**Pathway Home Referral Package:**

*Facilitating a seamless transition from hospital to home*

Referral Agency/ Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Worker’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Case Manager \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Completed Referral Package [Pathway Home referral forms, current psychosocial assessment & current psychiatric evaluation] should be e-mailed to** PathwayHomeInfo@cbcare.org **or faxed to (877) 418-5421.**

**CONSENT TO RELEASE INFORMATION**

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(referring provider) to disclose the completed Pathway Home Referral Application and all related supporting documents (Application), including confidential medical and mental health information, to Coordinated Behavioral Care (CBC), 123 William Street, New York, NY 10038, for the purposes of CBC conducting a clinical assessment and coordinating health care and related services, including community support services and housing placement assistance, for a period of one hundred and twenty (120) days. As part of this referral process, I understand that CBC will separately obtain my authorization and consent as part of the initial assessment and intake process before providing or coordinating the provision of any additional health care services.

I understand that I may revoke my consent to disclose the completed Application at any time. My revocation must be in writing. I am aware that my revocation will not be effective if CBC has already received the Application because of my earlier authorization and consent; however, I can instruct CBC to take no further action following its receipt of the Application.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Applicant Name (please print) |  | Applicant Signature |  | Date |
|  |  |  |  |  |
| Witness Name (please print) |  | Witness Signature |  | Date |

**Section A: Client Information**

**Consumer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:**  Male  Female

**Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Benefits:**

 SSI  SSD  Veteran Benefits  Public assistance cash program  SNAP (food stamps)  None  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Language (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**English Proficiency:**

**** Does not speak English **** Poor  Fair  Good  Excellent

**Marital Status:**

 Single, never married  Currently Married  Divorced/Separated  Widowed

 Cohabiting with significant other or domestic partner  Unknown  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicant’s race/ ethnicity:**

**** White, European American  Black, African American  American Indian or Alaskan Native

**** Asian Indian **** Chinese **** Filipino **** Vietnamese **** Other Asian **** Native Hawaiian

**** Guamonion/Chamorro  Samoan  Japanese  Latino/Latina  Korean  Unknown

**** Other Pacific Islander  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section B: Friend & Family Contacts**

**Family/ Friend/ Emergency Contact(s):**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Address: | Tel#: | Relationship |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Section C: Housing**

**Please document housing history over the past two years:**

|  |  |  |  |
| --- | --- | --- | --- |
| Dates: | Address: | Program Name: | Reason for Leaving: |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Detail any obstacles the applicant reports in regards to retaining housing:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please detail housing plan upon discharge including the **specific** program and/or address the client will be discharged to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section D: Community Supports**

**Please list all known community supports current and past that the applicant has been linked with:**

**Primary Care Physician:**  Current  Past  Never

|  |  |  |
| --- | --- | --- |
| Provider: | Address: | Telephone: |
|  |  |  |

**Outpatient Mental Health Clinic**:  Current  Past  Never

|  |  |  |
| --- | --- | --- |
| Provider: | Address: | Telephone: |
|  |  |  |

**Health Home:**  Current  Past  Never

|  |  |  |
| --- | --- | --- |
| Provider: | Address: | Telephone: |
|  |  |  |

**PROS:**  Current  Past  Never

|  |  |  |
| --- | --- | --- |
| Provider: | Address: | Telephone: |
|  |  |  |

**ACT Team:**  Current  Past  Never

|  |  |  |
| --- | --- | --- |
| Provider: | Address: | Telephone: |
|  |  |  |

**AOT:**  Current  Past  Never

|  |  |  |
| --- | --- | --- |
| Provider: | Address: | Telephone: |
|  |  |  |

**Substance Abuse Treatment Provider:**  Current  Past  Never

|  |  |  |
| --- | --- | --- |
| Provider: | Address: | Telephone: |
|  |  |  |

**Home Care Services**:  Current  Past  Never

|  |  |  |
| --- | --- | --- |
| Provider: | Address: | Telephone: |
|  |  |  |

**Other Community Services**:  Current  Past  Never

|  |  |  |
| --- | --- | --- |
| Provider: | Address: | Telephone: |
|  |  |  |
| Provider: | Address: | Telephone: |
|  |  |  |

**Current Plan for follow-up psychiatric care** (please check all that apply)**:**

* Return to previous providers and/or program (listed above)
* Referral to Outpatient Mental Health Clinic
* Referral to PROS
* Referral to MICA/Dual Diagnosis Program
* Referral to ACT team
* Other (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section E: Health History:**

**Please list all Mental Health Diagnoses:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Psychotropic Medications:

|  |  |  |
| --- | --- | --- |
| Name: | Dosage: | Schedule: |
|  |  |  |
|  |  |  |
|  |  |  |

List all Medical Disorders:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications for Physical Illness:

|  |  |  |
| --- | --- | --- |
| Name: | Dosage: | Schedule: |
|  |  |  |
|  |  |  |
|  |  |  |

**Level of support required for compliance with medication regimen:**

**** None  **** Reminders **** Supervision **** Dispensing  Not applicable **** Unknown

**Section F: Utilization:**

**Please list all psychiatric hospitalizations (including current) psychiatric emergency room visits and mobile crisis visits within the last two years.**

|  |  |  |  |
| --- | --- | --- | --- |
| Hospital/ER/Mobile Crisis: | Admission Date: | Discharge Date(if currently hospitalized, expected discharge date): | Source of Data: |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Current Criminal Justice Status:**

* Applicant is not under Criminal Justice Supervision
* CPL 330.20 order of conditions and order of release
* In NYS Dept. of Correctional Services (State Prison)
* On bail, released on own recognizance (ROR) conditional discharge, or other alternative to incarceration
* Under probation supervision
* Released from jail or prison within the last 30 days
* Under arrest in jail, lockup or court detention
* Unknown
* Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section G: Well-Being:**

**High Risk Behavior** (Please use the scale below to indicate levels of behavior)**:**

0 = no known history

1 = not at all in the past 6 months

2 = one or more times in the past 6 months, but not in the past 3 months

3 = one or more times in the past 3 months but not in the past month

4 = one or more times in the past month but not in the past week

5 = one or more times in the past week

U = unknown

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **High Risk Behavior** (Please check one.): | 0 | 1 | 2 | 3 | 4 | 5 | U |
| a. How often did applicant do physical harm to self? |  |  |  |  |  |  |  |
| b. How often did applicant attempt suicide? |  |  |  |  |  |  |  |
| c. How frequently did applicant physically abuse another? |  |  |  |  |  |  |  |
| d. How frequently did applicant assault another? |  |  |  |  |  |  |  |
| e. How frequently was applicant a victim of sexual abuse? |  |  |  |  |  |  |  |
| f. How frequently was applicant a victim of physical abuse? |  |  |  |  |  |  |  |
| g. How frequently did applicant engage in arson? |  |  |  |  |  |  |  |
| **High Risk Behavior**: | 0 | 1 | 2 | 3 | 4 | 5 | U |
| h. How frequently did applicant engage in accidental fire-setting? |  |  |  |  |  |  |  |
| i. How often did applicant exhibit the following symptoms? |  |  |  |  |  |  |  |
| i (a) Homicidal attempts |  |  |  |  |  |  |  |
| i (b) Delusions |  |  |  |  |  |  |  |
| i (c) Hallucinations |  |  |  |  |  |  |  |
| i (d) Disruptive behavior |  |  |  |  |  |  |  |
| i (e) Severe Thought Disorder |  |  |  |  |  |  |  |
| i (f) Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |

**Does applicant have current or history of substance abuse? If yes, complete the questions below.**  Yes  No

**Substance Abuse** (Please use the scale below to indicate levels of behavior)**:**

0 = no known history

1 = not at all in the past 6 months

2 = one or more times in the past 6 months, but not in the past 3 months

3 = one or more times in the past 3 months but not in the past month

4 = one or more times in the past month but not in the past week

5 = one or more times in the past week

6 = daily

U = unknown

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Substance Abuse** (Please check one.): | 0 | 1 | 2 | 3 | 4 | 5 | 6 | U |
| a. Alcohol |  |  |  |  |  |  |  |  |
| b. Cocaine |  |  |  |  |  |  |  |  |
| c. Amphetamines |  |  |  |  |  |  |  |  |
| d. Crack |  |  |  |  |  |  |  |  |
| e. PCP |  |  |  |  |  |  |  |  |
| **Substance Abuse**: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | U |
| f. Inhalants |  |  |  |  |  |  |  |  |
| g. Heroin/Opiates |  |  |  |  |  |  |  |  |
| h. Marijuana/Cannabis |  |  |  |  |  |  |  |  |
| i. Hallucinogens |  |  |  |  |  |  |  |  |
| j. Sedatives/hypnotics/anxiolytics |  |  |  |  |  |  |  |  |
| k. Other prescription drug abuse |  |  |  |  |  |  |  |  |
| l. Tobacco |  |  |  |  |  |  |  |  |
| m. Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |

Please comment below on any of the above sections.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Co-occurring Disabilities** (Please check all that apply)**:**

* None
* Drug or alcohol abuse
* Cognitive disorder
* Mental retardation or developmental disorder
* Blindness
* Impaired ability to walk
* Tobacco
* Wheelchair required
* Hearing Impairment
* Speech Impairment
* Visual Impairment
* Deaf
* Bedridden
* Amputee
* Incontinence
* Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_