easterseals New Jersey

Community Living Services
REFERRAL FORM

Referral For (Please Check One)		
☐ **Essex** 515 Valley Street Maplewood, NJ 07040 973-313-0976, 973-313-2479 (FAX)	☐ **Hunterdon** 200 Route 31 North, Suite 115 Flemington, New Jersey 08822 908-788-7580, 908-788-6760 (FAX)	☐ **Middlesex** Please refer to Essex contact information
☐ **Monmouth** 1215-1217 Main Street Asbury Park, NJ 07712 732-380-0390, 732-380-0391 (FAX)	☐ **Somerset** 200 Route 31 North, Suite 115 Flemington, New Jersey 08822 908-722-4300, 908-722-1134 (FAX)	☐ **Warren** 2083 Route 57 Washington, NJ 07882 908-689-6600,908-689-8241 (FAX)

Date: _____ **Agency:**_____

Submitted by: _____ **Phone Number:** _____

Referral For (Please Check One)		
☐ Residential	☐ HUD	
☐ Intensive Case Management Services (ICMS)	☐ Supported Housing	☐ Other (Please specify: _____

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. DSM-V DIAGNOSIS - CODE & DESCRIPTION

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: _____

Smoker: ☐ N ☐ Y If Yes, # of yrs _____

10. REASON FOR REFERRAL:

_____

_____

_____

11. RESOURCES (Please list amounts if known):

☐ SSI _____ ☐ AFDC _____ ☐ VA _____

☐ SSD _____ ☐ Rent Asst: _____ ☐ Payee: _____

☐ SSA _____ ☐ Gen. Asst: _____ ☐ Other: _____

☐ MLTSS _____

Medicare/Medicaid #: _____ Private Insurance: _____

12. WILL SPECIAL ACCOMODATIONS BE NEEDED TO COMPLETE THE ASSESSMENT PROCESS? ☐ No

☐ 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 (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)