

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

- | | |
|---|--|
| <input type="checkbox"/> Self, Family, Friends | <input type="checkbox"/> State Vocational Rehab |
| <input type="checkbox"/> Private Practitioner (Psychiatrist/MD) | <input type="checkbox"/> Supervised Community Services |
| <input type="checkbox"/> Community Mental Health Center/Clinic | <input type="checkbox"/> Public Shelter for the Homeless |
| <input type="checkbox"/> County, Local Hospital | <input type="checkbox"/> Homeless Outreach Team |
| <input type="checkbox"/> Another Clubhouse | <input type="checkbox"/> Police, Courts, Forensic Hospital |
| <input type="checkbox"/> State Social Services | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> County Social Services | |

Referral Agency Name: _____

Referral Contact: _____ Phone: (____) _____

Referral Notes:

Address

Applicant's Address

Street _____ Apt. _____

City _____ County/Borough _____ State _____ Zip Code _____

Phone Numbers

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Home _____ | <input type="checkbox"/> Business _____ | <input type="checkbox"/> Friend _____ |
| <input type="checkbox"/> Parents _____ | <input type="checkbox"/> Fax _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Beeper _____ | <input type="checkbox"/> Weekend _____ | <input type="checkbox"/> No Phone |

Hints on how to locate.

Housing Type

- | | |
|---|---|
| <input type="checkbox"/> Own Home/Apartment (Non-subsidized) | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> Home of a Family Member (Shared Responsibility) | <input type="checkbox"/> Psychiatric Hospital |
| <input type="checkbox"/> Home of Family Member (Dependent on Family) | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Rooming/Boarding House, Hotel | <input type="checkbox"/> Prison/Jail |
| <input type="checkbox"/> SRO, Temporary Housing | <input type="checkbox"/> Shelter |
| <input type="checkbox"/> Supported Apartment (Subsidized, Non-Supervised) | <input type="checkbox"/> Undomiciled/Homeless |
| <input type="checkbox"/> Supervised Housing (Part-time Supervision) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Group Home (24 hour Supervision) | |

Housing Status

- | | |
|---|--|
| <input type="checkbox"/> Alone | <input type="checkbox"/> With Minor Child(ren) Only |
| <input type="checkbox"/> With Roommate(s)/Housemates(s) | <input type="checkbox"/> With Partner and Child(ren) |
| <input type="checkbox"/> With Parent(s) | <input type="checkbox"/> Institutional Setting |
| <input type="checkbox"/> With Other Adult Relative(s) | |

Total number of people in household including applicant: _____

Housing Satisfaction

- | | | |
|---|---|---|
| <input type="checkbox"/> Very Satisfied | <input type="checkbox"/> Somewhat Satisfied | <input type="checkbox"/> Very Unsatisfied |
| <input type="checkbox"/> Neutral | <input type="checkbox"/> Somewhat Unsatisfied | |

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Background

Gender Male Female Other _____

Ethnicity 1

- | | |
|---|--|
| <input type="checkbox"/> African – American | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> American Indian/Native American | <input type="checkbox"/> Latino/Hispanic e.g. Puerto Rican, Cuban, Mexican |
| <input type="checkbox"/> Asian e.g. Chinese, Japanese, Korean | <input type="checkbox"/> Middle Eastern e.g. Indian, Turkish, Iranian |
| <input type="checkbox"/> Caribbean e.g. Haitian, Jamaican | <input type="checkbox"/> Pacific Islander e.g. Samoan, Fijian |

Ethnicity 2 (if applicable)

- | | |
|---|--|
| <input type="checkbox"/> African – American | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> American Indian/Native American | <input type="checkbox"/> Latino/Hispanic e.g. Puerto Rican, Cuban, Mexican |
| <input type="checkbox"/> Asian e.g. Chinese, Japanese, Korean | <input type="checkbox"/> Middle Eastern e.g. Indian, Turkish, Iranian |
| <input type="checkbox"/> Caribbean e.g. Haitian, Jamaican | <input type="checkbox"/> 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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Less than High School | <input type="checkbox"/> Some High School | <input type="checkbox"/> GED | <input type="checkbox"/> High School Diploma |
| <input type="checkbox"/> Trade School | <input type="checkbox"/> Some College | <input type="checkbox"/> Junior College | <input type="checkbox"/> Bachelor's Degree |
| <input type="checkbox"/> Some Graduate Work | <input type="checkbox"/> Master's Degree | <input type="checkbox"/> Advanced Graduate Degree | |

Primary Weekday Activity

- | | | |
|--|--|--|
| <input type="checkbox"/> Independent Employment | <input type="checkbox"/> School-High School | <input type="checkbox"/> School-Trade School/College |
| <input type="checkbox"/> Parenting/Care Taking at Home | <input type="checkbox"/> Transitional Employment | <input type="checkbox"/> Enclave Work Sheltered Workshop |
| <input type="checkbox"/> Clubhouse Work | <input type="checkbox"/> Other Volunteer Work | <input type="checkbox"/> Day Program outside the Clubhouse |
| <input type="checkbox"/> In Hospital/House Bound Psychiatric Reasons | | <input type="checkbox"/> No Structured Daytime Activity |

Income Source #1

Amount Income Source #1: \$ _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Wages – Independent Employment | <input type="checkbox"/> SSI | <input type="checkbox"/> Retirement Benefits |
| <input type="checkbox"/> Wages – Transitional Employment | <input type="checkbox"/> General Assistance (State) | <input type="checkbox"/> Family Support |
| <input type="checkbox"/> Wages – Supported Employment | <input type="checkbox"/> Local Assistance (County/State) | <input type="checkbox"/> Friend Support |
| <input type="checkbox"/> Wages – Shelter Workshop | <input type="checkbox"/> AFDC | <input type="checkbox"/> No financial support |
| <input type="checkbox"/> SSDI | <input type="checkbox"/> Veteran's Benefits | <input type="checkbox"/> Other _____ |

Income Source #2

Amount Income Source #2: \$ _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Wages – Independent Employment | <input type="checkbox"/> SSI | <input type="checkbox"/> Retirement Benefits |
| <input type="checkbox"/> Wages – Transitional Employment | <input type="checkbox"/> General Assistance (State) | <input type="checkbox"/> Family Support |
| <input type="checkbox"/> Wages – Supported Employment | <input type="checkbox"/> Local Assistance (County/State) | <input type="checkbox"/> Friend Support |
| <input type="checkbox"/> Wages – Shelter Workshop | <input type="checkbox"/> AFDC | <input type="checkbox"/> No financial support |
| <input type="checkbox"/> SSDI | <input type="checkbox"/> Veteran's Benefits | <input type="checkbox"/> Other _____ |

Income Source #3

Amount Income Source #3: \$ _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Wages – Independent Employment | <input type="checkbox"/> SSI | <input type="checkbox"/> Retirement Benefits |
| <input type="checkbox"/> Wages – Transitional Employment | <input type="checkbox"/> General Assistance (State) | <input type="checkbox"/> Family Support |
| <input type="checkbox"/> Wages – Supported Employment | <input type="checkbox"/> Local Assistance (County/State) | <input type="checkbox"/> Friend Support |
| <input type="checkbox"/> Wages – Shelter Workshop | <input type="checkbox"/> AFDC | <input type="checkbox"/> No financial support |
| <input type="checkbox"/> SSDI | <input type="checkbox"/> Veteran's Benefits | <input type="checkbox"/> Other _____ |

Additional Amount: \$ _____

TOTAL INCOME: \$ _____

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Emergency Information

Medical Alerts

- | | | |
|---|---|---|
| <input type="checkbox"/> Chronic Physical Illness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Deaf/Hearing Impairment | <input type="checkbox"/> Other Physical Disability | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blind/Vision Impairment | <input type="checkbox"/> Severe Allergic Reactions | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> New Psychiatric Medication | <input type="checkbox"/> 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:		
<i>Relationship to applicant:</i>		Phone:
Secondary:		
<i>Relationship to applicant:</i>		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 Job held the LONGEST

Job Title: _____

Job Type:

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

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad Checks/Shoplifting | <input type="checkbox"/> Manslaughter/Negligent Homicide | <input type="checkbox"/> Other Crimes of Dishonesty |
| <input type="checkbox"/> Physical Abuse/Assault | <input type="checkbox"/> Robbery/Breaking and Entering | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stealing/Forgery/Embezzlement | <input type="checkbox"/> Rape/Murder | <input type="checkbox"/> 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

- Medicaid
- Medicaid, Managed Care
- Medicare
- Medicare, Managed Care

Policy No. _____

- Private Insurance
- Private Insurance, Managed Care
- Veteran's Benefits
- Worker's Compensation
- Family pay
- Self-pay (no insurance)
- Other _____

Insurer 2

- Medicaid
- Medicaid, Managed Care
- Medicare
- Medicare, Managed Care

Policy No. _____

- Private Insurance
- Private Insurance, Managed Care
- Veteran's Benefits
- Worker's Compensation
- Family pay
- Self-pay (no insurance)
- Other _____

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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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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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 psychosocial history, psychiatric assessment and physical exam. 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: