Transitional Living Services of Northern New York

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

CASE MANAGEMENT PROGRAM:
Adult case management services will assist adults with serious mental illness to obtain needed medical, social, psychosocial, educational, financial, and other services.

- **FOR CASE MANAGEMENT REFERRALS**: Please complete the Adult Referral Form. Please attach a copy of the most recent psychological/psychiatric evaluation with documentation of psychiatric diagnosis.

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

Referring to:
Case Management

Identifying Data:

Please indicate if applicable:
☐ PC Long Stay
☐ MRT
☐ RCE

NAME: _____

ALIAS/MAIDEN: _____

SEX: ☐ Male ☐ Female

STREET: _____

CITY: _____

ZIP: _____

SS NUMBER: _____

DOB: _____

TELEPHONE #: _____

MARITAL STATUS: S M W D Separated

INSURANCE TYPE: _____

POLICY NUMBER: _____

ISSUING COUNTY: _____

VETERAN: ☐ Yes ☐ No

Emergency Contact:

NAME: _____

RELATIONSHIP: _____

STREET: _____

CITY: _____

NEAREST RELATIVE: _____

ADVANCED DIRECTIVES: ☐ Yes ☐ No

AGENT: _____

Psychiatric Information:

Psychiatric Providers:

Therapist: _____ Clinic: _____

Psychiatrist: _____ Clinic: _____

Diagnosis:

AXIS I: _____ CODE: _____

AXIS I: _____ CODE: _____

AXIS II: _____ CODE: _____

AXIS III: _____ CODE: _____

AVIS V: _____Current GAF: _____ CODE: _____

Current Medications:

☐ Psych ☐ Medical Name: _____ Dosage: _____

☐ Psych ☐ Medical Name: _____ Dosage: _____

☐ Psych ☐ Medical Name: _____ Dosage: _____

☐ Psych ☐ Medical Name: _____ Dosage: _____

☐ Psych ☐ Medical Name: _____ Dosage: _____

☐ Psych ☐ Medical Name: _____ Dosage: _____

Medical Information:

Physical Exam	☐ Yes	☐ No	Comments: _____
Mantoux Test (within 1 yr.) PPD	☐ Yes	☐ No	Comments: _____
Sleep Apnea	☐ Yes	☐ No	Comments: _____
Cardiac/COPD Problems	☐ Yes	☐ No	Comments: _____
If yes, do you require oxygen/breathing machine?		☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Comments: _____
If yes, are you required to test blood sugar?		☐ Yes	☐ No
If yes, are you independent with management?		☐ Yes	☐ No
Seizure Disorder	☐ Yes	☐ No	Date of last incident: _____
Allergies	☐ Yes	☐ No	Comments: _____
Special Diet	☐ Yes	☐ No	Comments: _____
Limited Ambulation	☐ Yes	☐ No	Comments: _____
Any restrictions of activities	☐ Yes	☐ No	Comments: _____

Medical Providers:

Medical Doctor: _____ Practice: _____

Dentist: _____ Practice: _____

Specialist: _____ Practice: _____

Other: _____ Practice: _____

Specific Problems:

Resistant to treatment and/or medications ☐ Yes ☐ No Comments: _____

Multiple psychiatric admissions ☐ Yes ☐ No Comments: _____

Long term psychiatric admission (over 1 year) ☐ Yes ☐ No Comments: _____

MICA ☐ Yes ☐ No Comments: _____

- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Substance abuse treatment

Suicidal Ideations ☐ Yes ☐ No Comments: _____

Suicidal Attempts ☐ Yes ☐ No Comments: _____

Trauma ☐ Yes ☐ No Comments: _____

Sexual Misconduct ☐ Yes ☐ No Comments: _____

Sexual Offender ☐ Yes ☐ No Comments: _____

Property Damage ☐ Yes ☐ No Comments: _____

History of Violence ☐ Yes ☐ No Comments: _____

Criminal History ☐ Yes ☐ No Probation/Parole Officer: _____

Arson ☐ Yes ☐ No Comments: _____

Management Problems:

Daily living skills (cooking, chores, budgeting, etc) ☐ Yes ☐ No Comments: _____

Nighttime agitation ☐ Yes ☐ No Comments: _____

Temper outbursts ☐ Yes ☐ No Comments: _____

Incontinence ☐ Yes ☐ No Comments: _____

Elopement ☐ Yes ☐ No Comments: _____

Smokes safely ☐ Yes ☐ No Comments: _____

Frequent crisis contacts (ER, police, etc) ☐ Yes ☐ No Comments: _____

Social or Family ☐ Yes ☐ No Comments: _____

Aware of basic fire safety ☐ Yes ☐ No Comments: _____

Are you able to self preserve? ☐ Yes ☐ No Comments: _____

Social Data:

Highest level of education: _____

ACCES-VR Involvement: ☐ Yes ☐ No Comments: _____

Employment training history: _____

Social/Day programs: _____

History of homelessness: _____

Previous supervised living placements: _____

Describe previous living environment the individual cannot return to along with specific problems/reasons:

Financial Information:

Social Security:

SSI	☐ Yes	☐ No	Amount: _____
SSDI	☐ Yes	☐ No	Amount: _____
Survivors	☐ Yes	☐ No	Amount: _____
Retirement	☐ Yes	☐ No	Amount: _____
Disabled Child	☐ Yes	☐ No	Amount: _____
Public Assistance/DSS Benefits	☐ Yes	☐ No	DSS Caseworker: _____
			Phone: _____
V.A. Pension	☐ Yes	☐ No	Amount: _____
Payee Status	☐ Self	☐ Rep Payee	Name: _____
			Address: _____
			Phone: _____
Are you employed	☐ Yes	☐ No	Where: _____

Checking Account: _____

Savings Account: _____

Property: _____

Other: _____

Statement of Need:

Please stated the reason(s) the referred individual needs this level of housing:

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: _____