



Project Live, Inc.
465-475 Broadway, Newark, NJ 07104
Phone: (973) 481-1211 Fax: (973) 481-0195
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REFERRAL PACKET

Thank you for your interest in Project Live, Inc. Our agency provides both group home and independent housing for persons with severe and persistent psychiatric illnesses. Our group homes range from transitional to long-term and provide services to both MICA and non-MICA consumers.

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: Group Homes

Individuals wishing to apply for Group Homes 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. There must be an Axis I diagnosis of Substance Abuse, if a M.I.C.A. group home is desired.
2. Be 18 years of age or older.
3. Demonstrate sufficient psychiatric stability such that he/she does not require inpatient services.
4. For a referral made to the 450/MICA and 324/IRP programs individuals referred from a state hospital with a minimum of a four-month length of stay will be given priority. Our other residences can take referrals from the community.
5. Be a resident of Essex County.

Exclusionary Criteria: Group Homes

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. If a M.I.C.A. referral, clean time of less than 90 days.
5. Persons with medical conditions requiring skilled nursing care.

Once your completed referral packet is received, it will be thoroughly reviewed. You will be contacted as to its disposition within three working days.

Once again, thank you for your interest in Project live, Inc.

GROUP HOME APPLICATION

REFERRAL SOURCE: Date of Referral: _____
Contact Person: _____ Date: _____
Referring Agency (if applicable): _____ Phone: () _____
Relationship to Client: _____ Fax: () _____
Address: _____ City: _____ State: _____ Zip: _____

CLIENT INFORMATION:

Client Name: _____ Phone#: _____
Address: _____ City: _____ State: _____ Zip: _____
D.O.B.: _____ Social Security #: _____ - _____ - _____ Sex: () Male () Female
Does client have any children? () Yes () No If yes, how many children? _____
Race/Ethnicity: () American Indian or Alaskan Native Marital Status: () Married
() Asian or Pacific Islander () Widowed
() Black, Not of Hispanic Origin () Divorced
() Hispanic () Separated
() White, Not of Hispanic Origin () Never Married
() Other: _____ () Unknown
Primary Lang: () English Veteran: () Yes
() Spanish () No
() American Sign Language Religion: _____
() Other: _____

COMMUNITY CONTACTS:

Name: _____ Relationship: _____ Phone: () _____
Address: _____ City: _____ State: _____ Zip: _____
Name: _____ Relationship: _____ Phone: () _____
Address: _____ City: _____ State: _____ Zip: _____

Would you like your family involved in the intake process? YES NO If so, whom? _____

DIAGNOSIS (DSM IV):

Axis I: _____ DSM Code: _____
Axis I: _____ DSM Code: _____
Axis II: _____ DSM Code: _____
Axis III: _____ DSM Code: _____

Axis IV: _____ DSM Code: _____

Axis V(GAF): _____ DSM Code: _____

REFERRAL FORM

Describe presenting illness. _____

MEDICATION HISTORY:

Medication	Dosage	Frequency	Physician	Date Prescribed	Date Stopped
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

HISTORY OF ILLNESS:

List previous hospitalizations.

Name of Hospital	Reason for Admission	Admission Date	Discharge Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe indicators of decompensation. _____

Has client ever been involved in outpatient/partial care treatment? () Yes () No If yes, explain:

Name of Facility	Dates of Attendance
_____	_____
_____	_____

REFERRAL FORM

Is there a history of suicide attempts/gestures/ideations? () Yes () No If yes, explain:

Is there a history of violent/assaultive behavior? () Yes () No If yes, explain:

Is there a history of fire setting? () Yes () No If yes, explain:

SUBSTANCE USE HISTORY:

Does client have history of alcohol or drug use? () Yes () No If yes, explain:

Substance(s)	Date of First Use	Amt./Freq. of Use	Date of Last Use
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What was the client's longest period of abstinence? _____

Has client ever been in treatment for substance use? () Yes () No If yes, explain:

Type of Treatment (IP, OP, Rehab, Residential, etc.)	Admission Date	Discharge Date
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REFERRAL FORM

Has client participated in self-help/support groups? () Yes () No If yes, explain:

Type of Group	Attended (Y/N)	Last Date Attended	Frequency of Attendance
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Alcoholics Anon. _____

Narcotics Anon. _____

MICA _____

Other (specify) _____

HEALTH CONCERNS/CURRENT HEALTH ISSUES:

Has client ever been treated for any of the following? Check all that apply and explain below.

- | | |
|--|--|
| <p>() Allergies
() Blood Pressure
() Cancer
() Diabetes
() Eating Disorders
() Gait/Balance Problems
() Gynecological Problems
() Hearing Problems
() Heart Disease
 () Heart Attack
 () Endocarditis
 () Other: _____
() Hepatitis A, B, or C</p> | <p>() Hyponatremia
() Kidney Disease
() Liver Disease
() Muscular/Skeletal Problems
() Pancreatitis
() Respiratory Problems
() Seizure Disorder
() Sexually Transmitted Diseases
() Sleep Problems
() Thyroid Problems
() Tuberculosis
() Ulcer
() Vision Problems
Other: _____</p> |
|--|--|

If any medical conditions are noted above, describe treatment of existing medical conditions.

Are there any restrictions on daily activity? () Yes () No If yes, explain:

REFERRAL FORM

When was the client last tested for Tuberculosis? What were the results?

When was the client last tested for Hepatitis? What were the results?

Has client undergone any surgery? () Yes () No If yes, explain:

Is client prone to falls or accidents? () Yes () No If yes, explain:

History of Abuse:

- () Physical () Emotional
() Sexual () Domestic

If yes, explain: _____

EDUCATION:

Can client read? () Yes () No If yes, what language(s)? _____

Can client write? () Yes () No If yes, what language(s)? _____

Can client do simple math? () Yes () No

What is the highest grade/level completed? _____

Has client attended special classes (e.g.: math, english, learning disabled)? () Yes () No If yes, explain:

Has client had any trade or technical training? () Yes () No If yes, explain:

LEGAL STATUS:

Has client ever been involved in the legal system? () Yes () No If yes, explain:

Describe Charge/Involvement	Date of Charge/Involvement	Current Status
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ECONOMIC RESOURCES:

Does client have an employment history? () Yes () No If yes, explain:

Type of Job	Dates of Employment	Salary	Reason for Leaving
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Does client receive any of the following assistance? () Yes () No If yes, explain:

Type of Assistance	Currently Receiving	Amount	Application Date
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SSI

SSD

Welfare

Food Stamps

Other

Does client receive Medicaid? () Yes () No Medicaid #: _____

Does client receive Medicare? () Yes () No Medicare #: _____

Does client have other insurance? () Yes () No

Name of insurance company: _____ Identification Number: _____

LIVING ARRANGEMENTS:

Describe client's living arrangements over the past 5 years (e.g., apartment, group/boarding home, with family).

Placement	Length of Stay	Reason for Leaving
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REFERRAL FORM

ACTIVITIES OF DAILY LIVING (ADL) SKILLS:

Please rate client's performance in the following areas by placing a checkmark in the appropriate space.

<u>Skill/Task</u>	<u>Performs Independently</u>	<u>Needs Reminders</u>	<u>Needs Hands-On Assistance</u>	<u>Unable to Perform</u>	<u>Unable to Assess</u>
Eating	_____	_____	_____	_____	_____
Cooking	_____	_____	_____	_____	_____
Hygiene/Grooming	_____	_____	_____	_____	_____
Cleaning	_____	_____	_____	_____	_____
Laundry	_____	_____	_____	_____	_____
Budgeting	_____	_____	_____	_____	_____
Shopping	_____	_____	_____	_____	_____
Public Transportation	_____	_____	_____	_____	_____
Self-Medication	_____	_____	_____	_____	_____
Use of Leisure Time	_____	_____	_____	_____	_____
Socializing	_____	_____	_____	_____	_____
Accessing Resources	_____	_____	_____	_____	_____

Please include the following documentation with this application:

- Copy of Social Security Card
- Copy of Birth Certificate
- Copy of Current Award Letter
- Proof of Income (if applicable)

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

Name of Referral Source

Phone: () _____

Signature of Referral Source

Date

Please send completed information to: Project Live, Inc.
 Attn: Jennifer Calchi
 465-475 Broadway
 Newark, NJ 07104
 Phone: (973) 481-1211
 Fax: (973) 481-0195