

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, such as Schizophrenia, Schizoaffective Disorder, Bipolar Disorder or Major Depression, Recurrent as classified in the DSM-V
2. Require active rehabilitation and support services to achieve community integration through the restoration of functioning in social, employment, education and housing domains.
3. Be 18 years of age or older
4. Demonstrate sufficient psychiatric stability such that they do not require inpatient services
5. Agree to sign a lease, which identifies the contracting parties’ rights and responsibilities

**Exclusionary Criteria:**

1. Persons with diagnoses of substance use or addictive disorders as classified in the DSM-V (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: |  |
| Agency Contact: |  |
| 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 |  |  |
|  | Own Home or Apartment |  |  |
|  | With Family/Friends |  |  |
|  | Other |  |  |

**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.:**

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| --- |
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**Diagnoses (DSM-V/ICD-10):**

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|  |

**Current Treatment Provider:**

|  |  |
| --- | --- |
| Name of Psychiatrist: |  |
| Psychiatrist’s Telephone Number: |  |
| Name of Therapist/Counselor: |  |
| Therapist’s/Counselor’s Telephone Number: |  |

**Medication History:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | Dosage |  | Frequency |  | Date Prescribed |  | Date Stopped |
|  |  |  |  |  |  |  |  |  |
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**Drug and Alcohol History:**

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| --- | --- |
| Age first used drugs/alcohol: |  |
|  |  |
| Substances used (list all alcohol/illegal drugs used): |  |
|  |
|  |
|  |
|  |  |
| Drug(s) of choice (including alcohol): |  |
| Date of last use: |  |
|  |  |
| Describe history of treatment (treatment providers, dates of treatment): |  |
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|  |
|  |  |
| Describe current services/treatment (e.g., AA, NA, Double Trouble, etc.): |  |
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|  |

**Financial Status:**

List sources of income (e.g., SSI, SSD, GA, Wages): Amount/month:

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Health Benefits: |
| Medicaid: ( ) YES ( ) NO Number: |  |
| Medicare: ( ) YES ( ) NO Number: |  |
| Other Health Insurance: ( ) YES ( ) NO |
| (Company and number) |  |

Employment:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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: |  |

**Legal Status:**

Is there a history of or current involvement with the legal system? If yes, explain:

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| --- |
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**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

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Signature of Applicant Date

 Please send completed information to: Project Live, Inc.

 Attn: Damyanti Aurora

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