**1520 Route 130 North, Ste 201**
**North Brunswick, NJ 08902**
Phone: (732) 297-5840
Fax: (732) 297-5851

# COMMUNITY SUPPORT SERVICES
# REFERRAL FORM

Triple C Housing, Inc. provides comprehensive, supportive services to individuals in recovery of severe and persistent mental illness, co-occurring conditions, and are in need of ongoing supports to maximize independence in the community.

Applicant Name: ______________________________ Date: __________

Referring Agency: ______________________________

Agency Contact Person: ______________________ and telephone #: ______________

Applicant's Current Address: ______________________________

City: __________________ State: __________ Zip Code: ____________

Phone #(s): __________________ Email: ____________________

Social Security #: _____-______-__________ Date of Birth: ______/______/__________

Health Insurance Type: ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Uninsured

If Medicaid, please provide the member ID number: ______________________

Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

US Citizen/ Legal Permanent Resident? ☐ *Yes* ☐ *No*

Serious Mental Illness verified by psychiatric assessment: ☐ *Yes* ☐ *No*

**VERIFICATION OF DISABILITY, BIRTH CERTIFICATE / PROOF OF LEGAL US RESIDENCY, VALID PHOTO IDENTIFICATION, AND SOCIAL SECURITY CARD MUST BE INCLUDED OR APPLICATION WILL NOT BE PROCESSED.**

| **Where is the applicant living this week?** | | |
|---|---|---|
| ☐ *Own Apartment* | ☐ *Living with Family* | ☐ *Couch Surfing* |
| ☐ *Rooming House* | ☐ *Boarding Home* | ☐ *Hotel/Motel* |
| ☐ *Shelter* | ☐ *Car* | ☐ *Street* |
| ☐ *Building not for habitation* | ☐ *Other*: | |
| | | |
| Facing Eviction : | ☐ *Yes* ☐ *No* | *If yes, pending eviction date:* |

| **Service Enrollment Questions** | | |
|---|---|---|
| Currently enrolled in any of the following services: | ☐ *PACT* ☐ *ICMS* ☐ *RIST* ☐ *CSS*<br><br>☐ *Other (please describe)* ______________________ | |
| Currently attending any of the following kinds of treatment:<br>*(please check all that apply)* | ☐ *Partial Care Program* ☐ *Outpatient Program*<br>☐ *Independent Counseling* ☐ *Private Psychiatrist*<br>☐ *IOP*<br><br>*Other (please describe)* ☐ ______________________ | |
| Employed | ☐*Yes* ☐*No* | ☐ *Full Time* ☐ *Part Time* ☐ *Volunteer* |
| Full-time Student | ☐*Yes* ☐*No* | |
| | | |
| | | |
| | | |
| | | |

Please tell us in your own words about your need for Supportive Services: ______________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

I certify that the information I have provided is true to the best of my knowledge.

**PRINT NAME**:______________________________________________

**APPLICANT SIGNATURE** :______________________________________________

**DATE**: ______________________

## DETERMINATION OF ELIGIBILITY AUTHORIZATION RELEASE FORM

Company: Triple C Housing, Inc.

Report Choice: (please check)

Medicaid Eligibility____________ Criminal ____________

Please indicate purpose of request: Supportive Service Application

For office use only

**APPLICANT – PLEASE PRINT CLEARLY**

Date: ________________________

**A COPY OF BIRTH CERTIFICATE AND SOCIAL SECURITY CARD MUST BE INCLUDED OR APPLICATION WILL NOT BE PROCESSED**

Last Name (print)______________________________ First ________________________ M.I.___________

Social Security Number ________________________ Date of Birth ______________________________

Present Address: ____________________________________________________________________________

City ___________ State__________ Zip Code ____________________

Home Phone ________________________ Cell Phone ______________________________________

Emergency Contact Person & Phone # ________________________________________________________

I understand that in conjunction with my application for supportive services, Triple C Housing, Inc. may use the services of an outside agency to research and verify the information I have provided on my application for supportive services including my personal background, character and previous addresses. I hereby authorize Triple C Housing, Inc. to verify any information provided by me in this application and any supplemental attachments, including but not limited to: criminal conviction record, current and former employers and residential addresses and I agree, authorize and consent to the release and disclosure of any and all information including but not limited to the above to Triple C Housing, Inc. and/or any eligibility screening service they engage. I understand that the procurement of such report may contain information as to my background, mode of living, character and personal reputation. I hereby release Triple C Housing, Inc. from any liability.

By signing below, I authorize that the above information is correct and complete and authorize Triple C Housing, Inc. to obtain information it deems desirable in the processing of my application as stated above. I also understand that the information on this form may be maintained in a participant database for up to 5 (five) years after I terminate services.

Print Name: ________________________________________________

Signature:____________________________________________________ Date: _________________

**1520 Route 130 North, Ste 201**
**North Brunswick, NJ 08902**
Phone: (732) 297-5840
Fax: (732) 297-5851

# VERIFICATION OF DISABILITY

Individual Claiming Disability: ____________________________________________

The above-named person is applying for participation in Community Support Services Expansion Program operated by Triple C Housing. To determine the applicant's eligibility, we must verify that he/she is disabled as defined by the program regulations which are as follows:

A person with a mental or emotional impairment that:

1. Is expected to be of long continued and indefinite duration; and
2. Substantially impedes his or her ability to live independently; and
3. Is of such a nature that such ability could be improved by ongoing supportive services.

CERTIFICATION OF DISABILITY

I certify that the above referenced person is disabled according to the above definition(s) I have indicated. Please describe the person's condition and include the appropriate ICD Code (F Code):

**1.** ________________________________________

**2.** ________________________________________

**3.** ________________________________________

Estimated duration that disability will continue: ________________________________

APN/Physician Name: ____________________________________________

APN/Physician License Number: ________________________________

Address:____________________________________________

____________________________________________

Telephone Number: ____________________________________________

APN/Physician Signature:______________________________ Date:__________________

APN/Physician Name Printed: ____________________________________________