

Residential Referral Cover Sheet:

Name and contract information for professional in community who will ensure completed application and will accompany client to residential selection committee meeting when scheduled (if hospital social worker is identified as this professional then social worker agrees to follow through with presentation at RSC meeting when scheduled.)

Name of referral: _____

Name of agency: _____

Referring person: _____

Address of agency: _____

Agency Phone #: _____

Agency Fax #: _____

Email Address: _____

The Mental Health Association in North Carolina Referral Form

Applicant applying for: Group Home Apartment Community

Date: _____

Consumer Name: _____
Last Name First Name Middle Initial Maiden Name

Medical Record # _____ Date of Referral: _____

Birth date: _____ Social Security #: _____

Address: _____

Telephone :(H) _____ (W) _____

Marital Status: S _____ M _____ D _____ W _____

Referral Source: Name/Phone #: _____

SPMI: Yes _____ No _____

A) Reason for Referral: _____

B) Number of psychiatric hospitalizations during last two years: _____

C) DIAGNOSIS: DSM IV

Axis IA: _____ :

Axis IB: _____ :

Axis IIA: _____ :

Axis IIB: _____ :

Axis III: _____ :

Axis IV: _____ :

Axis V: _____ :

E) Current GAF Score / Assessment Date: _____

F) CURRENT PSYCHIATRIC STATUS & HISTORY: (please add attachments, if necessary)

G) TRANSPORTATION: Own auto Others Walk Public None

H) Annual Income: _____
Medicare # _____ Medicaid # _____

I) Does the consumer have a guardian? If so, name, address and telephone number of guardian _____

J) Can the consumer self-medicate? Yes _____ No _____

The Mental Health Association in North Carolina Referral Form

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Consumer Name: _____ Record #: _____

Part One: Role Problems to be addressed by Residential Services (check when appropriate)

A) SOCIAL ROLE PROBLEMS:

- | | | |
|--------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Lacks activity | <input type="checkbox"/> Social isolation |
| <input type="checkbox"/> Isolation worsens symptoms | <input type="checkbox"/> Social Anxiety | <input type="checkbox"/> Parole |
| <input type="checkbox"/> Frequently fabricates truth | <input type="checkbox"/> Stealing | <input type="checkbox"/> Aggressive behavior |
| <input type="checkbox"/> Destroys property | <input type="checkbox"/> Poor impulse control | <input type="checkbox"/> Promiscuity |
| <input type="checkbox"/> Exhibitionism | <input type="checkbox"/> Probation | <input type="checkbox"/> Limited use of community resources |
| <input type="checkbox"/> Legal problems including convictions/imprisoned | | |

B) EMPLOYMENT ROLE PROBLEMS:

- | | |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Unemployed | <input type="checkbox"/> No work history |
| <input type="checkbox"/> Laid off | <input type="checkbox"/> Frequently fired |
| <input type="checkbox"/> Seeking disability | <input type="checkbox"/> Jobs held briefly (less than one year) |
| <input type="checkbox"/> Employment is high priority/needs Supported Employment | |

C) HOUSING ROLE PROBLEMS:

- | | | |
|--------------------------------------------------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Homeless | <input type="checkbox"/> Must move |
| <input type="checkbox"/> Problems with cohabitant | | |
| <input type="checkbox"/> Needs skills to move to less restricted housing | | |

D) EDUCATIONAL ROLE PROBLEMS:

- | | | |
|------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Behavior problems at school | <input type="checkbox"/> Reading skills Issues |
| <input type="checkbox"/> Needs special education, technical training, other: _____ | | |

Part Two: Other Role-Related Problem Areas (check when appropriate)

A) RELATIONSHIP PROBLEMS:

- | | | |
|------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> No/Few friends | <input type="checkbox"/> Running away from home |
| <input type="checkbox"/> Family desertion | <input type="checkbox"/> Separation or divorce | <input type="checkbox"/> Visitation or custody disputes |
| <input type="checkbox"/> Child neglect | <input type="checkbox"/> Child abuse | <input type="checkbox"/> Spouse abuse |
| <input type="checkbox"/> Death in family | <input type="checkbox"/> No significant relationships | |
| <input type="checkbox"/> Conflict with peers, siblings, parents, spouse, significant other, children | | |
| <input type="checkbox"/> Other: _____ | | |

B) FINANCIAL PROBLEMS:

- | | | |
|-------------------------------------------------|-------------------------------------------|------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Financial stress | <input type="checkbox"/> Debt |
| <input type="checkbox"/> Budgeting difficulties | <input type="checkbox"/> Bankrupt | <input type="checkbox"/> Destitute |

C) SUBSTANCE ABUSE:

- | | | | |
|-----------------------------------------------------------------|-------------------------------------------|------------------------------------------------|------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> D.T.'s | <input type="checkbox"/> Blackouts | |
| <input type="checkbox"/> Intoxicated now | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Family problems | |
| <input type="checkbox"/> Absenteeism | <input type="checkbox"/> Job loss | <input type="checkbox"/> Abuse-related arrests | |
| <input type="checkbox"/> History of abuse of: | | | |
| <input type="checkbox"/> Narcotics | <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Inhalants |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Marijuana | |
| <input type="checkbox"/> Prescription drugs (which ones): _____ | | | |
| <input type="checkbox"/> Current abuse of: | | | |
| <input type="checkbox"/> Narcotics | <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Inhalants |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Marijuana | |
| <input type="checkbox"/> Prescription drugs (which ones): _____ | | | |
| <input type="checkbox"/> Other: _____ | | | |

The Mental Health Association in North Carolina
Referral Form

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Consumer Name: _____ Record #: _____

Part Three: Current Psychiatric Status (check when appropriate):

A) Danger to Self:

- | | | |
|---------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Suicidal ideation | <input type="checkbox"/> Threats of suicide |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Preoccupation with death | <input type="checkbox"/> Suicide gestures |
| <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Family history of suicide | |
| <input type="checkbox"/> Inability to care for self, explain: _____ | | |

B) DANGER TO OTHERS:

- | | | |
|---------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Thoughts of harm to others | <input type="checkbox"/> Threats of harm to others |
| <input type="checkbox"/> Plans to harm others | <input type="checkbox"/> Attempts to harm others | |
| <input type="checkbox"/> Has harmed others | | |
| <input type="checkbox"/> Inability to care for dependents, explain: _____ | | |

C) DEPRESSIVE SYMPTOMS:

- | | | |
|-----------------------------------------|-------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Sadness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Hypoactive | <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Feelings of worthlessness |
| <input type="checkbox"/> Guilt feelings | <input type="checkbox"/> Crying | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Other: _____ | | |

D) ANXIETY SYMPTOMS:

- | | | |
|----------------------------------------------|----------------------------------|------------------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Obsessions |
| <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Phobia | <input type="checkbox"/> Multiple somatic complaints |
| <input type="checkbox"/> Other: _____ | | |

E) MANIC SYMPTOMS:

- | | | |
|----------------------------------------|---------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Euphoria | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Over-talkativeness | <input type="checkbox"/> Grandiosity |
| <input type="checkbox"/> Extravagance | | |
| <input type="checkbox"/> Other: _____ | | |

F) COGNITIVE SYMPTOMS:

- | | | |
|---------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Short-term memory | <input type="checkbox"/> Long-term memory |
| <input type="checkbox"/> Impaired judgment | <input type="checkbox"/> Comprehension | <input type="checkbox"/> Attention-Span |
| <input type="checkbox"/> Decision-making | | |
| <input type="checkbox"/> Orientation (Time, Place, Person, Circumstances) | | |
| <input type="checkbox"/> Mental retardation (Borderline, Moderate, Severe) | | |
| <input type="checkbox"/> MR must be tested: Verbal Score _____ Performance Score _____ Full Scale _____ | | |

G) PSYCHOTIC/ORGANIC SYMPTOMS:

- | | | |
|---------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Unmanageable | <input type="checkbox"/> Inability to care for self |
| <input type="checkbox"/> Obscene acts | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Wanders off |
| <input type="checkbox"/> Poor personal hygiene | <input type="checkbox"/> Incoherent | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Guarded/Suspicious | <input type="checkbox"/> Confusion | <input type="checkbox"/> Acting out/other behavior disorder |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Delusions | |
| <input type="checkbox"/> Orientation (Time, Place, Person, Circumstances) | | |
| <input type="checkbox"/> Other: _____ | | |

I) EXPLAIN NEED FOR HIGHER LEVEL OF CARE:

- Consumer has Serious Symptoms or Impairment in (check all that applies):
- Social Role Functioning
 - Educational Role Functioning
 - Vocational Role Functioning
- Less restrictive treatment:
- Has failed to improve role functioning
 - Is inappropriate

Referring Clinician Signature/Date _____

**PRELIMINARY APPLICATION FOR ASSISTANCE
CAC OR CHC _____**

1. List each person who would live with you if you receive housing assistance. (Start with yourself.)

LAST NAME	FIRST NAME	DOB	SEX	RELATIONSHIP TO YOU	ANNUAL INCOME	SOCIAL SECURITY NUMBER

2. Are you handicapped/disabled? Yes ___ No ___
3. Does anyone live with you now who is not listed above? Yes ___ No ___
4. Do you expect any change in your household composition? Yes ___ No ___
5. If you answered yes to either #3 or #4, please explain: _____
6. Current Address: Street Address _____
 City _____ State _____ Zip Code _____ Apt. No. _____
 Daytime Phone _____ Evening Phone _____
7. Please identify any special housing needs your household has. _____
8. (For statistical purpose only.) (Check one box each in "a" and "b".)
- a. Is the head of your household?
 ___ White ___ Black ___ American Indian/Alaskan Native ___ Asian/Pacific Islander
- b. Ethnicity of the Head of Household: ___ Hispanic ___ Non-Hispanic

APPLICANT CERTIFICATION: I certify that the statements made on this pre-application are true and complete to the best of my knowledge and belief. I understand that providing false statements or incomplete information may result in punishment under Federal Law.

SIGNATURE OF HEAD OF HOUSEHOLD/LEGAL GUARDIAN _____ DATE _____ TIME RECEIVED _____

SIGNATURE OF SPOUSE OR CO-HEAD _____ DATE _____

RECEIVED BY _____ TITLE _____ DATE _____

TIME _____

