

Sky Light Center

Referral Application

Enrollment –P.1

Intake

Date of Application: ___/___/___ Referral for: Day Program Returning Member Ace Program

Applicant

First Name: _____ MI: _____ Last Name: _____

DOB: _____ CMHCN: _____ SSN: _____

Referral Agency-Referral Type

- | | |
|---|--|
| <input type="checkbox"/> Self, Family, Friends | <input type="checkbox"/> State Vocational Rehab |
| <input type="checkbox"/> Private Practitioner (Psychiatrist/MD) | <input type="checkbox"/> Supervised Community Services |
| <input type="checkbox"/> Community Mental Health Center/Clinic | <input type="checkbox"/> Public Shelter for the Homeless |
| <input type="checkbox"/> County, Local Hospital | <input type="checkbox"/> Homeless Outreach Team |
| <input type="checkbox"/> Another Clubhouse | <input type="checkbox"/> Police, Courts, Forensic Hospital |
| <input type="checkbox"/> State Social Services | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> County Social Services | |

Referral Agency Name: _____

Referral Contact: _____ Phone: (____) _____

Referral Notes:

Address

Applicant's Address

Street _____ Apt. _____

City _____ County/Borough _____ State _____ Zip Code _____

Phone Numbers

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Home _____ | <input type="checkbox"/> Business _____ | <input type="checkbox"/> Friend _____ |
| <input type="checkbox"/> Parents _____ | <input type="checkbox"/> Fax _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Beeper _____ | <input type="checkbox"/> Weekend _____ | <input type="checkbox"/> No Phone |

Hints on how to locate.

Housing Type

- | | |
|---|---|
| <input type="checkbox"/> Own Home/Apartment (Non-subsidized) | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> Home of a Family Member (Shared Responsibility) | <input type="checkbox"/> Psychiatric Hospital |
| <input type="checkbox"/> Home of Family Member (Dependent on Family) | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Rooming/Boarding House, Hotel | <input type="checkbox"/> Prison/Jail |
| <input type="checkbox"/> SRO, Temporary Housing | <input type="checkbox"/> Shelter |
| <input type="checkbox"/> Supported Apartment (Subsidized, Non-Supervised) | <input type="checkbox"/> Undomiciled/Homeless |
| <input type="checkbox"/> Supervised Housing (Part-time Supervision) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Group Home (24 hour Supervision) | |

Housing Status

- | | |
|---|--|
| <input type="checkbox"/> Alone | <input type="checkbox"/> With Minor Child(ren) Only |
| <input type="checkbox"/> With Roommate(s)/Housemates(s) | <input type="checkbox"/> With Partner and Child(ren) |
| <input type="checkbox"/> With Parent(s) | <input type="checkbox"/> Institutional Setting |
| <input type="checkbox"/> With Other Adult Relative(s) | |

Total number of people in household including applicant: _____

Housing Satisfaction

- Very Satisfied Somewhat Satisfied

Sky Light Center Referral Application 2004

"Referral Application January 2010.doc" users/Membership1/Enrollment Documents

Last Updated 01/22/2004

Sky Light Center

Referral Application

Enrollment –P.2

Neutral

Somewhat Unsatisfied

Very Unsatisfied

Background

Gender Male Female Other _____

Ethnicity 1

African – American

American Indian/Native American

Asian e.g. Chinese, Japanese, Korean

Caribbean e.g. Haitian, Jamaican

Caucasian

Latino/Hispanic e.g. Puerto Rican, Cuban, Mexican

Middle Eastern e.g. Indian, Turkish, Iranian

Pacific Islander e.g. Samoan, Fijian

Ethnicity 2 (if applicable)

African – American

American Indian/Native American

Asian e.g. Chinese, Japanese, Korean

Caribbean e.g. Haitian, Jamaican

Caucasian

Latino/Hispanic e.g. Puerto Rican, Cuban, Mexican

Middle Eastern e.g. Indian, Turkish, Iranian

Pacific Islander e.g. Samoan, Fijian

Language

English Speaking

Primary Other: (please specify) _____

Marital Status

Single, Never Married

Widowed

Permanent Partner

Divorced

Separated

Married

Education Level

Less than High School

Some High School

GED

High School Diploma

Trade School

Some College

Junior College

Bachelor's Degree

Some Graduate Work

Master's Degree

Advanced Graduate Degree

Primary Weekday Activity

Independent Employment

School-High School

School-Trade School/College

Parenting/Care Taking at Home

Transitional Employment

Enclave Work Sheltered Workshop

Clubhouse Work

Other Volunteer Work

Day Program outside the Clubhouse

In Hospital/House Bound Psychiatric Reasons

No Structured Daytime Activity

Income Source #1

Amount Income Source #1: \$ _____

Wages – Independent Employment

SSI

Retirement Benefits

Wages – Transitional Employment

General Assistance (State)

Family Support

Wages – Supported Employment

Local Assistance (County/State)

Friend Support

Wages – Shelter Workshop

AFDC

No financial support

SSDI

Veteran's Benefits

Other _____

Income Source #2

Amount Income Source #2: \$ _____

Wages – Independent Employment

SSI

Retirement Benefits

Wages – Transitional Employment

General Assistance (State)

Family Support

Wages – Supported Employment

Local Assistance (County/State)

Friend Support

Wages – Shelter Workshop

AFDC

No financial support

SSDI

Veteran's Benefits

Other _____

Income Source #3

Amount Income Source #3: \$ _____

Wages – Independent Employment

SSI

Retirement Benefits

Wages – Transitional Employment

General Assistance (State)

Family Support

Wages – Supported Employment

Local Assistance (County/State)

Friend Support

Wages – Shelter Workshop

AFDC

No financial support

SSDI

Veteran's Benefits

Other _____

Sky Light Center

Referral Application

Enrollment –P.3

Additional Amount: \$ _____
TOTAL INCOME: \$ _____

Emergency Information

Medical Alerts

- | | | |
|---|---|---|
| <input type="checkbox"/> Chronic Physical Illness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Deaf/Hearing Impairment | <input type="checkbox"/> Other Physical Disability | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blind/Vision Impairment | <input type="checkbox"/> Severe Allergic Reactions | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> New Psychiatric Medication | <input type="checkbox"/> Other _____ |

Alert Memo

Medical and Psychiatric Contacts *(fill in as appropriate and include address and phone number.)*

Psychiatrist:	Address:	Phone:
Therapist:	Address:	Phone:
Primary Care MD:	Address:	Phone:
Clinic:	Address:	Phone:

Emergency Contacts

Primary:	
<i>Relationship to applicant:</i>	Phone:
Secondary:	
<i>Relationship to applicant:</i>	Phone:

Notes:

Employment

Employment

- Has applicant ever worked for pay? Yes No
 Has he/she worked for pay within the last 12 months? Yes No

Estimated TOTAL YEARS applicant has worked for pay. _____
 Estimated TOTAL NUMBER OF JOBS worked for pay. _____

Employment History Notes

Sky Light Center

Referral Application

Enrollment –P.4

Job held the LONGEST

Job Title: _____

Job Type:

- Mail Clerk/Messenger
- Clerical/Secretarial
- Guard/Doorman
- Food service worker
- Sales/Retail
- Sales/Non-retail
- Assembly/Gift Wrapper
- Cleaning/Maintenance
- Vehicle Operation
- Health/Nursing Aid
- Attendant/Guide/Usher
- Childcare/Teacher’s Aid
- Technician
- Mechanic/Repairer
- Laborer/Construction
- Labor/Non-construction
- Machine Operator/Factory Worker
- Farming/Forestry/Fishing
- Artist/Entertainer
- Military/Occupation
- Managerial
- Professional
- Other: _____

Start Date: ____/____/____ End Date: ____/____/____

Hours Per Week _____

Pay Per Hour _____

Termination Type

- Job Ended Leave of Absence Resigned Fired Medical Reasons Retired
- Not Applicable Other: _____

Current or Most Recent Job

Job Title: _____

Job Type:

- Mail Clerk/Messenger
- Clerical/Secretarial
- Guard/Doorman
- Food service worker
- Sales/Retail
- Sales/Non-retail
- Assembly/Gift Wrapper
- Cleaning/Maintenance
- Vehicle Operation
- Health/Nursing Aid
- Attendant/Guide/Usher
- Childcare/Teacher’s Aid
- Technician
- Mechanic/Repairer
- Laborer/Construction
- Labor/Non-construction
- Machine Operator/Factory Worker
- Farming/Forestry/Fishing
- Artist/Entertainer
- Military/Occupation
- Managerial
- Professional
- Other: _____

Start Date: ____/____/____ End Date: ____/____/____

Hours Per Week _____

Pay Per Hour _____

Termination Type

- Job Ended Leave of Absence Resigned Fired Medical Reasons Retired
- Not Applicable Other: _____

THIS SECTION MUST BE COMPLETED BY PROVIDER *Drug/Alcohol History*

History with Alcohol

- Has applicant had a problem with alcohol? Yes No
- Has applicant been in treatment for an alcohol problem? Yes No
- Is applicant currently in treatment or in a support group? Yes No
- Does he/she want help with an alcohol problem? Yes No

How long has he/she been clean and sober? _____

History with Drugs

- Has applicant had a problem with drugs? Yes No
- Has applicant been in treatment for a drug problem? Yes No
- Is applicant currently in treatment or in a support group? Yes No
- Does he/she want help with a drug problem? Yes No

How long has he/she been clean and sober? _____

Sky Light Center

Referral Application

Enrollment –P.5

Drug/Alcohol Notes: *(Include Type of Drug, Amount and Frequency.)*

Alcohol/Substance Abuse Assessment:

What is applicant's assessment of the effect of alcohol/drug use on her/his life: _____

THIS SECTION MUST BE COMPLETED BY PROVIDER *Legal History*

Has applicant ever been in jail? Yes No In prison? Yes No On probation? Yes No

Has applicant ever been convicted of a misdemeanor? Yes No

Has applicant ever had any arrests for felonies? Yes No

What felonies? *(check all that apply)*

<input type="checkbox"/> Bad Checks/Shoplifting	<input type="checkbox"/> Manslaughter/Negligent Homicide	<input type="checkbox"/> Other Crimes of Dishonesty
<input type="checkbox"/> Physical Abuse/Assault	<input type="checkbox"/> Robbery/Breaking and Entering	<input type="checkbox"/> Other _____
<input type="checkbox"/> Stealing/Forgery/Embezzlement	<input type="checkbox"/> Rape/Murder	<input type="checkbox"/> Sexual Misconduct

Has applicant ever physically injured another person? Yes No

Does he/she have a history of violent behavior toward others? Yes No

Legal History Notes *(dates, behaviors, precipitants, legal actions, etc. Please elaborate on any aggressive behaviors.)*

THIS SECTION MUST BE COMPLETED BY PROVIDER *Medical Information*

Medical Insurance

Insurer 1

- Medicaid
- Medicaid, Managed Care
- Medicare
- Medicare, Managed Care

Policy No. _____

- Private Insurance
- Private Insurance, Managed Care
- Veteran's Benefits
- Worker's Compensation

- Family pay
- Self-pay (no insurance)
- Other _____

Insurer 2

- Medicaid
- Medicaid, Managed Care
- Medicare
- Medicare, Managed Care

Policy No. _____

- Private Insurance
- Private Insurance, Managed Care
- Veteran's Benefits
- Worker's Compensation

- Family pay
- Self-pay (no insurance)
- Other _____

Date of Last Physical Exam: ____/____/____ **Date of Last Dental Exam:** ____/____/____

Psychiatric Information

Primary Diagnosis:

- Schizophrenia Schizoaffective Disorder Bi-Polar Disorder Major Depression
- Other Psychotic Disorder Other Major Mental Illness

Written Diagnosis

Diagnostic Code

DSM IV Axis I		
DSM IV Axis II		
DSM IV Axis III		

Sky Light Center

Referral Application

Enrollment –P.6

DSM IV Axis IV		
DSM IV Axis V		

THIS SECTION MUST BE COMPLETED BY PROVIDER Medication

Please List all Psychiatric Medications (include dosage and frequency)

Please List all Other Medications (include dosage and frequency)

THIS SECTION MUST BE COMPLETED BY PROVIDER Psychiatric Hospitalizations

Psychiatric History

Total Number of Hospital Admissions _____
 Estimated Total Months of ALL Hospitalizations _____
 Length (months) of LONGEST Hospitalization _____
 Applicant in which hospitals? (list all, name and location please)

Please indicate precipitants to all hospitalizations

First Psychiatric Hospitalization

Age at first hospitalization? _____
 Admission Date: ____/____/____ Discharge Date: ____/____/____
 Hospital Name: _____
 City: _____ State: _____ Zip Code: _____
 Country: _____

Most Recent Psychiatric Hospitalization

Admission Date: ____/____/____ Discharge Date: ____/____/____
 Hospital Name: _____
 City: _____ State: _____ Zip Code: _____ Country: _____
 Contact: _____ Contact's Position: _____

Notes:

Sky Light Center

Referral Application

Enrollment –P.7

THIS SECTION MUST BE COMPLETED BY PROVIDER

Parenting Skills

Does applicant have parenting responsibilities for minor children (circle one): Yes No
(If applicant does not have parenting responsibilities for minor children the rest of this section does not have to be completed)

Number and ages of minor children: _____

Presence or absence of child abuse (sexual or physical) or neglect of these children: (circle one)

 Presence Absence

Agency for Children’s Services (ACS) involvement:

History of involvement with (ACS): Yes No

Does applicant have an open case with ACS? and if so, the current status: _____

Please note referral applications can only be processed when submitted with detailed psychosocial history, psychiatric assessment and physical exam. Please contact the Clerical Unit at Sky Light Center, (718) 720-2585, if you have any questions.

This application must be signed by Provider

Referral Source Signature

Date

Member enrollment Date: