



Project Live, Inc.
465-475 Broadway, Newark, NJ 07104
Phone: (973) 481-1211 Fax: (973) 481-0195
E-mail: info@projectlive.org

COMMUNITY SUPPORT SERVICES REFERRAL PACKET

Thank you for your interest in Project Live, Inc (PLI). PLI provides residential and community support services to individuals with mental illness. These services range from 24 hour, supervised, group homes to independent living.

Housing opportunities for individuals able to live independently consist of apartments and single-family homes. The single-family homes accommodate 3-4 people. Rental rates are calculated at 30% or 40% of each person's monthly income, based on the funding source. Housemates are expected to share basic household responsibilities.

Please review the following criteria prior to completing the attached referral form. PLI does not discriminate based on race, creed, color, age, ethnicity, religion, gender, sexual orientation or national origin in either the eligibility or intake process.

Inclusionary Criteria:

Individuals wishing to apply for Community Support Services must:

1. Have a serious and persistent mental illness diagnosed on Axis I (DSM-IV), such as Schizophrenia, Schizoaffective Disorder, Bipolar Disorder or Major Depression.
2. Be 18 years of age or older
3. Demonstrate sufficient psychiatric stability such that they do not require inpatient services
4. Agree to sign a lease, which identifies the contracting parties' rights and responsibilities

Exclusionary Criteria:

1. Persons with Axis I (DSM-IV) diagnoses of Substance Abuse (without a concurrent primary diagnosis as indicated in item 1 on the inclusionary criteria)
2. Symptoms and/or behavior that present a danger to self, others, or property
3. Persons with a history of arson, homicide, attempted homicide, or patterns of violent behavior, including sexual assault/molestation will be assessed as to the clinical appropriateness of the referral
4. Persons with medical conditions requiring skilled nursing care

Once your completed referral packet is received, it will be reviewed. You will be contacted when a suitable opening becomes available. You may keep in touch to indicate your continued interest in Project Live's housing and/or services. Once again, thank you for your interest in Project live, Inc.

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COMMUNITY SUPPORT SERVICES APPLICATION

Date of Referral _____

Referral Source:

Name of Agency: _____
Type of Agency: _____
Agency Address: _____
Staff Person Referring: _____
Title: _____
Agency Telephone Number: _____

** If Project Live, Inc. is the referral source, please attach the resident's Basic Information Sheet

Application Information:

Applicant's Name _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

D.O.B.: _____ Social Security #: ____ - ____ - ____ Sex: () Male () Female

Current Residence: (Check One)

Check	Type of Housing	Name of Agency or Lease Holder	Move in Date
	Group Home		
	Supervised Apartment		
	Other		
	Own Home or Apartment		
	With Family/Friends		

Previous Residence: (last 5 years: use separate sheet if necessary)

Address: _____

Move In Date: _____ Move Out Date: _____

Landlord's Name & Telephone Number: _____

Reason for Leaving: _____

Reason for Referral to Project Live, Inc.:

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Current Treatment Source:

Name of Psychiatrist: _____

Psychiatrist's Telephone Number: _____

Name of Therapist/Counselor: _____

Therapist's/Counselor's Telephone Number: _____

Medication History:

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Date Prescribed</u>	<u>Date Stopped</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Drug and Alcohol History:

Age first used drugs/alcohol: _____

Which substances used/abused? List all alcohol/illegal drugs used:

Drug(s) of choice (including alcohol): _____

Date of last use of drugs/alcohol: _____

Describe history of treatment (treatment sources, dates of treatment):

Describe current support/treatment (e.g, AA, NA, Double Trouble, etc.):

Economic Resources:

Amount SSI: _____

Amount SSD _____

Amount of Welfare: _____

Amount of income from work: _____

Medicaid Number: _____

Medicare Number: _____

Other Health Insurance: _____

(Company and number) _____

Are you currently employed? Yes No

If yes:

Employer's Name: _____

Employer's Address: _____

Employer's Telephone Number: _____

Family/Community contact:

Name: _____

Address: _____

Telephone Number: _____

Relationship: _____

Name: _____

Address: _____

Telephone Number: _____

Relationship: _____

Pending Legal Charges:

If applicant has any legal charges pending, please explain:

Please include the following documentation with this application:

- Copy of Social Security Card
- Copy of Birth Certificate
- Copy of Current Social Security Award Letter or any other Proof of Income

Additional Information Required:

1. Copy of initial psychiatric evaluation
2. Copy of most recent psychiatric evaluation
3. Copy of initial (admission) psychosocial assessment and annual/(re-admission) assessments (if applicable)
4. Copy of most recent treatment plan
5. Copy of most recent physical examination
6. Copy of discharge summaries of previous admissions
7. Copy of most recent substance abuse assessment
8. Copy of case review/treatment team notes

Signature of Applicant

Date

Please send completed information to: Project Live, Inc.
Attn: Sherry Ethridge
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