#

**BUCKS COUNTY DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL PROGRAMS**

**ADULT MENTAL HEALTH CENTRALIZED RESIDENTIAL REFERRAL FORM**

**Please send the original referral to:**

**MH Residential - Attn: Eric D. Eck**

**Email:** **MHResReferrals@buckscounty.org**

 **INTRODUCTION**

* **This Referral is good for 9 months from the date it was completed. A new referral must be submitted at that time if the individual is not yet placed and still in need of housing.**
* If you have a Case Manager and or a Certified Peer Specialist, they can assist in the referral process for residential programs.
* Housing options are available to eligible Bucks County residents who are diagnosed with either a serious mental health disorder or a co-occurring disorder.
* Most of these programs are designed to be transitional, **up to** **a maximum two-year length of stay**.

**ELIGIBILITY CRITERIA**

* + These services are for individuals who meet the OMHSAS SPMI diagnostic criteria, are over the age of 18, and have Bucks County residency of 3 months or more preferred.
	+ Individuals who are experiencing homelessness, protracted inpatient psychiatric hospitalization, are forensically involved, or are transitional age youth will be given priority status.
	+ Income is required. Individuals without income is limited and will be approved on a case-by-case basis when available.
	+ Referrals should be completed for individuals who agree to this support, and potential mobile supports when recommended by the support team.
	+ All referrals are returned to Bucks County MH for review and may divert the applicant to other services and supports if MH funded housing is not required for an individual’s success in the community.
	+ Documents to be included are the MH Residential Referral document, Psychiatric Evaluation within one year, and Release of Information. Questions can be directed to Eric Eck at edeck@buckscounty.org.
	+ Questions about the referral process can also be directed to:

**Community Referrals/Non-Forensic involvement**: Todd Piorun, Diversion Navigator with Penndel MHC: tpiorun@penndelmhc.org

**Bucks County Correctional Facility:** Derek Davis, Forensic Re-entry Specialist: dsdavis@buckscounty.org

**On Probation, Pending New Charges & State Correction involvement**: Reanna Serafine, Forensic Diversion and Reintegration Specialist: rmserafine@buckscounty.org

* + Contingency funding to support an individual’s return to their home prior to admission or other community living situations can be discussed with Joyce Schug, Eric Eck or Todd Piorun.
	+ MH staff will encourage referents to make applications to any appropriate community housing resource. This could include a call to the Housing Link to access a rental subsidy program, housing location assistance or application to HUD’s Voucher program. Individuals may also be eligible for the 811 Project Rental Assistance program.

**Instructions for Completing the Centralized Referral**

**STEP 1:** Review the Eligibility Criteria and complete the information on theReferral form.

**STEP 2:** Have the individual read and sign the referral statement on the referral form.

**STEP 3:** Forward completed Referral to the BH/DP to **MHResReferrals@buckscounty.org**

**STEP 4:** The Bucks County MH Designee will review the referral to ensure the referral is

 complete, and information is entered into a centralized database for all residential

 referrals. It is the responsibility of the individual/referring agent to update the county

 of any changes, including contact information, level of interest, and medical

 and psychiatric updates, etc.

 **STEP 5:** If the referral meets eligibility criteria and the complete referral is received, the referral and additional information will be forwarded to Diversion Navigator.

**STEP 6:** When the county is notified of an upcoming vacancy, eligible referrals meeting the

vacancy criteria will be identified and forwarded to the provider.

**STEP 7:** Upon review of the referral and supporting documentation, the prospective provider(s)

will contact the referring agent to set up an interview. The county will be informed of

 the interview outcome and disposition of referral.

**STEP 8:**  The referring agent will be informed of outcome and next steps.

**\*PLEASE CHECK ALL APPROPRIATE RESIDENTIAL PREFERENCES, DO NOT CHECK ALL OPTIONS\***

**Check Level of Care Provider Gender #Beds/Forensic Staffing/Additional Supports**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  [ ]  | Enhanced CRRBARN | Lenape Valley Foundation | Coed | 6Forensic (Y) | 24 Hour Double Staffing/7 Days |
|  [ ]  | Intensive CRR | Penndel Mental Health Center  | Coed | 14Forensic (Y) | 24 Hour Staffing/7 Days  |
|  [ ]  | Max CRR | St. Luke’s Penn Foundation | Coed | 8Forensic (Y) | 24-hour Staffing/Staff shared between Max CRR and Townhomes; Staff located in CRR. |
|  [ ]  | Mod/MaxCRRS | Merakey | Coed | 8 Max and 8 ModForensic (Y) | 24 Hour Staffing/7 Days MaxMod has access to staff onsite as needed. |
|  [ ]  | Mod. CRR | COMANS, Inc. | Coed | 24 including9 Transitional Age YouthForensic (Y) | Weekdays- Daytime Staff.Weekends- Part-time Staff.No Overnight Staff. |
|  [ ]  | Intensive SLPMedically Enhanced | Horizon House | Coed | 10Forensic (Y) | 24 Hour Staffing/7 Days |
|  [ ]  | Intensive SLPForsythia | Lenape Valley Foundation  | Coed | 5Forensic (Y) | 24 Hour Staffing/7 Days |
|  [ ]  | Intensive SLPAging in Place | Penndel Mental Health Center  | Female | 8Forensic (N) | 24 Hour Staffing/7 Days |
|  [ ]  | Intensive SLPEaston Rd. | RHA | Male | 10Forensic (Y) | 24 Hour Staffing/7 DaysOvernight awake staff. |
|  [ ]  | Intensive SLPStreet Rd. | RHA | Female | 10Forensic (Y) | 24 Hour Staffing/7 Days Overnight awake staff.  |
|  [ ]  | Intensive SLP Village of Hope | St. Luke’s Penn Foundation | Coed | 16Forensic (Y) | 24 Hour staffing/7 Days.Cooccurring disorder (MH/D&A) |
|  [ ]  | SLPSparrow/Parker | COMANS, Inc.. | Coed | 15Forensic (Y) | Minimum 4 hours a day of staffing.No overnight staffing. |
|  [ ]  | SLPLeeward | COMANS, Inc. | Male | 5Forensic (Y) | Minimum 4 hours a day of staffing.No overnight staffing. |
|  [ ]  | SLP/HUD 811Leeward | COMANS, Inc. | Female | 5Forensic (Y) | Minimum 4 hours a day of staffing.No overnight staffing. |
|  [ ]  | SLP/HUD 811Durham | COMANS, Inc. | Coed | 8Forensic (Y) | Minimum 4 hours a day of staffing.No overnight staffing. |
|  [ ]  | SLPShady Retreat | Lenape Valley Foundation  | Coed | 12Forensic (Y) | Weekdays- Daytime/Evening Staff - 7 DaysStaff available for after-hour emergencies |
|  [ ]  | SLPFranklin Ave. | Penndel Mental Health Center | Male | 5Forensic (Y) | Daytime Staffing.Staff is available after hours for emergencies. |
|  [ ]  | SLP/HUDGlen Hollow Apts. | Penndel Mental Health | Coed | 12Forensic (N) | Staff full time weekdays Staff is available after hours for emergencies. |
|  [ ]  | SLPPenn Villa | St. Luke’s Penn Foundation  | Coed | 12Forensic (Y) | Staff shared between Max CRR and Penn Villa Townhomes; staff located in Max CRR. |
|  [ ]  | Independent SLPQuarters B | Lenape Valley Foundation  | Coed | 6Forensic (Y) | Independent.Staff is available or after-hour emergencies. |
|  [ ]  | Supportive HousingTrenton Ave. | COMANS, Inc.. | Coed | 4Forensic (Y) | Mobile supports, Co-Mans staff visits in person twice monthly. |
|  [ ]  | Supportive HousingValley House | Lenape Valley Foundation | Coed | 10Forensic (Y) | Mobile supports.Staff available for emergencies. |
|  [ ]  | Supportive HousingWashington Ave. | Penndel Mental Health Center | Coed | 9Forensic (Some)  | House is fully independent, there is no staff on site. Staff checks in as needed. |
|  [ ]  | Permanent Supportive Housing | Penndel Mental Health Center- HUD | Coed | 5Forensic (Y) | Rehabilitation and treatment including ACT, PATH, BCM, Peer. |

**\*Referrals To Be Completed Only By Direction of Department of MH/DP\***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  [ ]  | LTSR | RHA | Coed | 7Forensic (Y) | 24 Hour Staffing/7 Days including 8 hours of Psychiatry |
|  [ ]  | LTSR | Resources for Human Development | Coed | 8Forensic (Y) | 24 Hour Staffing/7 Days including 8 hours of Psychiatry |
|  [ ]  | Intensive SLP | Men’s Wellness HouseNewfound Freedom | Men | 9Forensic (Y) | 24 Hour Staffing/7 days  |
|  [ ]  | Intensive SLP | Woman’s Wellness HouseComans, INC | Women | 3Forensic (Y) | 24 Hour Staffing/7 days |
|  [ ]  | Enhanced Personal Care Home | Allegria at The Oaks | Coed | 12Forensic (Some) | 24 Hour Staffing/7 days |

**REGIONAL PROGRAM INFORMATION**

**\*\*\* Additional Referral Required, Contact Eric Eck for more information\*\*\***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  [ ]  | Cherry Hill LTSR | RHA—Pottstown PA | Coed | 2 Bucks BedsForensic (Y) Exception: sex offenders | 24 Hour Staffing/7 Days including 8 hours of Psychiatry **Must have Health Choices** |
|  [ ]  | STARMax CRR (locked)Sexualized Behaviors | CareLink Community Support ServicesNorristown, PA | Coed | 1 Regional Bed2 county funded bedsForensic (Y) | 24 hours staffing/7 Days |
|  [ ]  | Unity VillaSLP with Psych Rehab License | ElwynPhiladelphia, PA | Coed | 6 Bucks BedsForensic (Y) Exception: sex offenders, drug conviction or arson | 24 hours staffing/7 Days**Must have Health Choices** |
|  [ ]  | NOVA II SLP Medically Enhanced | RHD | Coed | 4 Bucks BedsForensic (Y) | 24 Hour Staffing including a nurse 24/7**Must have Health Choices** |
|  [ ]  | Friendship ManorISL | CareLink Community Support ServicesPottstown, PA | Coed | 3 Bucks BedsForensic (Y) | 24 hours staffing/7 Days |

**Bucks County Adult Centralized Residential Referral Form**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_ **Best contact number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D.O.B.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age\_\_\_\_\_\_\_ How would you describe your gender?** [ ]  Male [ ]  Female [ ]  Self describe as **Do you identify as transgender or have a transgender history?** [ ]  Y [ ]  N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a valid driver’s license?** [ ]  Y [ ]  N **Own a car?** [ ]  Y [ ]  N **Is your registration current?** [ ]  Y [ ]  N

**Medical Insurance**: [ ]  Medicaid [ ]  Medicare [ ]  Private [ ]  Community Health Choices

**Veteran:** [ ]  Y [ ]  N - If yes, honorable discharge: [ ]  Y [ ]  N **Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Natural Supports:** (family, friends, community) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Referral to MH Housing/Services**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What Skills Do You Wish to Gain Through MH Housing/Services?**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Level of Residential Program Requested**: [ ]  Intensive CRR [ ]  Maximum [ ]  Moderate [ ]  Supportive [ ]  VOH (MH/D&A) [ ]  Enhanced CRR [ ]  LTSR [ ]  Regional Program [ ]  Wellness House [ ]  Allegria (PCH)

**Current Housing Situation**

Currently With Family: [ ]  Y [ ]  N If yes, with whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently in Own Residence: [ ]  Y [ ]  N If yes, where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_

Currently in Hotel/Motel: [ ]  Y [ ]  N If yes, where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently in Recovery House: [ ]  Y [ ]  N If yes, where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently Inpatient: [ ]  Y [ ]  N If yes, where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently in EAC: [ ]  Y [ ]  N If yes, where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently Resident in CRR/SLP: [ ]  Y [ ]  NIf yes, provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently in Crisis Residential: [ ]  Y [ ]  N If yes, program name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently In Shelter: [ ]  Y [ ]  N If yes, shelter name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Impending Eviction: [ ]  Y [ ]  NIf yes, date of eviction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently Incarcerated: [ ]  Y [ ]  N If yes, name of correctional facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Release Date: \_\_\_\_\_\_\_\_\_\_\_

Homeless prior to Incarceration: [ ]  Y [ ]  N

Currently Homeless: [ ]  Y [ ]  NIf yes, where did you sleep last night?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of times you have been on the streets, or in an emergency shelter in the past 3 years including today: \_­­­­­\_­­­\_­­­­­­­­­­­­­­­­­­­­­­­\_­­­­­­­­­­­­­­­\_\_\_\_\_\_

Total number of consecutive months homeless on the street, or in an Emergency Shelter in the past 3 years: \_\_\_\_\_\_\_\_\_\_

Are you experiencing Domestic Violence, or homelessness because of Domestic Violence? [ ]  Y [ ]  N

Has Bucks County Housing Link (1-800-810-4434) been contacted? [ ]  Y [ ]  N If yes, date of contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have Street Outreach/PATH worker met with you? [ ]  Y [ ]  N If yes, date of contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you applied for a Housing Choice voucher**?** [ ]  Y [ ]  N If yes, date of application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Income/Employment/Education**

Monthly Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Source(s) of Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is an SSI or SOAR application in process? [ ]  Y [ ]  N If yes, date of application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rep Payee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently employed? [ ]  Y [ ]  N If yes, place of employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start date: \_\_\_\_\_\_\_\_\_\_

Interested in employment or volunteering? Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interested in becoming a Certified Peer Specialist? [ ]  Y [ ]  N Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interested in GED, continuing education, or college? [ ]  Y [ ]  N Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal**

Do you have any pending legal charges? [ ]  Y [ ]  N Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please search on provided website and attach to referral. (Criminal Docket Link:** [**https://ujsportal.pacourts.us/CaseSearch**](https://ujsportal.pacourts.us/CaseSearch)**)**

Current Probation/Parole Officer: [ ]  Y [ ]  N Name/Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health/Drug and Alcohol**

**Please check all community treatment, rehabilitation, and other services that you currently have:**

[ ]  Certified Peer Specialist [ ]  Employment [ ]  Education [ ]  Drop-in Center

[ ]  Outpatient [ ]  Partial Hospitalization [ ]  Psychiatric Rehabilitation [ ]  RTF

[ ]  Drug/Alcohol [ ]  Family Based [ ]  Bucks LIFE [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Management: [ ]  Y [ ]  N Type: [ ]  ACM [ ]  BCM [ ]  Penndel ACT [ ]  LVF ACT [ ]  FACT [ ]  D&A CM [ ]  TIP Current

Primary MH or Drug and Alcohol Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Psychiatric Evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health Diagnosis (List All): \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Drug/Alcohol Diagnosis (List All): \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Drug of Choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Marijuana Card: [ ]  Y [ ]  N

Tobacco Smoker? [ ]  Y [ ]  N Interested in quitting? [ ]  Y [ ]  N

Have you ever been diagnosed with **Autism** [ ]  Y [ ]  N **TBI** [ ]  Y [ ]  N **ID** [ ]  Y [ ]  N

Have you ever applied for the Autism, TBI, or ID Waiver? [ ]  Y [ ]  N If yes, which type & date applied: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced trauma? [ ]  Y [ ]  N

**List All Psychiatric, Drug and Alcohol AND Medical hospitalizations/placements within the past twelve (12) months:**Reason for Admission: Hospital: Dates of Inpatient Stay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prior State Hospitalization: [ ]  Y [ ]  N If yes, dates and hospital name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Health**

Current Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Physical Examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last TB Test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Diagnosis (List All): \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of any of the following medical conditions?

[ ]  Neurological Disorders [ ]  Dietary Restrictions [ ]  Require Oxygen

[ ]  Infectious / Communicable Diseases [ ]  Allergic Reactions [ ]  Wear Glasses/Contacts

[ ]  Diabetes [ ]  Immunodeficient Diseases [ ]  Use Hearing Aid

[ ]  Physical Disabilities [ ]  Prosthetics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Feeding Tube

[ ]  Incontinence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Specify Other Relevant Medical Needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Self-Preservation Skills:**

Are you ambulatory? [ ]  Y [ ]  N Do you use a wheelchair? [ ]  Y [ ]  N A cane? [ ]  Y [ ]  N A walker? [ ]  Y [ ]  N Can you climb stairs? [ ]  Y [ ]  N Do you **require** a first-floor bedroom? [ ]  Y [ ]  N

 **Can you vacate a residential site in the event of fire and/or the sounding of emergency alarms, recognize environmental danger signals or detect of the onset of fire or another emergency (PLEASE CIRCLE ONE):**

 **1.** Promptly without assistance. **2.** With minimal verbal assistance from staff. **3.** With minimal physical assistance from staff.

 **4.** With minimal physical and verbal assistance from staff. **5.** Only with continual physical and verbal assistance.

(It is the responsibility of the prospective residential provider to further assess for self-preservation during the interview process).

**Rate Your Current Interest in MH Housing/Services**

**(PLEASE CIRCLE 1) Very Interested Somewhat Interested Neutral Slightly Interested Opposed**

**Signature of Applicant**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Referring Agent**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name/Title of Referral Source**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Agency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ext:** \_\_\_\_\_\_\_ **E-Mail Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has the individual been referred to other services/programs (e.g. BCM/ACT/CPS)?** [ ]  Y [ ]  N

**If yes, date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Status of referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referral Source: Assess the extent to which individual requires assistance, education, or support in the following psychosocial areas, using the following indicators:** (1) **Totally self-sufficient** (2) Needs verbal advice or guidance (3) Needs some education or supervision (4) Needs substantial assistance (5) **Totally dependent** 1 2 3 4 5 Money Management 1 2 3 4 5 Household/Apartment Management

 1 2 3 4 5 Social Skills 1 2 3 4 5 Time Management 1 2 3 4 5 Community Awareness 1 2 3 4 5 Cooking Skills 1 2 3 4 5 Health-care Skills 1 2 3 4 5 Medication Management

 1 2 3 4 5 Emergency Evacuation 1 2 3 4 5 Ambulation

 1 2 3 4 5 Personal-care Skills 1 2 3 4 5 Housekeeping skills

**Referral Source: To the best of your knowledge, has individual ever presented with any of the following behaviors? Please check if applicable.**

[ ]  Physical Aggression [ ]  Eating Disorder [ ]  Sexual Acting Out

[ ]  Non-Compliance MH Treatment [ ]  Hygiene/ADL Concerns [ ]  Elopement

[ ]  Non-Compliance Medical Treatment [ ]  Self-Harm

[ ]  Non-Compliance- Medication Management [ ]  Suicide Attempts/Gestures

[ ]  Fire Setting Behavior [ ]  Criminal History

**To expedite the referral process, please ensure all information is completed and attached. Referrals without recent Psychiatric Evaluations will not be processed.**

[ ]  Most recent Psychiatric Evaluation (Within the last 6-12 months)

[ ]  Most recent Physical Examination and TB test. (Within 6 mo. required if accepted to placement.)

[ ]  Signed and dated referral by referred individual and the referral party.

[ ]  Copy of criminal docket/criminal history from [**https://ujsportal.pacourts.us/CaseSearch**](https://ujsportal.pacourts.us/CaseSearch)

[ ]  Include progress notes for the last (30) thirty days. (When available).

[ ]  Include current financial information (e.g., SSD, SSI, pension, income

[ ]  Signed releases by referred individual, allowing Diversion Navigator and Bucks County Department of MH/DP to share pertinent information with collaborative partners.

**\*Email: edeck@buckscounty.org for follow-up only, please do not send referrals directly to this email.**



