Triple C Housing
Your Journey Starts Here
Care. Community. Choice.

SERVICES REFERRAL FORM

Services Overview: Triple C Housing, Inc. provides comprehensive, supportive services to individuals in recovery of severe and persistent mental illness, co-occurring conditions, and at risk or experiencing homelessness.

Date of Referral:			
Name of Person Being Referred:		**DOB:**	
Contact # of Person Referred:			
Insurance :	☐Medicaid ☐Medicare ☐Other: _____		

The questions below should be answered by the individual being referred.

1. Please indicate your reasons for seeking supportive services and your individual needs?			
2. Please indicate what you expect/hope to achieve as your short and long term goals?			
3. Please indicate any strengths you have that may help both you, and the Community Support Specialists, manage your individual needs:			
Signature of Individual Referred:		**Date:**	

The questions below should be answered by the referring provider.

<u>Eligibility Criteria and Considerations for Enrollment</u>

The person being referred,

1. Is a resident of New Jersey? ☐Yes ☐No County of Last Known Residence: _____
2. Is 18 years or older? ☐Yes ☐No
3. Is in stable physical health (including not in need of inpatient detoxification services)? ☐Yes ☐No
4. Has the ability to manage his/her own medication independently, if he/she chooses to take medications? ☐Yes ☐No ☐N/A
5. Is a voluntary enrollee? ☐Yes ☐No

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The person being referred, (cont'd)

6. Does not have a history of violence within the last 30 days per program guidelines (Individuals with a history of violence within the last 30 days may still be considered on a case-by-case basis) ☐Yes ☐No
7. Has a diagnosis of serious mental illness or probable diagnosis of a serious mental illness ☐Yes ☐No

Comments: _____

_____

_____

Please confirm the person does not meet the below criteria.

1. The person being referred is at imminent risk to themselves or others? ☐Yes ☐No
2. Has a diagnosis of dementia, organic brain disorder or traumatic brain injury (TBI)? ☐Yes ☐No
3. Is unable to navigate a flight of stairs? ☐Yes ☐No

With my signature below, I attest that the individual being referred meets the indicated enrollment criteria, and would benefit from supportive services.

Provider Name:		Signature:		Date:	
License Number:		Relationship:			
Email:		Phone:		Fax:	

***While not required for referral, any additional documents such as the certification of disability and certification/affidavit of homelessness may be sent with this referral form and are appreciated.*

***We cannot process referrals unless there is a program vacancy for which you qualify.*

***All referrals are not an automatic admission to services and/or programs. Further review and an eligibility determination are required.*

Thank you for your referral.