



Transitional Living Services of Northern New York

482 Black River Parkway
 WATERTOWN, NEW YORK 13601
 (315)782-1777
 FAX (315)785-8628

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

- ❖ **FOR APARTMENT PROGRAM AND COMMUNITY RESIDENCE REFERRALS:** Psychiatric assessments, social assessments, history and physical, psychological reports and an Authorization for Restorative Services Form (page 7) signed by a permanently licensed psychiatrist must be submitted along with this completed referral (please attach an updated summary if assessments are over 1 year old).
- ❖ **FOR SUPPORTED HOUSING SERVICES:** An eligibility form signed by a qualified treatment provider must be attached (page 8).
- ❖ **FOR CASE MANAGEMENT REFERRALS:** Psychiatric and/or psychological reports must be attached (if the report is over 1 year old please attach an updated summary).
- ❖ **FOR MICA HOMELESS PROGRAM:** An eligibility form signed by a qualified treatment provider must be attached (page 9).

IDENTIFYING DATA		REFERRED TO: (Circle One)	
Name:		Community Residence	Apartment Program
Current Address:		Supported Housing	Case Management
Medicare:		MICA Homeless Program	
Medicaid:		EMERGENCY CONTACT:	
Soc. Sec. #:		Name:	
Date of Birth:		Relationship:	
Marital Status: S M W D Separated		Address:	
Veteran: Yes No		Phone:	
Current Telephone #:		Nearest Relative: (if not the same)	
		Advanced Directives: Yes No	
PSYCHIATRIC DATA:		Agent:	
Diagnosis:	Name	Code	
Axis I:			
Axis II:			
Axis III:			
Axis V:	GAF _____	Current	

Current Medications: (Dosage and Frequency) (Psychiatric and Medical)				
Name	Dosage			
		___ Psych	___ Med	
		___ Psych	___ Med	
		___ Psych	___ Med	
		___ Psych	___ Med	
		___ Psych	___ Med	
		___ Psych	___ Med	
MEDICAL DATA		Yes	No	DATES/COMMENTS
Physical Exam (Within 1yr.)				
Mantoux Test (Within 1 yr.) PPD				
Sleep Apnea				
Cardiac/COPD Problems				
Do they require oxygen/breathing machine?				
Diabetes				Are they required to test blood sugar?
If yes, are they independent with management (testing, injections, etc.)				
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/PHONE NUMBER		
Psychiatrist:				
Medical Doctor:				
Dentist:				
Eye Doctor:				
Primary Therapist:				
Specialists (cardiologist, podiatrist, pulmonary, neurologist, etc.)				
Other:				

Usual Symptoms of Recurring Illness/Stressors/Past Problem Areas/Methods employed to prevent acting out

SPECIFIC PROBLEMS	Yes	No	COMMENTS
Resistant to Tx. and/or medications			
Multiple Psychiatric Hospitalizations			When/Where/Frequency?
Long Term Psychiatric Hospitalization (over 1 year) *Please complete long term stay Form(page 6)			When/Where/Length of Stay?
MICA			
Alcohol Abuse			
Drug Abuse			
Substance Abuse Treatment			
Suicidal Ideation			Specify:
Suicidal Attempts			Specify:
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			
MANAGEMENT PROBLEMS	YES	NO	COMMENTS
Activities of Daily Living (hygiene, chores, laundry, cooking, shopping etc.)			
Nighttime Agitation			
Temper Outbursts			
Incontinence			
Elopement			
Smokes Safely			
Frequent Crisis Contacts(mobile crisis, ER visits, police contact etc.)			
Social or Family Network			
Aware of Basic Fire Safety			
Are they able to self preserve?			

SOCIAL DATA			
Education Level:		VESID INVOLVEMENT: yes___ no___	
Employment Training History:			
Current Day/Social Programs:			
History of Homelessness:			
Any previous Supervised Living(date/location):			
Describe any previous living environment the individual cannot return to along with specific Problems or reasons:			
Interests and Hobbies:			
FINANCIAL INFORMATION			
FUNDING SOURCE	ELIGIBLE		AMOUNT RECEIVING
Social Security:	YES	NO	
SSI			
Disability:			
Survivors:			
Retirement:			
Disabled Child:			
Public Assistance/DSS Benefits			DSS Caseworker _____ Phone: _____
V.A. Pension			
Payee Status	Own Payee ___	Representative Payee ___	Name: Address: Phone: Where?:
Employed			
HEALTH INSURANCE			
Medicaid Number:		Issuing County	
Medicare Number:		Plan Type (i.e. B, D)	
Private Plan:		VA:	

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 Transitional Living Services of Northern New York and its Admission Committee to determine eligibility for their programs. I understand this committee will be made up of individuals from within the agency and may include representatives from the adult programs, the Director of Adult Services, Director of Quality Assurance and Corporate Compliance and the Intake Coordinator. I give my permission for this committee to give and receive information regarding myself.

I am applying for admission to _____ program/residence.

Applicant's Signature: _____

Date: _____

