CHJC Human Services & Community-Based Programs

Jefferson County Adult Single Point of Entry (SPOE) Adult Case Management Referral Form (18 and older)

USE THIS FORM TO MAKE REFERRALS FOR:
(S.H.C.M.) Supported Housing Case Management Services: (Person usually seen 1-2x monthly)
(S.C.M.) Supportive Case Management Services: (Person usually seen 2-3x monthly)
(I.C.M.) Intensive Case Management Services: (Person usually seen weekly)
(C.B.C.M.) Community Based Case Management: (Person usually seen for weekly therapy)

Name of Individual: _____ Tel #: _____ Date Received: _____

Address: _____

DOB: _____ Gender: _____ Social Security #: __ __ __ / __ __ / __ __ __ __

Referrer: _____ Title: _____ Tel #:_____

Agency/Agency Address: _____

Relationship to Individual: _____

Emergency Contact Person: _____ Relationship: _____

Address: _____ Phone #: _____

INCOME: Total Monthly Income: _____

SSI ____ PA ____ SSD ____ Employed ____ Other (specify) _____

Applied for: SSI ____ PA ____

PSYCHIATRIC INFORMATION:

Therapist: _____ Tel # _____

Psychiatrist: _____ Tel # _____

Current Treatment Programs: _____

Diagnosis:		Name:	Code:
	Axis I	_____	_____
	Axis II	_____	_____
	Axis III	_____	_____
	Axis IV	_____	_____
	Axis V	_____	_____

Medications: _____ _____

_____ _____

History of Suicidal Ideation _____ If yes, specify: _____

_____

History of Suicidal Attempts _____ If yes, specify: _____

_____

History of Homicidal Ideation _____ If yes, specify: _____

_____

Recent Self-injurious Behavior _____ If yes, specify: _____

_____

History of Psychiatric Hospitalizations _____ If yes, list any psychiatric hospitalizations and or out-patient treatment during the last 3 years: _____

_____

_____

List all past successful services: _____

_____

_____

Does the individual use crisis services? (e.g. CPEP, Alcohol Crisis Center, ER, Respite, Emergency Shelters) Yes ____ No ____ If yes, specify: _____

_____

Person's Daily Routine: _____

_____

Is Person Literate? Yes ___ No ___ Explain as needed: _____

_____

Is Person a Veteran? Yes ___ No ___

AREAS OF SPECIAL CONCERN:	**YES**	**NO**
Criminal Justice (Forensic)	____	____
History of sexually assaultive behavior	____	____
Homelessness	____	____
Assaultive behavior	____	____
Arson	____	____
History of trauma	____	____
Traumatic brain injury	____	____
Alcohol / substance abuse	____	____
Developmentally disabled	____	____

For all areas checked yes, please elaborate: (For forensic history, please include specific charges, arrest history, dispositions and legal status) _____

_____

_____

RISK FACTORS:

Please check which risk factors apply to the person being referred. Use the space below to give a brief explanation of the checked risk factors and to expand on other information on the referral form as needed.

- ❑ **CURRENT OR HISTORY OF SUBSTANCE ABUSE ISSUES**
- ❑ **CURRENTLY IN JAIL**
- ❑ **AOT REFERRED**
- ❑ **CURRENT EXACERBATED SYMPTOMS OR RAPID CYCLING**
- ❑ **HISTORY OF HOSPITALIZATIONS PRIOR TO 1 YEAR AGO**
- ❑ **HISTORY OF VIOLENCE**
- ❑ **CHRONIC HISTORY OF SUICIDE ATTEMPTS OR SELF-INJURIOUS BEHAVIOR**
- ❑ **HISTORY OF NONCOMPLIANCE WITH TREATMENT**
- ❑ **CURRENT PARENT/CHILD ISSUES**
- ❑ **LACK OF SUPPORT SYSTEM**
- ❑ **CURRENT DIFFICULTY WITH SELF CARE**
- ❑ **CURRENT DIFFICULTY WITH ADL'S**
- ❑ **CHRONIC VOCATIONAL/ECONOMIC PROBLEMS**
- ❑ **CURRENT PROBLEMS WITH SELF DIRECTION/CONCENTRATION**
- ❑ **CURRENT DIFFICULTY COPING WITH MAJOR OR MULTIPLE MEDICAL PROBLEMS**
- ❑ **CHRONIC HOUSING ISSUES**
- ❑ **CHRONIC LEGAL ISSUES**
- ❑ **OTHER _____**

Explanation: _____
_____
_____
_____

HEALTH:

Medicaid Yes ____ No ____ Medicaid # __ __ __ __ __ __ __ __
Medicare Yes ____ No ____ Medicare # __ __ __ __ __ __ __ __
List all other insurance / managed care # _____
_____

Physician's Name: _____ Tel # _____

Dentists Name: _____ Tel # _____
If no current provider, where has the individual gone in the past? _____
_____
Medical Conditions: _____
_____

HOUSING:

Current living situation (e.g. independent living, group home etc): _____
_____

Does the person currently have a subsidy? _____ If yes, where? _____
If no, has a subsidy been applied for? Yes ____ No ____

CASE MANAGEMENT:

Previous case management: _____ If yes, where and when? _____
_____

Individual Being Referred For: Rental Assistance _____ Start-up Funding _____
Emergency Funding _____ Supported Housing CM _____ Supportive CM _____
Intensive CM _____ Community Based CM _____

What are the specific objectives for this referral? _____
_____
_____

Please describe the person's ability to:
1. Set realistic goals: _____
2. Follow through on agreed plan: _____

Is the individual aware of this referral? Y ____ N ____

Is the individual interested in services? Y ____ N ____

Please list the individual's skills and strengths
_____
_____
_____
_____

SUPPORTS / LEISURE TIME ACTIVITIES:

Natural Supports: _____

Leisure activities: _____

Social clubs / support groups: _____

VOCATIONAL:

VESID Involvement Current ____ Past ____ If so, when _____

Employment History: _____
_____

EDUCATIONAL:

Educational History: _____
_____

Additional Comments: _____
_____
_____
_____

Home Visit Safety: (Safety issues are addressed to help assure Case Manager can go into home).

Are there safety issues associated with the person or others in the household? ____ If yes, explain:
_____

Are there weapons in the home? ____ If yes, explain: _____
_____

Are there potentially dangerous animals in the home? _____ If yes, explain: _____
_____

Who else resides in the home? _____

Completed By: _____ **Signature:** _____ **Date:** _____
(Print Name)

Signature of Person Being Referred: _____ **Date:** _____

Please mail completed referral form to: Jefferson County SPOE Coordinator, Marcy Building Suite 240, 167 Polk Street, Watertown, NY 13601; or Fax to 315-777-9275.

- **To facilitate the processing of this referral, please ensure that all forms are completed and the following attachments are included:**
  - **Adult SPOE Eligibility Criteria and Level of Care Determination Form**
  - **Most recent Psychiatric and Social Assessment (include an updated summary if PSA is more than 1 year old).**
  - **Most recent Discharge Summary (if history of hospitalization).**

Thank you!