Janus Program Referral Form

Applicant Information: Referral Date: _____

Name: _____ Date of Birth: _____

Social Security Number: _____ County MC ID: _____

Are you a resident of Allegheny County? Yes ____ No ____ If no, what county? _____

Last known Address:

_____

_____

Phone: _____ Email: _____

Demographics:

Race/Ethnicity: _____

Highest Level of Education Completed: _____

Current Source of Income: _____ Amount: _____

Current or Last Employment: _____

Start Date: _____ End Date: _____

Veteran Status: _____ Marital Status: _____

Insurance/Benefits:

Do you currently have health insurance (select one)? Yes _____ No _____ Unsure_____

If yes, which type of insurance (please circle one)?

Medicaid Medicare Employer Provided Other

Insurance Provider: _____ Member ID# (if applicable): _____

Do you receive SNAP benefits? Yes_____ No _____ If yes, please provide amount: $_____

Mental Health History:

Have you ever been diagnosed with a mental illness: Yes____ No____

What is your diagnosis/diagnoses (if known)?

_____

_____

Are you currently receiving support/treatment for mental illness? Yes ___ No___

Are you currently receiving support/treatment for substance use? Yes ___ No___

Please list any past/current mental health providers (including drug & alcohol, if applicable).

_____

_____

_____

_____

Please list any hospitalizations in and outside of Allegheny County and/ or state.

_____

_____

_____

_____

Are you currently receiving Blended Service Coordination services (BSC)?

Yes _____ (please provide contact information below) No _____

Agency: _____

Name: _____

Address: _____

Phone: _____ Email: _____

Are you currently receiving Mobile Psychiatric Rehabilitation services (MPR)?

Yes _____ (please provide contact information below) No _____

Agency: _____

Name: _____

Address: _____

Phone: _____ Email: _____

Functional Assessment:

For each area, please rate on a scale of 0-5 the level of assistance the applicant needs or desires. Please identify the change that the applicant wishes to make in that domain, if any.

0-	Needs no assistance (or has no interest)	1-	Needs minimal assistance	2-	Needs some assistance
3-	Needs moderate assistance	4-	Needs substantial assistance	5-	Needs extensive assistance

Scale: Domain: Describe Needs/goals in each domain:

_____ Living/Self Maintenance: _____

_____ Learning: _____

_____ Working: _____

_____ Socializing: _____

_____ Wellness: _____

Legal Information:

Have you ever been convicted of any charges (including summary, misdemeanor and/or felony?

Yes _____ No _____ Unsure _____

If so, please provide what charges and when:

_____
_____
_____

Do you have any pending cases or charges? Yes _____ No _____ Unsure _____

If so, please provide what charges and upcoming court dates:

_____
_____
_____

Are you currently on probation or parole? Yes _____ No _____ Unsure _____

If yes, please provide parole or probation officer's contact information:

Name: _____

Address: _____

Phone: _____ Email: _____

Medical Information:

Name of PCP: _____

Address: _____

Phone: _____

Smoking Status: _____ Frequency/Amount (if applicable): _____

Housing History:

Current Living Arrangements:

_____

_____

Do you have a Section 8 voucher? Yes___ No___

Are you on the Section 8 waiting list? Yes___ No___

Have you ever been evicted? Yes _____ No _____ Unsure _____

If yes, please provide the date(s): _____

_____

Do you have any past due balances for utilities? Yes _____ No _____ Unsure _____

If yes, please provide provider and amount owed: _____

_____

Please list any concerns or barriers to obtaining and maintaining housing:

_____

_____

_____

_____

Referral Source:

Agency: _____

Name: _____

Address: _____

_____

_____

Email: _____ Phone: _____

Note: In accordance with Pennsylvania guidelines and regulations for Psychiatric Rehabilitation Services, this recommendation must be signed by a "physician for licensed practitioner of the health arts (LPHA) acting within the scope of professional practice." **Persons who are considered to be an LPHA currently only include Medical Doctor (MD, OD) Certified Registered Nurse Practitioners (CRNP), Physician's Assistants (PA), Licensed Psychologist, Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW).**

Reason for Recommendation (How will this individual benefit from Mobile Psychiatric Rehabilitation Services?):

_____ _____ _____

Signature of LPHA Title Date

_____ _____

Printed Name of LPHA NPI Number

Applicant Signature:

By signing, I acknowledge and understand that this referral has been discussed with me, and I authorize consideration for the program.

Applicant Signature: _____ Date: _____

Please return completed referral to jwebb@chartierscenter.org or fax to 412-752-7562