



Mary's Place
1301 West State Street, Annex
Trenton, New Jersey 08618
609.394.3337 (Phone)
609. 394.7876 (Fax)
Website: www.lifetiesinc.org

Scattered Site Supportive Housing Program for "aging-out" males and females 18-21 years old

Note: Please answer every question. If any question does not apply, please write "N.A."

REFERRAL FORM

Date:		KC/SPIRIT#:	
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Applicant Name:			
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Date of Birth:		Age Now:	
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CURRENT PLACEMENT:

Address:	City/State:		Zip code:	
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Home Phone: ()			
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Cell Phone: ()	E-mail Address:		
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Where does applicant currently reside?

- | | |
|--|---|
| <input type="checkbox"/> Group Home | <input type="checkbox"/> Transitional Housing |
| <input type="checkbox"/> In Foster Care | <input type="checkbox"/> Shelter |
| <input type="checkbox"/> Living with Relatives/Friends | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Residential Center | <input type="checkbox"/> Other: _____ |

EDUCATION/EMPLOYMENT

Does applicant have a high school diploma or GED? Yes No

Is applicant currently attending school/college? Yes No

If yes, specify name and location of school and current grade/year below:

If no, specify last school attended, last grade completed, and reason for leaving school below:

Is applicant currently participating in a training program? Yes No

If yes, specify name and location of program, status and anticipated completion date below:

Please indicate applicant's current employment status below:

- | | |
|---|---|
| <input type="checkbox"/> Full-Time Job (35+ hours/week) | <input type="checkbox"/> previously employed, job searching |
| <input type="checkbox"/> Part-Time Job | <input type="checkbox"/> Never employed, job searching |
| <input type="checkbox"/> Stipend Job | <input type="checkbox"/> Not employed |

If employed, please complete the following below:

Name of Employer:

Address:

Position/Title:

Duties/ Responsibilities:

Hourly pay rate:

Weekly Schedule:

MENTAL HEALTH

Is this applicant receiving any type of mental health services? Yes No If yes, please indicate type below:

Individual therapy Group therapy

Family therapy School-based services (specify) _____

Has applicant ever had a psychological or psychiatric evaluation? Yes No

If yes, specify dates, name and location of facility/mental health professional, and reasons below:

Has applicant ever required psychiatric treatment or hospitalization? Yes No

If yes, specify date(s), name and location of facility, reason for each hospitalization below:

Indicate any mental health/psychiatric diagnoses for this applicant including date of diagnosis and current status:

BEHAVIOR ISSUES

Please indicate current and/or past problem behaviors for this applicant:

	Current	Past	Explain
Aggressive/violence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fire setting/arson	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gang involvement or affiliation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self-mutilation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexual acting-out	<input type="checkbox"/>	<input type="checkbox"/>	_____
Substance use	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suicidal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other dangerous or acting-out behaviors (specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

HEALTH

Is this applicant pregnant or parenting? Yes No Not Applicable

Does this applicant have any current health issues? Yes No

If yes, explain:

Does this applicant currently have medical insurance? Yes No If No, please explain below:

Is this applicant currently taking prescribed medication(s)? Yes No

If yes, indicate:

Medication(s):	Dosage	Reason for Taking Medication:
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1.

2.

3.

4.

5.

6.

7.

Is this applicant currently receiving any type of substance abuse/addiction services? Yes No

If yes, please indicate type:

- detox
- outpatient
- individual therapy
- group therapy
- 12-step or other self-help support group
- other (specify) _____

LEGAL

Has applicant:

If yes, explain:

Been incarcerated Yes No _____

Been convicted of or pled guilty to an offense Yes No _____

Had past police involvement Yes No _____

Have pending charges Yes No _____

On probation Yes No _____

U.S. citizen or legal citizenship status in U.S. Yes No _____

OTHER SERVICES

Does this applicant have a mentor? Yes No If yes, please provide contact information below:

Name of mentor:

Contact Number:

Name of organization:

Is this applicant receiving services from any other organizations or professionals not previously listed?

If yes, please explain:

Referring Agency Information:

Please check the appropriate box and complete the information below:

DCF (Department of Children and Families) Other Rainbow House Triad House T.I.L.T.

Case Worker:

Phone # ()

Ext:

Email Address:

Worker's Supervisor Name:

Phone # ()

Ext.

Address:

Please note: As part of the referral we may request:

- ___ *Recent Psychiatric Evaluation*
- ___ *Strength & Needs Assessment*
- ___ *Progress Report for present placement*
- ___ *Educational Reports (or IEP)*
- ___ *Recent Physical*

- ___ *Recent Psychological Evaluation*
- ___ *Sex Abuse/Offender Evaluation (if applies)*
- ___ *Discharge Summary*
- ___ *Criminal History (if applies)*
- ___ *Recent TB results*