# PATHWAY HOME™ REFERRAL PACKAGE:

*Facilitating a seamless transition*

Referral Agency/ Program: _____

Referring Worker's Name: _____

Contact Phone: _____ E-mail: _____

Other Alternative 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), 55 Broadway, New York, NY 10006, 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 |
|---|---|---|

**Applicant Name:** _____ **DOB:** _____

**Gender:** ☐ Male ☐ Female ☐ Transgender ☐ Other _____

**Insurance Type and #:** _____ **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: _____

**Alternative Emergency Contact(s):**

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

**Planned/Current type of housing:**

☐Independent (alone)

☐ Independent (with family/friend)

☐ NYS-Operated Transitional Residence (TLR/SOCR)

☐Community Care/Level I (Supported Housing/Supported SRO)

☐Level II (CR/SRO, Apartment Treatment, MICA Residence)

☐ MICA - Community Residential Services

☐ Emergency Shelter/Homeless

☐ Other: _____

Address (Post-Discharge): _____

Residence Name (if applicable): _____

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

_____

Applicant Phone Number(s): _____

**Please list all (including current) behavioral health hospitalizations/ED visits, rehab/detox, and arrest/ incarcerations within the last two years.**

| Hospital/ER/Arrest/Incarceration/Detox/Rehab: | Admission Date: | Discharge Date (if currently inpatient, expected discharge date): | Source of Data: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Outpatient Behavioral Health Clinic / PROS / PHP / Health Home/ ACT Team:**

| Provider/Clinic Name: | Address: | Contact Info (Telephone/Email): |
|---|---|---|
| | | |
| | | |
| | | |

**Please list all Behavioral Health Diagnoses:**

1. _____ 2. _____

Current Psychotropic Medications:

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

List all Medical Disorders:

1. _____ 2. _____

Current Medications for Physical Conditions:

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

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

- ☐ None
- ☐ Drug or alcohol use
- ☐ Cognitive disorder
- ☐ Intellectual disability or developmental disorder
- ☐ Blindness
- ☐ Impaired ability to walk
- ☐ Tobacco
- ☐ Wheelchair required
- ☐ Hearing Impairment
- ☐ Speech Impairment
- ☐ Visual Impairment
- ☐ Deaf
- ☐ Bedridden
- ☐ Amputee
- ☐ Incontinence
- ☐ Other (specify): _____

History of Suicide Attempts, Suicidal Ideation, and/or Self-Harm Behaviors? ☐ Yes ☐ No

If **Yes**, please elaborate and/or attach additional documentation: _____

_____

History of Aggressive, Threatening, or Violent Behaviors? ☐ Yes ☐ No

If **Yes**, please elaborate and/or attach additional documentation: _____

_____

History of criminal justice involvement? ☐ Yes ☐ No

If **YES**, please elaborate and/or attach additional documentation: _____

_____

History of substance use? ☐ Yes ☐ No

If **YES**: Substance(s) of choice: _____

Amount of sober time: _____

Please comment below on any of the above sections.

_____

**Please ensure all items below are included in package:**

- ☐ Pathway Home™ referral form
- ☐ Current psychosocial assessment & psychiatric evaluation
- ☐ PSYCKES summary with High Utilizer/Flags (If available)
- ☐ Available information on hospitalizations/emergency room visits, rehab/detox, and incarcerations within the last two years (including current).

**Provide complete Discharge Summary prior to hospital discharge (when available).**

**Documentation should be e-mailed to PathwayHomeInfo@cbcare.org or faxed to (877) 418-5421**