job Type:

☐ Mail Clerk/Messenger	☐ Vehicle Operation	☐Machine Operator/Factory Worker
☐ Clerical/Secretarial	☐ Health/Nursing Aid	☐ Farming/Forestry/Fishing
☐ Guard/Doorman	☐ Attendant/Guide/Usher	☐ Artist/Entertainer
☐ Food service worker	☐ Childcare/Teacher's Aid	☐ Military/Occupation
☐ Sales/Retail	☐ Technician	☐ Managerial
☐ Sales/Non-retail	☐ Mechanic/Repairer	☐ Professional
☐ Assembly/Gift Wrapper	☐ Laborer/Construction	☐Other:_____
☐ Cleaning/Maintenance	☐ Labor/Non-construction	

Start Date: _____/ _____/ _____ **End Date: _____/ _____/ _____**

Hours Per Week_____ **Pay Per Hour_____**

Termination Type

☐ Job Ended ☐ Leave of Absence ☐ Resigned ☐ Fired ☐ Medical Reasons ☐ Retired
☐ Not Applicable ☐ Other:_____

Current or Most Recent Job

Job Title:_____

Job Type:

☐ Mail Clerk/Messenger	☐ Vehicle Operation	☐Machine Operator/Factory Worker
☐ Clerical/Secretarial	☐ Health/Nursing Aid	☐ Farming/Forestry/Fishing
☐ Guard/Doorman	☐ Attendant/Guide/Usher	☐ Artist/Entertainer
☐ Food service worker	☐ Childcare/Teacher's Aid	☐ Military/Occupation
☐ Sales/Retail	☐ Technician	☐ Managerial
☐ Sales/Non-retail	☐ Mechanic/Repairer	☐ Professional
☐ Assembly/Gift Wrapper	☐ Laborer/Construction	☐Other:_____
☐ Cleaning/Maintenance	☐ Labor/Non-construction	

Start Date: _____/ _____/ _____ **End Date: _____/ _____/ _____**

Hours Per Week_____ **Pay Per Hour_____**

Termination Type

☐ Job Ended ☐ Leave of Absence ☐ Resigned ☐ Fired ☐ Medical Reasons ☐ Retired
☐ Not Applicable ☐ Other:_____

THIS SECTION MUST BE COMPLETED BY PROVIDER ***Drug/Alcohol History***

History with Alcohol

Has applicant had a problem with alcohol? ☐ Yes ☐ No
Has applicant been in treatment for an alcohol problem? ☐ Yes ☐ No
Is applicant currently in treatment or in a support group? ☐ Yes ☐ No
Does he/she want help with an alcohol problem? ☐ Yes ☐ No

How long has he/she been clean and sober?_____

History with Drugs

Has applicant had a problem with drugs? ☐ Yes ☐ No
Has applicant been in treatment for a drug problem? ☐ Yes ☐ No
Is applicant currently in treatment or in a support group? ☐ Yes ☐ No
Does he/she want help with a drug problem? ☐ Yes ☐ No

How long has he/she been clean and sober?_____

Drug/Alcohol Notes: *(Include Type of Drug, Amount and Frequency.)*

_____
_____
_____
_____
_____

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Referral Application **Enrollment –P.5**

Alcohol/Substance Abuse Assessment:
What is applicant's assessment of the effect of alcohol/drug use on her/his life:_____
_____
_____
_____

THIS SECTION MUST BE COMPLETED BY PROVIDER *Legal History*

Has applicant ever been in jail? ☐ Yes ☐ No In prison? ☐ Yes ☐ No On probation? ☐ Yes ☐ No
Has applicant ever been convicted of a misdemeanor? ☐ Yes ☐ No
Has applicant ever had any arrests for felonies? ☐ Yes ☐ No
What felonies? *(check all that apply)*

☐ Bad Checks/Shoplifting	☐ Manslaughter/Negligent Homicide	☐ Other Crimes of Dishonesty
☐ Physical Abuse/Assault	☐ Robbery/Breaking and Entering	☐ Other_____
☐ Stealing/Forgery/Embezzlement	☐ Rape/Murder	☐ Sexual Misconduct

Has applicant ever physically injured another person? ☐ Yes ☐ No
Does he/she have a history of violent behavior toward others? ☐ Yes ☐ No

Legal History Notes *(dates, behaviors, precipitants, legal actions, etc. **Please elaborate on any aggressive behaviors**.)*
_____
_____
_____
_____

THIS SECTION MUST BE COMPLETED BY PROVIDER *Medical Information*

Medical Insurance

Insurer 1 **Policy No._____**

☐ Medicaid	☐ Private Insurance	☐ Family pay
☐ Medicaid, Managed Care	☐ Private Insurance, Managed Care	☐ Self-pay (no insurance)
☐ Medicare	☐ Veteran's Benefits	☐ Other_____
☐ Medicare, Managed Care	☐ Worker's Compensation	

Insurer 2 **Policy No._____**

☐ Medicaid	☐ Private Insurance	☐ Family pay
☐ Medicaid, Managed Care	☐ Private Insurance, Managed Care	☐ Self-pay (no insurance)
☐ Medicare	☐ Veteran's Benefits	☐ Other_____
☐ Medicare, Managed Care	☐ Worker's Compensation	

Date of Last Physical Exam: ____/____/_____ Date of Last Dental Exam: ____/____/_____

Psychiatric Information

Primary Diagnosis:
☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Bi-Polar Disorder ☐ Major Depression
☐ Other Psychotic Disorder ☐ Other Major Mental Illness

	Written Diagnosis	Diagnostic Code
DSM IV Axis I		
DSM IV Axis II		
DSM IV Axis III		
DSM IV Axis IV		
DSM IV Axis V		

THIS SECTION MUST BE COMPLETED BY PROVIDER *Medication*

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Referral Application **Enrollment –P.6**

Please List all Psychiatric Medications ***(include dosage and frequency)***

_____
_____
_____
_____
_____
_____

Please List all Other Medications *(include dosage and frequency)*

_____
_____
_____
_____
_____
_____

THIS SECTION MUST BE COMPLETED BY PROVIDER ***Psychiatric Hospitalizations***

Psychiatric History

Total Number of Hospital Admissions_____
Estimated Total Months of ALL Hospitalizations_____
Length (months) of LONGEST Hospitalization_____
Applicant in which hospitals? ***(list all, name and location please)***

_____
_____
_____

Please indicate precipitants to all hospitalizations

_____
_____
_____

First Psychiatric Hospitalization

Age at first hospitalization?_____

Admission Date: _____/_____/_____ Discharge Date: _____/_____/_____

Hospital Name:_____
City:_____ State:_____ Zip Code:_____
Country:_____

Most Recent Psychiatric Hospitalization

Admission Date: _____/_____/_____ Discharge Date: _____/_____/_____

Hospital Name:_____
City:_____ State:_____ Zip Code:_____ Country:_____
Contact:_____ Contact's Position:_____

Notes:

_____
_____
_____
_____
_____
_____
_____

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Referral Application **Enrollment –P.7**

THIS SECTION MUST BE COMPLETED BY PROVIDER *Parenting Skills*

Does applicant have parenting responsibilities for minor children (circle one): Yes No
(If applicant does not have parenting responsibilities for minor children the rest of this section does not have to be completed)

Number and ages of minor children:_____

Presence or absence of child abuse (sexual or physical) or neglect of these children: (circle one)

Presence Absence

Agency for Children's Services (ACS) involvement:

History of involvement with (ACS): Yes No

Does applicant have an open case with ACS? and if so, the current status:_____
_____
_____

Please note referral applications can only be processed when submitted with detailed <u>psychosocial history, psychiatric assessment and physical exam</u>. Please contact the Clerical Unit at Sky Light Center, (718) 720-2585, if you have any questions.

This application must be signed by Provider

_____ _____

Referral Source Signature **Date**

_____

Member enrollment Date: