



## COMMUNITY SERVICES NETWORK REFERRAL PACKET Residential, Social, and Supported Employment Services

**CSN Residential referrals are for individuals seeking transitional housing services only and should have a minimum income of \$735 per month.**

**Completion Instructions:** **Do not leave sections blank.** Please complete the entire packet as it is related to services requested. **Incomplete** and **illegible** forms are not accepted. Therefore, we recommend completing this writable pdf that can be printed to fax, mail, or drop off. Please do not email referrals.

- ✓ **Release of Information made out to the Community Services Network (CSN)**
- ✓ **Name of clinician and/or Provider contact information**
- ✓ **Clinical assessment**
  - **Residential** referrals must include: recent clinical assessment with treatment plan, current medication list, psychosocial history, and current clinical status.
  - **All referrals** require current clinical information to receive services (i.e., completed or updated **within the last 12 months**)
  - Attach additional sheets as necessary
- ✓ This packet should **always** be completed in collaboration with your client
- ✓ Clinicians should **always** maintain a copy of the submitted referral in their client's files
- ✓ Please submit a single copy of this form for referral to one or more services
- ✓ Use discretion in providing personal and/or family history when appropriate, delete data deemed not relevant to this referral

**All CSN referrals expire one year from the date of submission.**

### **For information on permanent housing options:**

- **Greater New Haven Supportive Housing Services**  
<http://nhregionalsupportivehousing.blogspot.com/>
- **Greater New Haven Housing Resource Guide:**  
also includes information on emergency shelters, recovery houses, and subsidized housing  
[https://docs.google.com/file/d/0B7mVvcTz\\_jvDeXhuTEt3em9YS28/edit?pli=1](https://docs.google.com/file/d/0B7mVvcTz_jvDeXhuTEt3em9YS28/edit?pli=1)

Mail, fax, or drop off packets to:

Connecticut Mental Health Center  
Attention: Jennifer Gambaccini-Denillo  
34 Park Street - Room 144  
New Haven, CT 06519  
**Fax 203-974-7719**

**\*\*Use the secure drop box when dropping off a packet \*\***

For questions, please contact:

**Ann Joy – Coordinator Supported Employment, Socialization, & Education 203-974-7874**

**Lauren Rusconi – CSN Housing Coordinator 203-974-7311**

**Jennifer Gambaccini-Denillo – Data Coordinator/Senior Administrative Assistant 203-974-7082**

**Additional information can be found at <http://csnct.org>**

CLIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

**Service(s)** check all that apply:

Residential      Social      Vocational      Educational

**Referral Source:**

Referring Case Manager/Clinician: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone (required): \_\_\_\_\_ Fax (required): \_\_\_\_\_

Email: \_\_\_\_\_

Referring Agency: \_\_\_\_\_ If CMHC – Team: \_\_\_\_\_

Primary **Outpatient** clinician (if different than above):

Referring Case Manager/Clinician: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Primary Phone (required): \_\_\_\_\_ Fax (required): \_\_\_\_\_

Email: \_\_\_\_\_

**Client Information:**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (mm/dd/yy) Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Client identifies gender as:      Female      Male      Trans\*      Other \_\_\_\_\_

Is Client a Veteran:      Yes      No

Primary Language \_\_\_\_\_

Education:      GED      HS Diploma      College      Other level of education \_\_\_\_\_

Client Contact Information:

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Race:**

African American/Black      Hawaiian/Pacific Islander  
 Asian      White  
 Native Alaskan      Other \_\_\_\_\_  
 Native American/American Indian

**Ethnicity/Hispanic:**

Central American      South American  
 Mexican      Non-Hispanic  
 Puerto Rican  
 Other (specify) \_\_\_\_\_

**Please Indicate Housing Type at Time of Referral:**

* Hospital (non-psychiatric)		
* Jail/prison or juvenile detention facility		
* Psychiatric hospital or other psychiatric facility		
* Substance abuse treatment facility or detox center		
Emergency shelter		
Permanent housing for formerly homeless persons		
Transitional housing for homeless persons		
Rental by client with no subsidy		
Owned by client with no subsidy		
Place not meant for habitation/streets/cars/parks/sidewalks		
Group Home		
Sober House		
Hotel/Motel		
Staying or living in a family member's room apartment or house	Permanent	Temporary
Staying or living in a friend's room apartment or house	Permanent	Temporary
Other (Please specify)		

**Date address/housing became effective:** \_\_\_\_\_ (mm/dd/yy)

**\* If in hospital or other facility, please provide admission date**

**Legal History**

In order to best serve your client, it is important that we understand the details of his/her legal history. Please provide the information below.

Does client have a legal history:      Yes      No      Any charges pending:      Yes      No

Was client ever incarcerated?      Yes      No

Legal Issues (all that apply):

Arson      Assault      Drug charges      Homicide      Misdemeanor

Robbery      Sex Offense      Weapons      Other \_\_\_\_\_

Currently: Probation      Parole

**Income/Financial**

**MONTHLY Cash Income Sources:**

Earned Income	\$
Unemployment Income	\$
Supplemental Social Security (SSI)	\$
Social Security Disability Income (SSDI)	\$
Retirement Income from Social Security	\$
Private Disability Insurance	\$
Veteran's Pension	\$
Veteran's Disability Payment	\$
Temporary Assistance for Needy Families (TANF)	\$
SAGA Cash	\$
Worker's Compensation	\$
Pension from a former job	\$
Child Support	\$
Alimony or other Spousal Support	\$
State Supplement	\$
Other Client Income (do not include food stamps)	\$
No income	

**Please specify any income benefit applications that are in process or denied, including dates applied:**

**Does client utilize money management assistance?**      Yes      No

If yes, which:      Payee      Conservator      Guardian      CMHC Money Management

**Health Insurance**

Medicare      Medicaid - specify ->      Husky A      Husky C (Title 19)      Husky D

Private Insurance      VA/CHAMPUS      No health coverage

**Disability**

Physical disability?    Yes      No

Accommodations needed: \_\_\_\_\_

Is the client deaf or hard of hearing?      Yes      No

Does the client require an ASL or deaf interpreter? (specify) \_\_\_\_\_

## Clinical/Diagnoses

Please indicate, in detail, all DSM-5 codes and diagnoses: **(All fields are DMHAS requirements and will not be processed if left blank)**

GAF Score: \_\_\_\_\_ Medical: \_\_\_\_\_

Psychosocial/enviromental: \_\_\_\_\_

Has client used substances in the past six months:        Yes        No

If yes, which substances: \_\_\_\_\_ Date of last use: \_\_\_\_\_

Current risk behaviors in the last six months (e.g. suicidality, homicidality, assaultive behavior)

**Please do not leave blank - enter n/a if no risk behaviors**

## SECTION A: Residential Services

Is client currently homeless?        Yes        No        If yes, date became homeless:        (mm/dd/yy)

Client's town of origin:

**Please describe, in detail, client's housing history and what supports the client needs from DMHAS funded services:**

**SECTION B: Social Rehabilitation Services**

**Fellowship Place** provides you with an opportunity to meet people, to learn, and to have fun. We have a variety of programs and services designed with you in mind. You choose the programs you want to try. Please complete the following, so that we can assign to you a Recovery Advisor, who will assist you in choosing the activities you are interested in and in setting recovery goals.

**Please check all programs of interest:**

**Advocacy:** Opportunities for involvement in local and statewide initiatives.

**Career Development:** Activities include on-site volunteering, tutoring, GED preparation, computer classes, community volunteering and resume and other pre-vocational classes.

**Expressive Arts:** Activities include visual art groups, creative writing, music, dance and the ArtShip Collaborative.

**Health and Wellness:** Activities include life skills trainings, cooking class, softball, health groups, smoking reduction/cessation, relaxation/stress management, recovery groups, spirituality groups, and substance abuse recovery groups.

**Social/Recreational:** Activities include field trips, cultural events, community outings, Monday night socials, computer open lab, morning coffee and conversation, weekend drop-in, and meals.

**Spanish Language programming:** A variety of groups facilitated by bilingual staff are available. Please see the most current Program Calendar.

**Young Adult Services:** Specialized programming and activities for individuals ages 18-25.

**Fellowship Inn:** Services are available for individuals who are **homeless.\*\*\*** Activities include help with basic needs, recovery groups, life skills, and case management services.

**\*\*\* Homelessness & Disability Verification forms are required to enroll at Fellowship Inn.**

**Forms can be found at <http://csnct.org>**

**SECTION C: Vocational Services**

**What are the client’s agency preferences?**

APT Foundation

Marrakech Work Services

Easter Seals Goodwill Industries

No preference in a vocational provider

Fellowship Place Career Development

**SAMHSA Grant**

**(eligibility requirements: Criminal justice background and mental illness)**

**Relevant Employment Information:**

Please elaborate on the client’s specific strengths and interests as they relate to employment: