VOCATIONAL MANAGED SERVICES REFERRAL APPLICATION

Managed Services Division
Department of Mental Health and Addiction Services
Capitol Region Mental Health Center

Please complete application thoroughly.

Vocational Services Available: ☐ Easter Seals ☐ Bureau of Rehabilitation Services
Agency Preference: ☐ Supported Employment ☐ MHAC Choices II – DHOH (Deaf/Hard of Hearing only)
Services Requested: ☐ Supported Education

Client information:

Name: _____
Sex: ☐ M ☐ F Age: ___ Birth date: _____ SS #: _____
Address: _____
Phone #: _____
Does applicant plan to retain present permanent address? ☐ Yes ☐ No
If not, please explain: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Religious Affiliation: _____
Ethnic Origin: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Other
Primary Language: _____ Secondary Language: _____

Referring Professional:

Name: _____
Agency/Program: _____
Address: _____
Phone: _____
Reason for Referral: _____

Emergency Contact Person(s): See Attached: ☐

Name: _____
Address: _____
Phone #: _____ Relationship to applicant: _____

Conservator (of Estate): ☐ N/A See Attached: ☐

Name: _____
Address: _____
Phone #: _____

Conservator (of Person): ☐ N/A

Name: _____
Address: _____
Phone #: _____

Financial Information: *(Please specify dollar amounts.)* See Attached: ☐

SAGA: _____ SSI: _____ SSDI: _____
State Supplement: _____ AFDC: _____
Employed (monthly earnings): _____ Unemployment (monthly earnings): _____
Medical: Medicare: _____ Medicaid: _____
Please specify any additional entitlement for which application has been made or are pending: _____

Legal Status: *Copy of terms of probation must be included with this application.* See Attached: ☐

Current Arrest/Active Charges: _____
Court Date: ☐ Yes ☐ No If yes, please give dates: _____
Under Jurisdiction of Psychiatric Security Review Board? ☐ Yes ☐ No
If yes, give detail, including duration: _____
Is applicant currently on probation? ☐ Yes ☐ No
Please give detail: _____
Name of Probation/Parole Officer: _____
Address: _____
Phone #: _____

Medical Information: See Attached: ☐

Date of Last Physical Examination: _____ Name of Examining Physician: _____
Agency: _____
Is this the applicant's current physician? ☐ Yes ☐ No
If not, please explain: _____
Please list any known medical conditions which require ongoing attention: (e.g., hypertension, diabetes etc.): _____
Is client capable of self-monitoring care or are nursing services required? _____
If medical services are required, with what frequency? _____
Does applicant have any physical or neurological impairments which require special monitoring/services? _____
Is applicant presently, or has applicant ever been, treated for a communicable disease? ☐ Yes ☐ No
If yes, please give detail: _____
Please list any known allergies: _____

Educational/Vocational Information: See Attached: ☐

High School Diploma: ☐ Yes ☐ No Highest Grade Completed? __
College Experience: _____ Degree(s): ☐ Yes ☐ No If yes, type: _____
Technical/Vocational Experience: _____ Other (Please specify): _____
Is applicant currently enrolled in an educational program? If so, please specify: _____
Is applicant currently employed? Yes ☐ No ☐
Method of Transportation: ☐ Own Car ☐ Public Transportation ☐ Other _____
Employer/Location: _____
Is applicant involved with any Managed Services Network community vocational providers? ☐ Yes ☐ No
If so, please specify: _____
Is applicant currently involved with the Bureau of Rehabilitation Services? ☐ Yes ☐ No
If yes, please give detail: _____

Vocational Information: (List last two (2) jobs of most significance) See Attached: ☐

Employer: _____ Job Title: _____
Length of Time Held (Include Dates): _____ Reason for Leaving: _____
Employer: _____ Job Title: _____
Length of Time Held (Include Dates): _____ Reason for Leaving: _____
Please specify any other vocational training programs applicant has been involved in, including Bureau of Rehabilitation Services. List Dates. _____

Psychiatric Eligibility: See Attached: ☐

DSM IV Diagnosis: ***All five axes must be completed.***

	Principal Diagnosis	Code	Expansion
Axis I	☐	_____	_____
Axis I	☐	_____	_____
Axis II	☐	_____	_____
Axis II	☐	_____	_____
Axis III		_____	_____
Axis III		_____	_____

Axis IV (check all that apply)

- 0 ☐ PROBLEMS WITH PRIMARY SUPPORT GROUP
- 1 ☐ PROBLEMS RELATED TO THE SOCIAL ENVIR.
- 2 ☐ EDUCATIONAL PROBLEMS
- 3 ☐ OCCUPATIONAL PROBLEMS
- 4 ☐ HOUSING PROBLEMS
- 5 ☐ ECONOMIC PROBLEMS
- 6 ☐ PROBLEMS WITH ACCESS TO HEALTH CARE SERVICES
- 7 ☐ PROBLEMS REL. TO INTERACTION WITH LEGAL SYSTEM/CRIME
- 8 ☐ OTHER PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS

Axis V (GAF) Present: ____ Past: ____

Psychiatric/Clinical Information: See Attached: ☐

Current Treatment Services:

Location: _____ Type: _____ Frequency: _____

Current Clinical Contact Person: _____ Phone #: _____

Current Prescribing Psychiatrist: _____ Phone #: _____

VNA: ☐ Yes ☐ No

Psychiatric Medications:

Present Psychiatric Medication and Dosage: _____

Date of Last Medication Review: _____ Frequency of Medication Review: _____

Non-Psychiatric Medications:

Non-Psychiatric Medication and Dosage: _____

Prescribing Physician(s) : _____ Phone #: _____

: _____ Phone #: _____

Agency: _____ Phone #: _____

Is client able to self-administer medication? ☐ Yes ☐ No

If medication monitoring is required, with what frequency? _____

By whom is monitoring presently being done? _____

If none presently, what is the recommendation? _____

Please note any specific reactions/behaviors that may result from non-compliance: _____

Behavioral Information: See Attached: ☐

Please describe any specific behaviors historically unique to this applicant: _____

Please describe interpersonal skills, both positive and negative: _____

Please describe any interventions which may be required: _____

Family Abusive Behavior - as perpetrator or victim: (Please be specific.) _____

Other Conflictive Relationships: (Please be specific.) _____

Substance Abuse: (Please give prior history - be specific regarding substances and current use.) _____

Precipitating events requiring respite services: _____

Risk Information: See Attached: ☐

Suicidal/Homicidal Behavior: (Please specify current and past behaviors.) _____

Assaultive Behavior: (Please specify current and past legal involvement.) _____

Inappropriate/Sexual Behavior: (Please specify and include any legal consequences.) _____

Arson Behavior: (Please list any arrests and/or convictions.) _____

Does client have any specific/intentional careless behaviors that could pose a danger to applicant or others? _____

Criminal Behavior: (Please list any arrests and/or convictions.) _____

Self-Mutilating Behavior: (Please give specific examples.) _____

Please add a psychosocial and most recent master treatment plan with referral application.

I certify that the foregoing information is correct and complete to the best of my knowledge, and will notify coordinators of any significant changes.

_____	_____	_____	_____
Name	Title	Signature	Date

Conservator of Person (if applicable) :

_____	_____	_____	_____
Name	Title	Signature	Date

DO NOT COMPLETE THIS SECTION:

Date Received: _____ Date Distributed: _____ Location: _____

Eligible: ☐ Not Eligible: ☐ (State Reasons): _____

Authorized By:

_____	_____	_____
Name	Signature	Date

Please Return

Vocational Referrals to :

Glenn Woods
Managed Services Division
Capital Region Mental Health Center
500 Vine Street
Hartford, CT 06112
Phone: 297-0847
Fax: 297-0930