



Transitional Living Services of Northern New York

482 Black River Parkway
 Watertown, New York 13601
 (315) 782-1777
 (315) 785-8628

REFERRAL TO ADULT JEFFERSON COUNTY PROGRAMS

Date: _____ Referring Agent: _____
 Title: _____
 Agency: _____
 Telephone#: _____

FOR APARTMENT PROGRAM AND COMMUNITY RESIDENCE REFERRALS: Psychiatric assessments, social assessments, admission note, history and physical, psychological reports, an Authorization for Restorative Services Form (pg. 5) signed by a permanently licensed psychiatrist must be submitted along with this completed referral.

*** FOR SUPPORTED HOUSING SERVICES:** An eligibility form (pg. 5) signed by a qualified treatment provider must be attached.

IDENTIFYING DATA		REFERRED TO: (Circle One)	
Name:		<input type="radio"/> Community Residence <input type="radio"/> Apartment Program <input type="radio"/> Supported Housing Services	
Medicare:		EMERGENCY CONTACT:	
Medicaid:		Name:	
Soc. Sec. #:		Relationship:	
Date of Birth:		Address:	
Religion:	Identified Cultural Background:		
Marital Status: S M W D Separated		Phone:	
Veteran: Yes	No	Nearest Relative: (if not the same)	
Current Address:		Proxy: Yes	No
Current Telephone #:		Advanced Directives: Yes	No
PSYCHIATRIC DATA:		Agent:	
Diagnosis:	Name	Code	
Axis			
Axis			
Axis			
GAF _____ Current			

(over)

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Current Medications: (Dosage and Frequency) (Psychiatric and Medical)			
Name	Dosage	_____ Psych	_____ Med
		_____ Psych	_____ Med
		_____ Psych	_____ Med
		_____ Psych	_____ Med
		_____ Psych	_____ Med
		_____ Psych	_____ Med
Usual Symptoms of Recurring Illness/Stressors/Past Problem Areas			
MEDICAL DATA	Yes	No	DATES/COMMENTS
Physical Exam (Within 1yr.)			
Mantoux Test (Within 1 yr.) PPD			
Cardiac/COPD Problems			
Diabetes			
Seizure Disorder (Indicate date of last Seizure)			
Allergies			
Special Diet			
Limited Ambulation			Able to do stairs?
Any Restrictions of Activities			
NAMES OF OTHER SERVICE PROVIDERS	ADDRESS		
Psychiatrist:			
Medical Doctor:			
Dentist:			
Eye Doctor:			
Primary Therapist:			
Other:			

SPECIFIC PROBLEMS	Yes	No	COMMENTS
Resistant to Tx. and/or medications			
MICA			
Suicidal Attempts or Ideation			
Trauma			<input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Other
Sexual Misconduct			
Sexual Offender			Level:
Property Damage			
History of Violence			
Criminal History			Probation: Parole:
Arson			

FINANCIAL INFORMATION			
FUNDING SOURCE	ELIGIBLE		AMOUNT RECEIVING
	YES	NO	
Social Security:			
Disability:			
Survivors:			
Retirement:			
Disabled Child:			
SSI			
Public Assistance/DSS Benefits			DSS Caseworker _____ Phone: _____
V.A. Pension			
Payee Status	Own Payee __	Representative Payee __	Name: Address: Phone:
Employed			Where?:
HEALTH INSURANCE			
Medicaid Number:		Issuing County	
Medicare Number:		Plan Type(ie. B, D)	

Private Plan:	VA:
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(over)

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Checking Account:
Savings Account:
Property:
Burial Fund:
Other:

STATEMENT OF NEED:
Please state the reason(s) the referred individual needs this level of housing:

OTHER COMMENTS

Please have person who is applying for services sign.

I am requesting that my referral packet be submitted to North Country Transitional Living, Inc. (NCTLS) and its Admission committee to determine eligibility for their programs. I understand this committee will be made up of representatives from the community and could include people from Social Services, the referral source, and/or other agencies within the community. I also understand that I can participate if I chose to do so. I give my permission for this committee to give and receive information regarding myself.

I understand the referral packet will be checked for completeness. NCTLS may need to contact me or the referral source for further clarification or to request additional documentation.

I am applying for admission to _____ program/residence. I understand and agree to the rules of the program.

Applicant's Signature: _____

Date: _____

***FOR SUPPORTED HOUSING ONLY!*
North Country Transitional Living
Services, Inc. Supported Housing
Program**

I verify that _____ has a severe and persistent mental illness and meets the criteria below. S/he has the DSM-IV Psychiatric diagnosis of _____
Code: _____

Date

**Signature of Registered Nurse,
MSW/CSW, Psychiatrist, or Psychologist**

Please Print Name

Eligibility Criteria

To be considered an adult diagnosed with a severe and persistent mental illness A must be met and B or C or D must be met.

- A. Designated Mental Illness Diagnosis: The individual must be 18 years of age and currently meets the criteria for a DSM-IV psychiatric diagnosis other than alcohol or drug disorders, organic brain syndromes, developmental disabilities, or personality disorders. ICD-9-CM categories and codes that do not have an equivalent in DSM-IV are also NOT included as designated mental illness diagnoses.
- B. SSI or SSDI Enrollment due to Mental Illness: The individual is currently enrolled in SSI or SSDI due to a designated mental illness.
- C. Extended Impairment in Functioning due to Mental Illness: The individual must meet 1 or 2 below:
 - 1. The individual must be functionally disabled due to mental illness for at least the past twelve months either continuously or intermittently in at least two of the following areas: Self Care; Social Functioning; Activities of Daily Living; Ability to Concentrate
 - 2. The individual has met the criteria for ratings of 50 or less on the Global Assessment of Functioning Scale due to a designated mental illness over the past twelve months on a continuous or intermittent basis.

D. Reliance on Psychiatric Treatment, Rehabilitation and Supports: A documented history shows the individual at some point prior, met the threshold for C (above), but symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports.